DIVISION BB—PRIVATE HEALTH INSURANCE AND PUBLIC HEALTH PROVISIONS

SEC. 1. TABLE OF CONTENTS.

The table of contents of the division is as follows:

TITLE I—NO SURPRISES ACT

SEC. 101. SHORT TITLE.

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

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

(a) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—

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

"PART D—ADDITIONAL COVERAGE PROVISIONS

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

''(a) COVERAGE OF EMERGENCY SERVICES.—

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

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

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

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

''(i) such services will be provided without imposing any requirement under the plan or coverage for prior authorization of services or any limitation on cov-

erage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities with respect to such plan or coverage, respectively;

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

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

''(iv) the group health plan or health insurance issuer, respectively—

''(I) not later than 30 calendar days after the bill for such services is transmitted by such provider or facility, sends to the provider or facility,

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

''(II) pays a total plan or coverage payment directly to such provider or facility, respectively (in accordance, if applicable, with the timing requirement described in subsection (c)(6)) that is, with application of any initial payment under subclause (I), equal to the amount by which the out-of-network rate (as defined in paragraph (3)(K)) for such services exceeds the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii)) and year; and

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

cost-sharing payments were made with respect to emergency services furnished by a participating provider or a participating emergency facility; and

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

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

''(A) AUDIT PROCESS.—

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

or applicable State authority to ensure that—

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

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

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

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

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

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

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

''(i) the methodology the group health plan or health insurance issuer offering group or individual health insurance coverage shall use to determine the qualifying

payment amount, differentiating by individual market, large group market, and small group market;

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

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

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

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

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

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

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

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

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

''(C) EMERGENCY SERVICES.—

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

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

''(II) within the capabilities of the staff and facilities available at the hospital or the independent free-

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

''(ii) INCLUSION OF ADDITIONAL SERVICES.—

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

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

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

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

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

nished additional items and services described in subclause (I) after such stabilization by a provider or facility described in subclause (I), are the following;

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

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

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

tion, in accordance with applicable State law.

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

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

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

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

''(E) QUALIFYING PAYMENT AMOUNT.—

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

"(I) for an item or service furnished during 2022, the median of the contracted rates recognized by the plan or issuer, respectively (determined with respect to all such plans of such sponsor or all such coverage offered by such issuer that are offered within the same insurance market (specified in subclause (I), (II), (III), or (IV) of clause (iv)) as the plan or coverage) as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by the plan or issuer, respectively) under such plans or coverage, respectively, on January 31, 2019, for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established by the Secretary under paragraph (2)(B), increased by the percentage increase in

the consumer price index for all urban consumers (United States city average) over 2019, such percentage increase over 2020, and such percentage increase over 2021; and

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

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

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

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

''(iii) INSUFFICIENT INFORMATION; NEWLY COVERED ITEMS AND SERVICES.—

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

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

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

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

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

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

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

such item or service, the reference to 'furnished during 2023 or a subsequent year' shall be treated as a reference to furnished during the year after such first sufficient information year or a subsequent year.

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

''(I) The individual market.

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

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

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

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

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

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

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

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

calculate the median of such contracted rates in the year previous to such first subsequent year; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

coverage offered by a health insurance issuer, a State law that provides for a method for determining the total amount payable under such a plan, coverage, or issuer, respectively (to the extent such State law applies to such plan, coverage, or issuer, subject to section 514 of the Employee Retirement Income Security Act of 1974) in the case of a participant, beneficiary, or enrollee covered under such plan or coverage and receiving such item or service from such a nonparticipating provider or nonparticipating emergency facility.

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

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

from a nonparticipating provider or nonparticipating emergency facility—

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

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

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

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

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

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

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

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

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

''(A) shall not impose on such participant, beneficiary, or enrollee a cost-sharing requirement for such items and services so furnished that is greater than the cost-sharing requirement that would apply under such plan or coverage, respectively, had such items or services

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

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

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

''(D) shall pay a total plan or coverage payment directly, in accordance, if applicable,with the timing requirement described in subsection (c)(6), to such provider furnishing such items and services to such participant, beneficiary, or enrollee that is, with application of any initial payment under subparagraph (C), equal to the amount by which the out-of-network rate (as defined in subsection (a)(3)(K)) for such items and services involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such items and serv-

ices (as determined in accordance with subparagraphs (A) and (B)) and year; and

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

''(2) DEFINITIONS.—In this section:

''(A) PARTICIPATING HEALTH CARE FACILITY.—

''(i) IN GENERAL.—The term 'participating health care facility' means, with respect to an item or service and a group health plan or health insurance issuer offering group or individual health insurance coverage, a health care facility described in clause (ii) that has a direct or indirect contractual relationship with the plan or issuer, respectively, with respect to the fur-

nishing of such an item or service at the facility.

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

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

''(II) A hospital outpatient department.

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

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

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

''(B) VISIT.—The term 'visit' shall, with respect to items and services furnished to an in-

dividual at a health care facility, include equipment and devices, telemedicine services, imaging services, laboratory services, preoperative and postoperative services, and such other items and services as the Secretary may specify, regardless of whether or not the provider furnishing such items or services is at the facility.

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

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

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

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

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

''(b) ACCESS TO PEDIATRIC CARE.—

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

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

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

''(1) GENERAL RIGHTS.—

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

''(B) OBSTETRICAL AND GYNECOLOGICAL CARE.—A group health plan or health insurance issuer described in paragraph (2) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pur-

suant to the direct access described under subparagraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

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

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

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

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

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

''(B) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider

notify the primary care health care professional or the plan or issuer of treatment decisions.''.

(3) CONFORMING AMENDMENTS.—

(A) Section 2719A of the Public Health Service Act (42 U.S.C. 300gg–19a) is amended by adding at the end the following new subsection:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) in subsection (a)(1)—

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

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

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

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

(b) ERISA AMENDMENTS.—

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

''SEC. 716. PREVENTING SURPRISE MEDICAL BILLS.

''(a) COVERAGE OF EMERGENCY SERVICES.—

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

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

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

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

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

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

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

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

''(iv) the group health plan or health insurance issuer, respectively—

''(I) not later than 30 calendar days after the bill for such services is transmitted by such provider or facility, sends to the provider or facility, as applicable, an initial payment or notice of denial of payment; and

''(II) pays a total plan or coverage payment directly to such provider or facility, respectively (in accordance, if applicable, with the timing requirement described in subsection (c)(6)) that is, with application of any initial payment under subclause (I), equal to the amount by which the out-of-network rate (as defined in paragraph (3)(K)) for such services exceeds the cost-sharing

amount for such services (as determined in accordance with clauses (ii) and (iii)) and year; and

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

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

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

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

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

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

"(D) a process to receive complaints of violations of the requirements described in subclauses (I) and (II) of subparagraph (A)(i) by group health plans and health insurance issuers

offering health insurance coverage in the group market.

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

''(3) DEFINITIONS.—In this subpart:

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

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

''(C) EMERGENCY SERVICES.—

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

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

applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

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

''(ii) INCLUSION OF ADDITIONAL SERVICES.—

''(I) IN GENERAL.—For purposes of this subsection and section 2799B–1 of the Public Health Service Act, in the case of a participant or beneficiary who is enrolled in a group

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

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

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

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

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

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

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

''(cc) Such individual is in a condition to receive (as deter-

mined in accordance with guidelines issued by the Secretary pursuant to rulemaking) the information described in section 2799B–2 and to provide informed consent under such section, in accordance with applicable State law.

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

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

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

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

''(E) QUALIFYING PAYMENT AMOUNT.—

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

"(I) for an item or service furnished during 2022, the median of the contracted rates recognized by the plan or issuer, respectively (determined with respect to all such plans of such sponsor or all such coverage offered by such issuer that are offered within the same insurance market (specified in subclause (I), (II), or (III) of clause (iv)) as the plan or coverage) as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by the plan or issuer, respectively) under such plans or coverage, respectively, on January 31, 2019, for the same or a similar item or service that is provided by a provider in the same or similar spe-

cialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established by the Secretary under paragraph (2), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, such percentage increase over 2020, and such percentage increase over 2021; and

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

''(ii) NEW PLANS AND COVERAGE.—The term 'qualifying payment amount' means, with respect to a sponsor of a group health plan or health insurance

issuer offering group health insurance coverage in a geographic region in which such sponsor or issuer, respectively, did not offer any group health plan or health insurance coverage during 2019—

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

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

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

"(I) for an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for such item or service with respect to such

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

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

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

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

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

such item or service, the reference to 'furnished during 2023 or a subsequent year' shall be treated as a reference to furnished during the year after such first sufficient information year or a subsequent year.

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

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

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

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

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

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

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

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

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

to such first subsequent year; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(I) subject to subclause (II), if the provider or facility (as applicable) and such plan or coverage agree on an amount of payment (including if such agreed on amount is the initial payment sent by the plan under subsection (a)(1)(C)(iv)(I), subsection (b)(1)(C), or section 717(a)(3)(A), as applicable, or is agreed on through open negotiations under subsection (c)(1)) with respect to such item or service, such agreed on amount; or

''(II) if such provider or facility (as applicable) and such plan or coverage enter the independent dispute resolution process under subsection

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

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

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

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

''(1) IN GENERAL.—In the case of items or services (other than emergency services to which subsection (a) applies) for which any benefits are provided or covered by a group health plan or health insurance issuer offering group health insurance coverage furnished to a participant or beneficiary of

such plan or coverage by a nonparticipating provider (as defined in subsection (a)(3)(G)(i)) (and who, with respect to such items and services, has not satisfied the notice and consent criteria of section 2799B–2(d) of the Public Health Service Act) with respect to a visit (as defined by the Secretary in accordance with paragraph (2)(B)) at a participating health care facility (as defined in paragraph (2)(A)), with respect to such plan or coverage, respectively, the plan or coverage, respectively—

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

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

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

''(D) shall pay a total plan or coverage payment directly, in accordance, if applicable, with the timing requirement described in subsection (c)(6), to such provider furnishing such items and services to such participant or beneficiary that is, with application of any initial payment under subparagraph (C), equal to the amount by which the out-of-network rate (as defined in subsection (a)(3)(K)) for such items and services exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such items and services (as determined in accordance with subparagraphs (A) and (B)) and year; and

''(E) shall count toward any in-network deductible and in-network out-of-pocket maximums (as applicable) applied under the plan or coverage, respectively, any cost-sharing payments made by the participant or beneficiary (and such in-network deductible and out-of-pocket maximums shall be applied) with respect

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

''(2) DEFINITIONS.—In this section:

''(A) PARTICIPATING HEALTH CARE FACILITY.—

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

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

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

"(II) A hospital outpatient department.

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

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

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

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

"(c) CERTAIN ACCESS FEES TO CERTAIN DATABASES.—In the case of a sponsor of a group health plan or health insurance issuer offering group health insurance

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

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

''SEC. 722. OTHER PATIENT PROTECTIONS.

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

''(b) ACCESS TO PEDIATRIC CARE.—

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

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

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

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

''(1) GENERAL RIGHTS.—

''(A) DIRECT ACCESS.—A group health plan, or health insurance issuer offering group health insurance coverage, described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant 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 or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

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

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

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

''(B) requires the designation by a participant 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 or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

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

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

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

(c) IRC AMENDMENTS.—

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

''SEC. 9816. PREVENTING SURPRISE MEDICAL BILLS.

''(a) COVERAGE OF EMERGENCY SERVICES.—

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

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

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

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

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

participating emergency facilities with respect to such plan;

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

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

''(iv) the group health plan—

''(I) not later than 30 calendar days after the bill for such services is transmitted by such provider or facility, sends to the provider or facility, as applicable, an initial payment or notice of denial of payment; and

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

ble, with the timing requirement described in subsection (c)(6)) that is, with application of any initial payment under subclause (I), equal to the amount by which the out-of-network rate (as defined in paragraph (3)(K)) for such services exceeds the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii)) and year; and

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

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

waiting period, permitted under section 2704 of the Public Health Service Act, including as incorporated pursuant to section 715 of the Employee Retirement Income Security Act of 1974 and section 9815 of this Act, and other than applicable cost-sharing).

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

''(A) AUDIT PROCESS.—

''(i) IN GENERAL.—Not later than October 1, 2021, the Secretary, in consultation with the Secretary of Health and Human Services and the Secretary of Labor, shall establish through rulemaking a process, in accordance with clause (ii), under which group health plans are audited by the Secretary or applicable State authority to ensure that—

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

''(II) such qualifying payment amount so applied satisfies the definition under paragraph (3)(E) with re-

spect to the year involved, including with respect to a group health plan described in clause (ii) of such paragraph (3)(E).

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

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

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

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

were conducted during such year pursuant to this subparagraph.

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

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

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

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

''(iv) a process to receive complaints of violations of the requirements described

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

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

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

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

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

''(C) EMERGENCY SERVICES.—

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

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

applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

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

''(ii) INCLUSION OF ADDITIONAL SERVICES.—

''(I) IN GENERAL.—For purposes of this subsection and section 2799B–1 of the Public Health Service Act, in the case of a participant or beneficiary who is enrolled in a group

health plan and who is furnished services described in clause (i) with respect to an emergency medical condition, the term 'emergency services' shall include, unless each of the conditions described in subclause (II) are met, in addition to the items and services described in clause (i), items and services—

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

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

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

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

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

"(cc) Such individual is in a condition to receive (as determined in accordance with guidelines issued by the Secretary pursuant to rulemaking) the infor-

mation described in section 2799B–2 and to provide informed consent under such section, in accordance with applicable State law.

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

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

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

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

''(E) QUALIFYING PAYMENT AMOUNT.—

''(i) IN GENERAL.—The term 'qualifying payment amount' means, subject to

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

"(I) for an item or service furnished during 2022, the median of the contracted rates recognized by the plan (determined with respect to all such plans of such sponsor that are offered within the same insurance market (specified in subclause (I), (II), or (III) of clause (iv)) as the plan) as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by the plan) under such plans on January 31, 2019 for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established by the Secretary under paragraph (2)(B), increased by the percentage increase in the consumer price index for all urban con-

sumers (United States city average) over 2019, such percentage increase over 2020, and such percentage increase over 2021; and

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

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

''(I) for the first year in which such group health plan is offered in such region, a rate (determined in accordance with a methodology estab-

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

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

"(iii) INSUFFICIENT INFORMATION; NEWLY COVERED ITEMS AND SERVICES.—In the case of a sponsor of a group health plan that does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019 (or, in the case of a newly covered item or service (as defined in clause (v)(III)), in the first coverage year (as defined in clause (v)(I)) for such item or service with respect to such plan) for an

item or service (including with respect to provider type, or amount, of claims for items or services (as determined by the Secretary) provided in a particular geographic region (other than in a case with respect to which clause (ii) applies)) the term 'qualifying payment amount'—

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

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

''(III) for an item or service furnished in the first sufficient information year for such item or service with respect to such plan, has the meaning given the term qualifying payment amount in clause (i)(I), except that in applying such clause to such item or service, the reference to 'furnished during 2022' shall be treated as a reference to furnished during such first sufficient information year, the ref-

erence to 'on January 31, 2019' shall be treated as a reference to in such sufficient information year, and the increase described in such clause shall not be applied; and

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

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

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

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

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

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

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

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

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

tracted rates described in clause (i)(I) in 2019, the first year subsequent to 2022 for which such sponsor has such sufficient information to calculate the median of such contracted rates in the year previous to such first subsequent year; and

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

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

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

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

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

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

"(G) NONPARTICIPATING PROVIDERS; PARTICIPATING PROVIDERS.—

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

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

"(H) RECOGNIZED AMOUNT.—The term 'recognized amount' means, with respect to an

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

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

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

''(iii) in the case of such item or service furnished in a State with an All-Payer

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

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

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

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

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

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

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

''(I) subject to subclause (II), if the provider or facility (as applicable) and such plan or coverage agree on an amount of payment (including if such agreed on amount is the initial payment sent by the plan under subsection (a)(1)(C)(iv)(I), subsection (b)(1)(C), or section 9817(a)(3)(A), as applicable, or is agreed on through

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

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

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

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

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

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

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

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

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

"(D) shall pay a total plan payment directly, in accordance, if applicable, with the timing requirement described in subsection (c)(6), to such provider furnishing such items and services to such participant or beneficiary that is, with application of any initial payment under subparagraph (C), equal to the amount by which the out-of-network rate (as defined in subsection (a)(3)(K)) for such items and services exceeds the cost-sharing amount imposed under the plan for such items and services (as determined in accordance with subparagraphs (A) and (B)) and year; and

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

''(2) DEFINITIONS.—In this section:

''(A) PARTICIPATING HEALTH CARE FACILITY.—

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

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

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

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

"(II) A hospital outpatient department.

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

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

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

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

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

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

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

''SEC. 9822. OTHER PATIENT PROTECTIONS.

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

''(b) ACCESS TO PEDIATRIC CARE.—

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

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

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

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

''(1) GENERAL RIGHTS.—

''(A) DIRECT ACCESS.—A group health plan described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant 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, including procedures regarding re-

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

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

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

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

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

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

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

(4) CONFORMING AMENDMENTS.—

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

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

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

Service Act, or section 716 or 717 of the Employee Retirement Income Security Act of 1974, or any State law providing similar protections to such individual.''; and

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

''(F) SPECIAL RULE FOR SURPRISE BILLING.—A plan shall not fail to be treated as a high deductible health plan by reason of providing benefits for medical care in accordance with section 9816 or 9817, section 2799A–1 or 2799A–2 of the Public Health Service Act, or section 716 or 717 of the Employee Retirement Income Security Act of 1974, or any State law providing similar protections to individuals, prior to the satisfaction of the deductible under paragraph (2)(A)(i).''.

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

(d) ADDITIONAL APPLICATION PROVISIONS.—

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

''(p) Each contract under this chapter shall require the carrier to comply with requirements described in the provisions of sections 2799A–1, 2799A–2, and 2799A–7 of the Public Health Service Act, sections 716, 717, and 722 of the Employee Retirement Income Security Act of 1974, and sections 9816, 9817, and 9822 of the Internal Revenue Code of 1986 (as applicable) in the same manner as such provisions apply to a group health plan or health insurance issuer offering group or individual health insurance coverage, as described in such sections. The provisions of sections 2799B–1, 2799B–2, 2799B–3, and 2799B–5 of the Public Health Service Act shall apply to a health care provider and facility and an air ambulance provider described in such respective sections with respect to an enrollee in a health benefits plan under this chapter in the same manner as such provisions apply to such a provider and facility with respect to an enrollee in a group health plan or group or individual health insurance coverage offered by a health insurance issuer, as described in such sections.''.

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

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

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

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

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

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

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

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

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

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

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

''(1) DETERMINATION THROUGH OPEN NEGOTIATION.—

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

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

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

vider or facility (as applicable) or group health plan or health insurance issuer offering group or individual health insurance coverage that was party to such negotiations may, during the 4-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process under paragraph (2) with respect to such item or service. The independent dispute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the other party and to the Secretary of a notification (containing such information as specified by the Secretary) and for purposes of this subsection, the date of initiation of such process shall be the date of such submission or such other date specified by the Secretary pursuant to regulations that is not later than the date of receipt of such notification by both the other party and the Secretary.

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

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

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

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

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

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

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

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

services are permitted to be considered jointly as part of a single determination by an entity for purposes of encouraging the efficiency (including minimizing costs) of the IDR 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 group health plan or health insurance issuer;

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

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

procedural efficiency and minimize health plan and provider administrative costs.

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

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

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

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

''(ii) is not—

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

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

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

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

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

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

''(vi) does not under the IDR process carry out any determination with respect

to which the entity would not pursuant to subclause (I), (II), or (III) of subparagraph (F)(i) be eligible for selection; and

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

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

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

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

paragraph for failure of meeting a requirement of this subsection.

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

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

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

mination, an entity certified under this paragraph that—

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

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

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

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

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

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

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

''(5) PAYMENT DETERMINATION.—

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

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

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

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

certified IDR entity with respect to a determination for a qualified IDR item or service, the provider or facility and the group health plan or health insurance issuer offering group or individual health insurance coverage party to such determination—

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

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

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

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

''(C) CONSIDERATIONS IN DETERMINATION.—

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

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

"(II) subject to subparagraph (D), information on any circumstance described in clause (ii), such information as requested in subparagraph (B)(i)(II), and any additional information provided in subparagraph (B)(ii).

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

cumstances described in this clause are, with respect to a qualified IDR item or service of a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer of group or individual health insurance coverage the following:

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

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

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

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

participating facility that furnished such item or service.

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

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

ity payable by a public payor, including under the Medicare program under title XVIII of the Social Security Act, under the Medicaid program under title XIX of such Act, under the Children's Health Insurance Program under title XXI of such Act, under the TRICARE program under chapter 55 of title 10, United States Code, or under chapter 17 of title 38, United States Code.

''(E) EFFECTS OF DETERMINATION.—

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

''(I) shall be binding upon the parties involved, in the absence of a fraudulent claim or evidence of misrepresentation of facts presented to the IDR entity involved regarding such claim; and

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

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

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

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

''(iv) REPORTS.—The Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury, shall examine the impact of the application of clause (ii) and whether the application of such clause delays payment determinations or impacts early, alternative resolution of claims (such as through open negotiations), and shall submit to Congress, not later than 2 years after the date of implementation of such clause an interim report (and not later than 4 years after such date of implementation, a final report) on whether any group health plans or health insurance issuers offering group or individual health insurance coverage or types of such plans or coverage have a pattern or practice of

routine denial, low payment, or down-coding of claims, or otherwise abuse the 90-day period described in such clause, including recommendations on ways to discourage such a pattern or practice.

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

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

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

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

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

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

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

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

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

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

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

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

"(vii) the total amount of fees paid under paragraph (8) during such calendar quarter; and

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

"(B) INFORMATION.—For purposes of subparagraph (A), the information described in

this subparagraph is, with respect to a notification under paragraph (1)(B) by a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer offering group or individual health insurance coverage—

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

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

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

''(iv) whether the offer selected by the certified IDR entity under paragraph (5) to be the payment applied was the offer submitted by such plan or issuer (as applicable) or by such provider or facility (as

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

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

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

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

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

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

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

''(D) CLARIFICATION.—The Secretary shall ensure the public reporting under this

paragraph does not contain information that would disclose privileged or confidential information of a group health plan or health insurance issuer offering group or individual health insurance coverage or of a provider or facility.

''(8) ADMINISTRATIVE FEE.—

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

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

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

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

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

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

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

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

''(1) DETERMINATION THROUGH OPEN NEGOTIATION.—

''(A) IN GENERAL.—With respect to an item or service furnished in a year by a nonparticipating provider or a nonparticipating facility, with respect to a group health plan or

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

"(B) ACCESSING INDEPENDENT DISPUTE RESOLUTION PROCESS IN CASE OF FAILED NEGOTIATIONS.—In the case of open negotiations pursuant to subparagraph (A), with respect to an item or service, that do not result in a determination of an amount of payment for such item or service by the last day of the open negotiation period described in such subparagraph with respect to such item or service, the provider or facility (as applicable) or group health plan or health insurance issuer offering group health insurance coverage that was party to such negotiations may, during the 4-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process under paragraph (2) with respect to such item or service. The independent dispute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the other party and to the Secretary of a notification (containing such information as specified by the Secretary) and for purposes of this subsection, the date of initiation of such process shall be the date of such submission or such other date specified by the

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

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

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

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

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

''(C) CLARIFICATION.—A nonparticipating provider may not, with respect to an item or service furnished by such provider, submit a notification under paragraph (1)(B) if such pro-

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

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

''(A) IN GENERAL.—Under the IDR process, the Secretary shall specify criteria under which multiple qualified IDR dispute items and services are permitted to be considered jointly as part of a single determination by an entity for purposes of encouraging the efficiency (including minimizing costs) of the IDR 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 group health plan or health insurance issuer;

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

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

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

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

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

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

''(ii) is not—

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

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

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

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

"(iv) meets appropriate indicators of fiscal integrity;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

business days after such date of initiation—

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

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

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

''(5) PAYMENT DETERMINATION.—

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

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

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

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

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

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

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

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

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

"(C) CONSIDERATIONS IN DETERMINATION.—

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

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

"(II) subject to subparagraph (D), information on any circumstance described in clause (ii), such information as requested in subparagraph (B)(i)(II), and any additional information provided in subparagraph (B)(ii).

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

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

"(II) The market share held by the nonparticipating provider or facil-

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

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

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

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

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

provider or facility, the certified IDR entity with respect to a determination shall not consider usual and customary charges, the amount that would have been billed by such provider or facility with respect to such items and services had the provisions of section 2799B–1 of the Public Health Service Act or 2799B–2 of such Act (as applicable) not applied, or the payment or reimbursement rate for such items and services furnished by such provider or facility payable by a public payor, including under the Medicare program under title XVIII of the Social Security Act, under the Medicaid program under title XIX of such Act, under the Children's Health Insurance Program under title XXI of such Act, under the TRICARE program under chapter 55 of title 10, United States Code, or under chapter 17 of title 38, United States Code.

''(E) EFFECTS OF DETERMINATION.—

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

''(I) shall be binding upon the parties involved, in the absence of a

fraudulent claim or evidence of misrepresentation of facts presented to the IDR entity involved regarding such claim; and

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

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

"(iii) SUBSEQUENT SUBMISSION OF REQUESTS PERMITTED.—In the case of a notification that pursuant to clause (ii) is not permitted to be submitted under paragraph (1)(B) during a 90-day period specified in such clause, if the end of the open negotiation period specified in paragraph (1)(A), that but for this clause would otherwise apply with respect to such notification, occurs during such 90-day period, such paragraph (1)(B) shall be applied as if the reference in such paragraph to the 4-day period beginning on the day after such open negotiation period were instead a reference to the 30-day period beginning on the day after the last day of such 90-day period.

"(iv) REPORTS.—The Secretary, jointly with the Secretary of Health and Human Services and the Secretary of the Treasury, shall examine the impact of the application of clause (ii) and whether the application of such clause delays payment determinations or impacts early, alternative resolution of claims (such as

through open negotiations), and shall submit to Congress, not later than 2 years after the date of implementation of such clause an interim report (and not later than 4 years after such date of implementation, a final report) on whether any group health plans or health insurance issuers offering group or individual health insurance coverage or types of such plans or coverage have a pattern or practice of routine denial, low payment, or down-coding of claims, or otherwise abuse the 90-day period described in such clause, including recommendations on ways to discourage such a pattern or practice.

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

''(i) if such entity makes a determination with respect to such notification under

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

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

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

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

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

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

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

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

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

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

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

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

"(vii) the total amount of fees paid under paragraph (8) during such calendar quarter; and

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

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

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

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

"(iii) the amount of the offer submitted under paragraph (5)(B) by the group health plan or health insurance issuer (as applicable) and by the non-

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

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

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

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

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

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

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

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

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

"(8) ADMINISTRATIVE FEE.—

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

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

''(9) WAIVER AUTHORITY.—The Secretary may modify any deadline or other timing requirement specified under this subsection (other than the establishment date for the IDR process under paragraph (2)(A) and other than under paragraph (6)) in cases of extenuating circumstances, as specified by the Secretary, or to ensure that all claims that occur during a 90-day period described in paragraph (5)(E)(ii), but with respect to which a notification is not permitted by reason of such paragraph to be submitted under paragraph (1)(B) during such period, are eligible for the IDR process.''.

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

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

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

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

"(1) DETERMINATION THROUGH OPEN NEGOTIATION.—

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

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

''(B) ACCESSING INDEPENDENT DISPUTE RESOLUTION PROCESS IN CASE OF FAILED NEGOTIATIONS.—In the case of open negotiations pursuant to subparagraph (A), with respect to an item or service, that do not result in a determination of an amount of payment for such item or service by the last day of the open negotiation period described in such subparagraph with respect to such item or service, the provider or facility (as applicable) or group health plan that was party to such negotiations may, during the 4-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process under paragraph (2) with respect to such item or service. The independent dispute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the

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

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

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

graph (4) determines, subject to subparagraph (B) and in accordance with the succeeding provisions of this subsection, the amount of payment under the plan for such item or service furnished by such provider or facility.

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

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

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

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

group health plan or health insurance issuer;

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

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

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

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

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

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

''(ii) is not—

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

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

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

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

"(iv) meets appropriate indicators of fiscal integrity;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(5) PAYMENT DETERMINATION.—

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

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

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

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

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

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

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

''(ii) may each submit to the certified IDR entity with respect to such determination any information relating to such offer submitted by either party, including infor-

mation relating to any circumstance described in subparagraph (C)(ii).

''(C) CONSIDERATIONS IN DETERMINATION.—

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

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

''(II) subject to subparagraph (D), information on any circumstance described in clause (ii), such information as requested in subparagraph (B)(i)(II), and any additional infor-

mation provided in subparagraph (B)(ii).

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

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

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

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

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

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

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

Act (as applicable) not applied, or the payment or reimbursement rate for such items and services furnished by such provider or facility payable by a public payor, including under the Medicare program under title XVIII of the Social Security Act, under the Medicaid program under title XIX of such Act, under the Children's Health Insurance Program under title XXI of such Act, under the TRICARE program under chapter 55 of title 10, United States Code, or under chapter 17 of title 38, United States Code.

''(E) EFFECTS OF DETERMINATION.—

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

''(I) shall be binding upon the parties involved, in the absence of a fraudulent claim or evidence of misrepresentation of facts presented to the IDR entity involved regarding such claim; and

''(II) shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4)

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

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

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

(1)(A), that but for this clause would otherwise apply with respect to such notification, occurs during such 90-day period, such paragraph (1)(B) shall be applied as if the reference in such paragraph to the 4-day period beginning on the day after such open negotiation period were instead a reference to the 30-day period beginning on the day after the last day of such 90-day period.

''(iv) REPORTS.—The Secretary, jointly with the Secretary of Labor and the Secretary of the Health and Human Services, shall examine the impact of the application of clause (ii) and whether the application of such clause delays payment determinations or impacts early, alternative resolution of claims (such as through open negotiations), and shall submit to Congress, not later than 2 years after the date of implementation of such clause an interim report (and not later than 4 years after such date of implementation, a final report) on whether any group health plans or health insurance issuers offering group or indi-

vidual health insurance coverage or types of such plans or coverage have a pattern or practice of routine denial, low payment, or down-coding of claims, or otherwise abuse the 90-day period described in such clause, including recommendations on ways to discourage such a pattern or practice.

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

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

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

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

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

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

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

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

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

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

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

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

"(vii) the total amount of fees paid under paragraph (8) during such calendar quarter; and

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

"(B) INFORMATION.—For purposes of subparagraph (A), the information described in

this subparagraph is, with respect to a notification under paragraph (1)(B) by a nonparticipating provider, nonparticipating emergency facility, or group health plan—

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

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

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

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

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

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

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

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

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

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

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

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

''(8) ADMINISTRATIVE FEE.—

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

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

''(9) WAIVER AUTHORITY.—The Secretary may modify any deadline or other timing requirement specified under this subsection (other than the establishment date for the IDR process under paragraph (2)(A) and other than under paragraph (6)) in cases of extenuating circumstances, as specified

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

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

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

''PART E—HEALTH CARE PROVIDER REQUIREMENTS

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

''(a) IN GENERAL.—In the case of a participant, beneficiary, or enrollee with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who is furnished during a plan year beginning on or after January 1, 2022, emergency services (for which benefits are provided under the plan or coverage) with respect to an emergency medical condition with respect to a visit at an emergency de-

partment of a hospital or an independent freestanding emergency department—

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

''(2) in the case that such services are furnished by a nonparticipating provider, the health care provider shall not bill, and shall not hold liable, such participant, beneficiary, or enrollee for a payment amount for an emergency service furnished to such individual by such provider with respect to such emergency medical condition and visit for which the individual receives emergency services at the hospital or emergency department that is more than the cost-

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

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

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

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

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

''(b) EXCEPTION.—

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

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

''(A) subject to paragraph (3), items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology,

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

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

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

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

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

''(c) CLARIFICATION.—In the case of a nonparticipating provider that satisfies the notice and consent criteria of subsection (d) with respect to an item or service (referred to in this subsection as a 'covered item or service'), such notice and consent criteria may not be con-

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

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

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

''(A) in the case that the participant, beneficiary, or enrollee makes an appointment to be furnished such items or services at least 72 hours prior to the date on which the individual is to be furnished such items or services, provides to the participant, beneficiary, or enrollee

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

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

''(ii) clearly states that consent to receive such items and services from such nonparticipating provider or nonparticipating facility is optional and that the participant, beneficiary, or enrollee may in-

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

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

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

''(C) provides a signed copy of such consent to the participant, beneficiary, or enrollee through mail or email (as selected by the participant, beneficiary, or enrollee).

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

information described in this paragraph, with respect to a nonparticipating provider or nonparticipating facility and a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, is each of the following:

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

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

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

ficiary, or enrollee may be referred, at their option, to such a participating provider.

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

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

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

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

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

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

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

"(4) RULE OF CONSTRUCTION.—The consent described in paragraph (3), with respect to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, shall constitute only consent to the receipt of the information provided pursuant to this subsection and shall not con-

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

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

''(f) DEFINITIONS.—In this section:

''(1) The terms 'nonparticipating provider' and 'participating provider' have the meanings given such terms, respectively, in subsection (a)(3) of section 2799A–1.

''(2) The term 'participating health care facility' has the meaning given such term in subsection (b)(2) of section 2799A–1.

"(3) The term 'nonparticipating facility' means—

"(A) with respect to emergency services (as defined in section 2799A–1(a)(3)(C)(i)) and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such services under the plan or coverage, respectively; and

"(B) with respect to services described in section 2799A–1(a)(3)(C)(ii) and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a hospital or an independent freestanding emergency department, that does not have a contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such services under the plan or coverage, respectively.

"(4) The term 'participating facility' means—

"(A) with respect to emergency services (as defined in clause (i) of section 2799A–1(a)(3)(C)) that are not described in clause(ii) of such section and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, an emergency department of a hospital, or an independent freestanding emergency department, that has a direct or indirect contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such services under the plan or coverage, respectively; and

"(B) with respect to services that pursuant to clause (ii) of section 2799A–1(a)(3)(C), of section 9816(a)(3) of the Internal Revenue Code of 1986, and of section 716(a)(3) of the Employee Retirement Income Security Act of 1974, as applicable are included as emergency services (as defined in clause (i) of such section and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a hospital or an independent freestanding emergency department, that has a contractual relationship with the plan or coverage, respectively, with respect to the fur-

nishing of such services under the plan or coverage, respectively.

"SEC. 2799B–3. PROVIDER REQUIREMENTS WITH RESPECT TO DISCLOSURE ON PATIENT PROTECTIONS AGAINST BALANCE BILLING.

''Beginning not later than January 1, 2022, each health care provider and health care facility shall make publicly available, and (if applicable) post on a public website of such provider or facility and provide to individuals who are participants, beneficiaries, or enrollees of a group health plan or group or individual health insurance coverage offered by a health insurance issuer a one-page notice (either postal or electronic mail, as specified by the participant, beneficiary, or enrollee) in clear and understandable language containing information on—

''(1) the requirements and prohibitions of such provider or facility under sections 2799B–1 and 2799B–2 (relating to prohibitions on balance billing in certain circumstances);

''(2) any other applicable State law requirements on such provider or facility regarding the amounts such provider or facility may, with respect to an item or service, charge a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a

health insurance issuer with respect to which such provider or facility does not have a contractual relationship for furnishing such item or service under the plan or coverage, respectively, after receiving payment from the plan or coverage, respectively, for such item or service and any applicable cost-sharing payment from such participant, beneficiary, or enrollee; and

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

''SEC. 2799B–4. ENFORCEMENT.

''(a) STATE ENFORCEMENT.—

''(1) STATE AUTHORITY.—Each State may require a provider or health care facility (including a provider of air ambulance services) subject to the requirements of this part to satisfy such requirements applicable to the provider or facility.

''(2) FAILURE TO IMPLEMENT REQUIREMENTS.—In the case of a determination by the Secretary that a State has failed to substantially enforce the requirements to which paragraph (1) applies with respect to applicable providers and facili-

ties in the State, the Secretary shall enforce such requirements under subsection (b) insofar as they relate to violations of such requirements occurring in such State.

''(3) NOTIFICATION OF APPLICABLE SECRETARY.—A State may notify the Secretary of Labor, Secretary of Health and Human Services, or the Secretary of the Treasury, as applicable, of instances of violations of sections 2799B–1, 2799B–2, or 2799B–5 with respect to participants, beneficiaries, or enrollees under a group health plan or group or individual health insurance coverage, as applicable offered by a health insurance issuer and any enforcement actions taken against providers or facilities as a result of such violations, including the disposition of any such enforcement actions.

''(b) SECRETARIAL ENFORCEMENT AUTHORITY.—

''(1) IN GENERAL.—If a provider or facility is found by the Secretary to be in violation of a requirement to which subsection (a)(1) applies, the Secretary may apply a civil monetary penalty with respect to such provider or facility (including, as applicable, a provider of air ambulance services) in an amount not to exceed $10,000 per violation. The provisions of subsections (c) (with the exception of

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

''(2) LIMITATION.—The provisions of paragraph (1) shall apply to enforcement of a provision (or provisions) specified in subsection (a)(1) only as provided under subsection (a)(2).

''(3) COMPLAINT PROCESS.—The Secretary shall, through rulemaking, establish a process to receive consumer complaints of violations of such provisions and provide a response to such complaints within 60 days of receipt of such complaints.

''(4) EXCEPTION.—The Secretary shall waive the penalties described under paragraph (1) with respect to a facility or provider (including a provider of air ambulance services) who does not knowingly violate, and should not have reasonably known it violated, section 2799B–1 or 2799B–2 (or, in the case of a provider of air ambulance services, section 2799B–5) with respect to a participant, beneficiary, or enrollee, if such facility or provider, within 30

days of the violation, withdraws the bill that was in violation of such provision and reimburses the health plan or enrollee, as applicable, in an amount equal to the difference between the amount billed and the amount allowed to be billed under the provision, plus interest, at an interest rate determined by the Secretary.

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

''(c) CONTINUED APPLICABILITY OF STATE LAW.—The sections specified in subsection (a)(1) shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any requirement or prohibition except to the extent that such requirement or prohibition prevents the application of a requirement or prohibition of such a section.''.

(b) SECRETARY OF LABOR ENFORCEMENT.—

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

"SEC. 522. COORDINATION OF ENFORCEMENT REGARDING VIOLATIONS OF CERTAIN HEALTH CARE PROVIDER REQUIREMENTS; COMPLAINT PROCESS.

''(a) INVESTIGATING VIOLATIONS.—Upon receiving a notice from a State or the Secretary of Health and Human Services of violations of sections 2799B–1, 2799B–2, or 2799B–5 of the Public Health Service Act, the Secretary of Labor shall identify patterns of such violations with respect to participants or beneficiaries under a group health plan or group health insurance coverage offered by a health insurance issuer and conduct an investigation pursuant to section 504 where appropriate, as determined by the Secretary. The Secretary shall coordinate with States and the Secretary of Health and Human Services, in accordance with section 506 and with section 104 of Health Insurance Portability and Accountability Act of 1996, where appropriate, as determined by the Secretary, to ensure that appropriate measures have been taken to correct such violations retrospectively and prospectively with respect to participants or beneficiaries under a group health plan or group health insurance coverage offered by a health insurance issuer.

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

''(1) may receive complaints from participants and beneficiaries of group health plans or group health insurance coverage offered by a health insurance issuer relating to alleged violations of the sections specified in subsection (a); and

''(2) transmits such complaints to States or the Secretary of Health and Human Services (as determined appropriate by the Secretary) for potential enforcement actions.''.

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

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

SEC. 105. ENDING SURPRISE AIR AMBULANCE BILLS.

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

(1) PHSA AMENDMENTS.—Part D of title XXVII of the Public Health Service Act, as added and amended by section 102 and further amended by the previous provisions of this title, is further amended by inserting after section 2799A–1 the following:

"SEC. 2799A–2. ENDING SURPRISE AIR AMBULANCE BILLS.

''(a) IN GENERAL.—In the case of a participant, beneficiary, or enrollee who is in a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who receives air ambulance services from a nonparticipating provider (as defined in section 2799A–1(a)(3)(G)) with respect to such plan or coverage, if such services would be covered if provided by a participating provider (as defined in such section) with respect to such plan or coverage—

''(1) the cost-sharing requirement with respect to such services shall be the same requirement that would apply if such services were provided by such a participating provider, and any coinsurance or deductible shall be based on rates that would apply for such services if they were furnished by such a participating provider;

''(2) such cost-sharing amounts shall be counted towards the in-network deductible and in-network out-of-pocket maximum amount under the plan or coverage for the plan year (and such in-network deductible shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider; and

''(3) the group health plan or health insurance issuer, respectively, shall—

''(A) not later than 30 calendar days after the bill for such services is transmitted by such provider, send to the provider, an initial payment or notice of denial of payment; and

''(B) pay a total plan or coverage payment, in accordance with, if applicable, subsection (b)(6), directly to such provider furnishing such services to such participant, beneficiary, or enrollee that is, with application of any initial payment under subparagraph (A), equal to the amount by which the out-of-network rate (as defined in section 2799A–1(a)(3)(K)) for such services and year involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such services (as determined in accordance with paragraphs (1) and (2)).

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

''(1) DETERMINATION THROUGH OPEN NEGOTIATION.—

"(A) IN GENERAL.—With respect to air ambulance services furnished in a year by a nonparticipating provider, with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage, and for which a payment is required to be made by the plan or coverage pursuant to subsection (a)(3), the provider or plan or coverage may, during the 30-day period beginning on the day the provider receives an initial payment or a notice of denial of payment from the plan or coverage regarding a claim for payment for such service, initiate open negotiations under this paragraph between such provider and plan or coverage for purposes of determining, during the open negotiation period, an amount agreed on by such provider, and such plan or coverage for payment (including any cost-sharing) for such service. For purposes of this subsection, the open negotiation period, with respect to air ambulance services, is the 30-day period beginning on the date of initiation of the negotiations with respect to such services.

''(B) ACCESSING INDEPENDENT DISPUTE RESOLUTION PROCESS IN CASE OF FAILED NEGOTIATIONS.—In the case of open negotiations pursuant to subparagraph (A), with respect to air ambulance services, that do not result in a determination of an amount of payment for such services by the last day of the open negotiation period described in such subparagraph with respect to such services, the provider or group health plan or health insurance issuer offering group or individual health insurance coverage that was party to such negotiations may, during the 4-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process under paragraph (2) with respect to such item or service. The independent dispute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the other party and to the Secretary of a notification (containing such information as specified by the Secretary) and for purposes of this subsection, the date of initiation of such process shall be the date of such submission or such other date specified by the Secretary pursuant

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

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

''(A) ESTABLISHMENT.—Not later than 1 year after the date of the enactment of this subsection, the Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury, shall establish by regulation one independent dispute resolution process (referred to in this subsection as the 'IDR process') under which, in the case of air ambulance services with respect to which a provider or group health plan or health insurance issuer offering group or individual health insurance coverage submits a notification under paragraph (1)(B) (in this subsection referred to as a 'qualified IDR air ambulance services'), a certified IDR entity under paragraph (4) determines, subject to subparagraph (B) and in accordance with the succeeding provisions of this subsection, the amount of payment under the plan or coverage for such services furnished by such provider.

"(B) AUTHORITY TO CONTINUE NEGOTIATIONS.—Under the independent dispute resolution process, in the case that the parties to a determination for qualified IDR air ambulance services agree on a payment amount for such services during such process but before the date on which the entity selected with respect to such determination under paragraph (4) makes such determination under paragraph (5), such amount shall be treated for purposes of section 2799A–1(a)(3)(K)(ii) as the amount agreed to by such parties for such services. In the case of an agreement described in the previous sentence, the independent dispute resolution process shall provide for a method to determine how to allocate between the parties to such determination the payment of the compensation of the entity selected with respect to such determination.

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

to such item or service pursuant to subsection (b) of such section.

''(3) TREATMENT OF BATCHING OF SERVICES.—The provisions of section 2799A–1(c)(3) shall apply with respect to a notification submitted under this subsection with respect to air ambulance services in the same manner and to the same extent such provisions apply with respect to a notification submitted under section 2799A–1(c) with respect to items and services described in such section.

''(4) IDR ENTITIES.—

''(A) ELIGIBILITY.—An IDR entity certified under this subsection is an IDR entity certified under section 2799A–1(c)(4).

''(B) SELECTION OF CERTIFIED IDR ENTITY.—The provisions of subparagraph (F) of section 2799A–1(c)(4) shall apply with respect to selecting an IDR entity certified pursuant to subparagraph (A) with respect to the determination of the amount of payment under this subsection of air ambulance services in the same manner as such provisions apply with respect to selecting an IDR entity certified under such section with respect to the determination of the amount of payment under section

2799A–1(c) of an item or service. An entity selected pursuant to the previous sentence to make a determination described in such sentence shall be referred to in this subsection as the 'certified IDR entity' with respect to such determination.

''(5) PAYMENT DETERMINATION.—

''(A) IN GENERAL.—Not later than 30 days after the date of selection of the certified IDR entity with respect to a determination for qualified IDR ambulance services, the certified IDR entity shall—

''(i) taking into account the considerations specified in subparagraph (C), select one of the offers submitted under subparagraph (B) to be the amount of payment for such services determined under this subsection for purposes of subsection (a)(3); and

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

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

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

''(I) an offer for a payment amount for such services furnished by such provider; and

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

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

''(C) CONSIDERATIONS IN DETERMINATION.—

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

"(I) the qualifying payment amounts (as defined in section 2799A–1(a)(3)(E)) for the applicable year for items or services that are comparable to the qualified IDR air ambulance service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR air ambulance service; and

"(II) subject to clause (iii), information on any circumstance described in clause (ii), such information as requested in subparagraph (B)(i)(II), and any additional information provided in subparagraph (B)(ii).

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

cumstances described in this clause are, with respect to air ambulance services included in the notification submitted under paragraph (1)(B) of a nonparticipating provider, group health plan, or health insurance issuer the following:

''(I) The quality and outcomes measurements of the provider that furnished such services.

''(II) The acuity of the individual receiving such services or the complexity of furnishing such services to such individual.

''(III) The training, experience, and quality of the medical personnel that furnished such services.

''(IV) Ambulance vehicle type, including the clinical capability level of such vehicle.

''(V) Population density of the pick up location (such as urban, suburban, rural, or frontier).

''(VI) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating

provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider and the plan or issuer, as applicable, during the previous 4 plan years.

''(iii) PROHIBITION ON CONSIDERATION OF CERTAIN FACTORS.—In determining which offer is the payment amount to be applied with respect to qualified IDR air ambulance services furnished by a provider, the certified IDR entity with respect to such determination shall not consider usual and customary charges, the amount that would have been billed by such provider with respect to such services had the provisions of section 2799B–5 not applied, or the payment or reimbursement rate for such services furnished by such provider payable by a public payor, including under the Medicare program under title XVIII of the Social Security Act, under the Medicaid program under title XIX of such Act, under the Children's Health Insurance Program under title XXI of such Act,

under the TRICARE program under chapter 55 of title 10, United States Code, or under chapter 17 of title 38, United States Code.

''(D) EFFECTS OF DETERMINATION.—The provisions of section 2799A–1(c)(5)(E)) shall apply with respect to a determination of a certified IDR entity under subparagraph (A), the notification submitted with respect to such determination, the services with respect to such notification, and the parties to such notification in the same manner as such provisions apply with respect to a determination of a certified IDR entity under section 2799A–1(c)(5)(E), the notification submitted with respect to such determination, the items and services with respect to such notification, and the parties to such notification.

''(E) COSTS OF INDEPENDENT DISPUTE RESOLUTION PROCESS.—The provisions of section 2799A–1(c)(5)(F) shall apply to a notification made under this subsection, the parties to such notification, and a determination under subparagraph (A) in the same manner and to the same extent such provisions apply to a noti-

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

''(6) TIMING OF PAYMENT.—The total plan or coverage payment required pursuant to subsection (a)(3), with respect to qualified IDR air ambulance services for which a determination is made under paragraph (5)(A) or with respect to an air ambulance service for which a payment amount is determined under open negotiations under paragraph (1), shall be made directly to the nonparticipating provider not later than 30 days after the date on which such determination is made.

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

''(A) IN GENERAL.—For each calendar quarter in 2022 and each calendar quarter in a subsequent year, the Secretary shall publish on the public website of the Department of Health and Human Services—

''(i) the number of notifications submitted under the IDR process during such calendar quarter;

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

"(iii) the information described in subparagraph (B) with respect to each notification with respect to which such a determination was so made.

"(iv) the number of times the payment amount determined (or agreed to) under this subsection exceeds the qualifying payment amount;

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

"(vi) the total amount of fees paid under paragraph (8) during such calendar quarter; and

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

"(B) INFORMATION WITH RESPECT TO REQUESTS.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to a notification under the IDR

process of a nonparticipating provider, group health plan, or health insurance issuer offering group or individual health insurance coverage—

''(i) a description of each air ambulance service included in such notification;

''(ii) the geography in which the services included in such notification were provided;

''(iii) the amount of the offer submitted under paragraph (2) by the group health plan or health insurance issuer (as applicable) and by the nonparticipating provider expressed as a percentage of the qualifying payment amount;

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

''(v) ambulance vehicle type, including the clinical capability level of such vehicle;

"(vi) the identity of the group health plan or health insurance issuer or air ambulance provider with respect to such notification;

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

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

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

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

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

''(8) ADMINISTRATIVE FEE.—

''(A) IN GENERAL.—Each party to a determination under paragraph (5) to which an entity is selected under paragraph (4) in a year shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a fee for participating in the IDR process with respect to such determination in an amount described in subparagraph (B) for such year.

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

''(9) WAIVER AUTHORITY.—The Secretary may modify any deadline or other timing requirement specified under this subsection (other than the establishment date for the IDR process under paragraph (2)(A) and other than under paragraph (6)) in cases of extenuating circumstances, as specified by the Secretary, or to ensure that all claims that occur during a 90-day period applied through para-

graph (5)(D), but with respect to which a notification is not permitted by reason of such paragraph to be submitted under paragraph (1)(B) during such period, are eligible for the IDR process.

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

''(1) AIR AMBULANCE SERVICE.—The term 'air ambulance service' means medical transport by helicopter or airplane for patients.

''(2) QUALIFYING PAYMENT AMOUNT.—The term 'qualifying payment amount' has the meaning given such term in section 2799A–1(a)(3).

''(3) NONPARTICIPATING PROVIDER.—The term 'nonparticipating provider' has the meaning given such term in section 2799A–1(a)(3).''.

(2) ERISA AMENDMENT.—

(A) IN GENERAL.—Subpart B of part 7 of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by section 102(b) and further amended by the previous provisions of this title, is further amended by inserting after section 716 the following:

''SEC. 717. ENDING SURPRISE AIR AMBULANCE BILLS.

''(a) IN GENERAL.—In the case of a participant or beneficiary who is in a group health plan or group health

insurance coverage offered by a health insurance issuer and who receives air ambulance services from a nonparticipating provider (as defined in section 716(a)(3)(G)) with respect to such plan or coverage, if such services would be covered if provided by a participating provider (as defined in such section) with respect to such plan or coverage—

''(1) the cost-sharing requirement with respect to such services shall be the same requirement that would apply if such services were provided by such a participating provider, and any coinsurance or deductible shall be based on rates that would apply for such services if they were furnished by such a participating provider;

''(2) such cost-sharing amounts shall be counted towards the in-network deductible and in-network out-of-pocket maximum amount under the plan or coverage for the plan year (and such in-network deductible shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider; and

''(3) the group health plan or health insurance issuer, respectively, shall—

"(A) not later than 30 calendar days after the bill for such services is transmitted by such provider, send to the provider, an initial payment or notice of denial of payment; and

"(B) pay a total plan or coverage payment, in accordance with, if applicable, subsection (b)(6), directly to such provider furnishing such services to such participant, beneficiary, or enrollee that is, with application of any initial payment under subparagraph (A), equal to the amount by which the out-of-network rate (as defined in section 716(a)(3)(K)) for such services and year involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such services (as determined in accordance with paragraphs (1) and (2)).

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

"(1) DETERMINATION THROUGH OPEN NEGOTIATION.—

"(A) IN GENERAL.—With respect to air ambulance services furnished in a year by a nonparticipating provider, with respect to a group health plan or health insurance issuer of-

fering group health insurance coverage, and for which a payment is required to be made by the plan or coverage pursuant to subsection (a)(3), the provider or plan or coverage may, during the 30-day period beginning on the day the provider receives a payment or a statement of denial of payment from the plan or coverage regarding a claim for payment for such service, initiate open negotiations under this paragraph between such provider and plan or coverage for purposes of determining, during the open negotiation period, an amount agreed on by such provider, and such plan or coverage for payment (including any cost-sharing) for such service. For purposes of this subsection, the open negotiation period, with respect to air ambulance services, is the 30-day period beginning on the date of initiation of the negotiations with respect to such services.

''(B) ACCESSING INDEPENDENT DISPUTE RESOLUTION PROCESS IN CASE OF FAILED NEGOTIATIONS.—In the case of open negotiations pursuant to subparagraph (A), with respect to air ambulance services, that do not result in a determination of an amount of payment for

such services by the last day of the open negotiation period described in such subparagraph with respect to such services, the provider or group health plan or health insurance issuer offering group health insurance coverage that was party to such negotiations may, during the 4-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process under paragraph (2) with respect to such item or service. The independent dispute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the other party and to the Secretary of a notification (containing such information as specified by the Secretary) and for purposes of this subsection, the date of initiation of such process shall be the date of such submission or such other date specified by the Secretary pursuant to regulations that is not later than the date of receipt of such notification by both the other party and the Secretary.

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

"(A) ESTABLISHMENT.—Not later than 1 year after the date of the enactment of this subsection, the Secretary, jointly with the Secretary of Health and Human Services and the Secretary of the Treasury, shall establish by regulation one independent dispute resolution process (referred to in this subsection as the 'IDR process') under which, in the case of air ambulance services with respect to which a provider or group health plan or health insurance issuer offering group health insurance coverage submits a notification under paragraph (1)(B) (in this subsection referred to as a 'qualified IDR air ambulance services'), a certified IDR entity under paragraph (4) determines, subject to subparagraph (B) and in accordance with the succeeding provisions of this subsection, the amount of payment under the plan or coverage for such services furnished by such provider.

"(B) AUTHORITY TO CONTINUE NEGOTIATIONS.—Under the independent dispute resolution process, in the case that the parties to a determination for qualified IDR air ambulance services agree on a payment amount for such services during such process but before the date

on which the entity selected with respect to such determination under paragraph (4) makes such determination under paragraph (5), such amount shall be treated for purposes of section 716(a)(3)(K)(ii) as the amount agreed to by such parties for such services. In the case of an agreement described in the previous sentence, the independent dispute resolution process shall provide for a method to determine how to allocate between the parties to such determination the payment of the compensation of the entity selected with respect to such determination.

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

''(3) TREATMENT OF BATCHING OF SERVICES.—The provisions of section 716(c)(3) shall apply with respect to a notification submitted under this subsection with respect to air ambulance serv-

ices in the same manner and to the same extent such provisions apply with respect to a notification submitted under section 716(c) with respect to items and services described in such section.

''(4) IDR ENTITIES.—

''(A) ELIGIBILITY.—An IDR entity certified under this subsection is an IDR entity certified under section 716(c)(4).

''(B) SELECTION OF CERTIFIED IDR ENTITY.—The provisions of subparagraph (F) of section 716(c)(4) shall apply with respect to selecting an IDR entity certified pursuant to subparagraph (A) with respect to the determination of the amount of payment under this subsection of air ambulance services in the same manner as such provisions apply with respect to selecting an IDR entity certified under such section with respect to the determination of the amount of payment under section 716(c) of an item or service. An entity selected pursuant to the previous sentence to make a determination described in such sentence shall be referred to in this subsection as the 'certified IDR entity' with respect to such determination.

''(5) PAYMENT DETERMINATION.—

''(A) IN GENERAL.—Not later than 30 days after the date of selection of the certified IDR entity with respect to a determination for qualified IDR ambulance services, the certified IDR entity shall—

''(i) taking into account the considerations specified in subparagraph (C), select one of the offers submitted under subparagraph (B) to be the amount of payment for such services determined under this subsection for purposes of subsection (a)(3); and

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

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

"(i) shall each submit to the certified IDR entity with respect to such determination—

"(I) an offer for a payment amount for such services furnished by such provider; and

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

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

"(C) CONSIDERATIONS IN DETERMINATION.—

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

"(I) the qualifying payment amounts (as defined in section

716(a)(3)(E)) for the applicable year for items and services that are comparable to the qualified IDR air ambulance service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR air ambulance service; and

"(II) subject to clause (iii), information on any circumstance described in clause (ii), such information as requested in subparagraph (B)(i)(II), and any additional information provided in subparagraph (B)(ii).

"(ii) ADDITIONAL CIRCUMSTANCES.—For purposes of clause (i)(II), the circumstances described in this clause are, with respect to air ambulance services included in the notification submitted under paragraph (1)(B) of a nonparticipating provider, group health plan, or health insurance issuer the following:

"(I) The quality and outcomes measurements of the provider that furnished such services.

''(II) The acuity of the individual receiving such services or the complexity of furnishing such services to such individual.

''(III) The training, experience, and quality of the medical personnel that furnished such services.

''(IV) Ambulance vehicle type, including the clinical capability level of such vehicle.

''(V) Population density of the pick up location (such as urban, suburban, rural, or frontier).

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

''(iii) PROHIBITION ON CONSIDERATION OF CERTAIN FACTORS.—In determining which offer is the payment amount

to be applied with respect to qualified IDR air ambulance services furnished by a provider, the certified IDR entity with respect to such determination shall not consider usual and customary charges, the amount that would have been billed by such provider with respect to such services had the provisions of section 2799B–5 of the Public Health Service Act not applied, or the payment or reimbursement rate for such services furnished by such provider payable by a public payor, including under the Medicare program under title XVIII of the Social Security Act, under the Medicaid program under title XIX of such Act, under the Children's Health Insurance Program under title XXI of such Act, under the TRICARE program under chapter 55 of title 10, United States Code, or under chapter 17 of title 38, United States Code.

''(D) EFFECTS OF DETERMINATION.—The provisions of section 716(c)(5)(E)) shall apply with respect to a determination of a certified IDR entity under subparagraph (A), the notifi-

cation submitted with respect to such determination, the services with respect to such notification, and the parties to such notification in the same manner as such provisions apply with respect to a determination of a certified IDR entity under section 716(c)(5)(E), the notification submitted with respect to such determination, the items and services with respect to such notification, and the parties to such notification.

''(E) COSTS OF INDEPENDENT DISPUTE RESOLUTION PROCESS.—The provisions of section 716(c)(5)(F) shall apply to a notification made under this subsection, the parties to such notification, and a determination under subparagraph (A) in the same manner and to the same extent such provisions apply to a notification under section 716(c), the parties to such notification and a determination made under section 716(c)(5)(A).

''(6) TIMING OF PAYMENT.—The total plan or coverage payment required pursuant to subsection (a)(3), with respect to qualified IDR air ambulance services for which a determination is made under paragraph (5)(A) or with respect to air ambulance

services for which a payment amount is determined under open negotiations under paragraph (1), shall be made directly to the nonparticipating provider not later than 30 days after the date on which such determination is made.

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

''(A) IN GENERAL.—For each calendar quarter in 2022 and each calendar quarter in a subsequent year, the Secretary shall publish on the public website of the Department of Labor—

''(i) the number of notifications submitted under the IDR process during such calendar quarter;

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

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

''(iv) the number of times the payment amount determined (or agreed to)

under this subsection exceeds the qualifying payment amount;

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

''(vi) the total amount of fees paid under paragraph (8) during such calendar quarter; and

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

''(B) INFORMATION WITH RESPECT TO REQUESTS.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to a notification under the IDR process of a nonparticipating provider, group health plan, or health insurance issuer offering group health insurance coverage—

''(i) a description of each air ambulance service included in such notification;

''(ii) the geography in which the services included in such notification were provided;

"(iii) the amount of the offer submitted under paragraph (2) by the group health plan or health insurance issuer (as applicable) and by the nonparticipating provider expressed as a percentage of the qualifying payment amount;

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

"(v) ambulance vehicle type, including the clinical capability level of such vehicle;

"(vi) the identity of the group health plan or health insurance issuer or air ambulance provider with respect to such notification;

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

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

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

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

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

"(8) ADMINISTRATIVE FEE.—

"(A) IN GENERAL.—Each party to a determination under paragraph (5) to which an entity is selected under paragraph (4) in a year shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a fee for participating in the IDR process with respect to such determination in an amount described in subparagraph (B) for such year.

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

''(9) WAIVER AUTHORITY.—The Secretary may modify any deadline or other timing requirement specified under this subsection (other than the establishment date for the IDR process under paragraph (2)(A) and other than under paragraph (6)) in cases of extenuating circumstances, as specified by the Secretary, or to ensure that all claims that occur during a 90-day period applied through paragraph (5)(D), but with respect to which a notification is not permitted by reason of such paragraph to be submitted under paragraph (1)(B) during such period, are eligible for the IDR process.

''(c) DEFINITION.—For purposes of this section:

''(1) AIR AMBULANCE SERVICES.—The term 'air ambulance service' means medical transport by helicopter or airplane for patients.

''(2) QUALIFYING PAYMENT AMOUNT.—The term 'qualifying payment amount' has the meaning given such term in section 716(a)(3).

''(3) NONPARTICIPATING PROVIDER.—The term 'nonparticipating provider' has the meaning given such term in section 716(a)(3).''.

(3) IRC AMENDMENTS.—

(A) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 102(c) and further amended by the previous provisions of this title, is further amended by inserting after section 9816 the following:

''SEC. 9817. ENDING SURPRISE AIR AMBULANCE BILLS.

''(a) IN GENERAL.—In the case of a participant or beneficiary in a group health plan who receives air ambulance services from a nonparticipating provider (as defined in section 9816(a)(3)(G)) with respect to such plan, if such services would be covered if provided by a participating provider (as defined in such section) with respect to such plan—

''(1) the cost-sharing requirement with respect to such services shall be the same requirement that would apply if such services were provided by such a participating provider, and any coinsurance or de-

ductible shall be based on rates that would apply for such services if they were furnished by such a participating provider;

''(2) such cost-sharing amounts shall be counted towards the in-network deductible and in-network out-of-pocket maximum amount under the plan for the plan year (and such in-network deductible shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider; and

''(3) the group health plan shall—

''(A) not later than 30 calendar days after the bill for such services is transmitted by such provider, send to the provider, an initial payment or notice of denial of payment; and

''(B) pay a total plan payment, in accordance with, if applicable, subsection (b)(6), directly to such provider furnishing such services to such participant, beneficiary, or enrollee that is, with application of any initial payment under subparagraph (A), equal to the amount by which the out-of-network rate (as defined in section 9816(a)(3)(K)) for such services and year involved exceeds the cost-sharing amount

imposed under the plan for such services (as determined in accordance with paragraphs (1) and (2)).

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

''(1) DETERMINATION THROUGH OPEN NEGOTIATION.—

''(A) IN GENERAL.—With respect to air ambulance services furnished in a year by a nonparticipating provider, with respect to a group health plan, and for which a payment is required to be made by the plan pursuant to subsection (a)(3), the provider or plan may, during the 30-day period beginning on the day the provider receives a payment or a statement of denial of payment from the plan regarding a claim for payment for such service, initiate open negotiations under this paragraph between such provider and plan for purposes of determining, during the open negotiation period, an amount agreed on by such provider, and such plan for payment (including any cost-sharing) for such service. For purposes of this subsection, the open negotiation period, with respect to air am-

bulance services, is the 30-day period beginning on the date of initiation of the negotiations with respect to such services.

''(B) ACCESSING INDEPENDENT DISPUTE RESOLUTION PROCESS IN CASE OF FAILED NEGOTIATIONS.—In the case of open negotiations pursuant to subparagraph (A), with respect to air ambulance services, that do not result in a determination of an amount of payment for such services by the last day of the open negotiation period described in such subparagraph with respect to such services, the provider or group health plan that was party to such negotiations may, during the 4-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process under paragraph (2) with respect to such services. The independent dispute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the other party and to the Secretary of a notification (containing such information as specified by the Secretary) and for purposes of this subsection, the date of initiation of such process shall be the date of such submission or such

other date specified by the Secretary pursuant to regulations that is not later than the date of receipt of such notification by both the other party and the Secretary.

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

''(A) ESTABLISHMENT.—Not later than 1 year after the date of the enactment of this subsection, the Secretary, jointly with the Secretary of Health and Human Services and the Secretary of Labor, shall establish by regulation one independent dispute resolution process (referred to in this subsection as the 'IDR process') under which, in the case of air ambulance services with respect to which a provider or group health plan submits a notification under paragraph (1)(B) (in this subsection referred to as a 'qualified IDR air ambulance services'), a certified IDR entity under paragraph (4) determines, subject to subparagraph (B) and in accordance with the succeeding provisions of this subsection, the amount of payment under the plan for such services furnished by such provider.

"(B) AUTHORITY TO CONTINUE NEGOTIATIONS.—Under the independent dispute resolution process, in the case that the parties to a determination for qualified IDR air ambulance services agree on a payment amount for such services during such process but before the date on which the entity selected with respect to such determination under paragraph (4) makes such determination under paragraph (5), such amount shall be treated for purposes of section 9816(a)(3)(K)(ii) as the amount agreed to by such parties for such services. In the case of an agreement described in the previous sentence, the independent dispute resolution process shall provide for a method to determine how to allocate between the parties to such determination the payment of the compensation of the entity selected with respect to such determination.

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

service pursuant to subsection (b) of such section.

''(3) TREATMENT OF BATCHING OF SERVICES.—The provisions of section 9816(c)(3) shall apply with respect to a notification submitted under this subsection with respect to air ambulance services in the same manner and to the same extent such provisions apply with respect to a notification submitted under section 9816(c) with respect to items and services described in such section.

''(4) IDR ENTITIES.—

''(A) ELIGIBILITY.—An IDR entity certified under this subsection is an IDR entity certified under section 9816(c)(4).

''(B) SELECTION OF CERTIFIED IDR ENTITY.—The provisions of subparagraph (F) of section 9816(c)(4) shall apply with respect to selecting an IDR entity certified pursuant to subparagraph (A) with respect to the determination of the amount of payment under this subsection of air ambulance services in the same manner as such provisions apply with respect to selecting an IDR entity certified under such section with respect to the determination of the amount of payment under section

9816(c) of an item or service. An entity selected pursuant to the previous sentence to make a determination described in such sentence shall be referred to in this subsection as the 'certified IDR entity' with respect to such determination.

''(5) PAYMENT DETERMINATION.—

''(A) IN GENERAL.—Not later than 30 days after the date of selection of the certified IDR entity with respect to a determination for qualified IDR ambulance services, the certified IDR entity shall—

''(i) taking into account the considerations specified in subparagraph (C), select one of the offers submitted under subparagraph (B) to be the amount of payment for such services determined under this subsection for purposes of subsection (a)(3); and

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

''(B) SUBMISSION OF OFFERS.—Not later than 10 days after the date of selection of the certified IDR entity with respect to a deter-

mination for qualified IDR air ambulance services, the provider and the group health plan party to such determination—

"(i) shall each submit to the certified IDR entity with respect to such determination—

"(I) an offer for a payment amount for such services furnished by such provider; and

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

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

"(C) CONSIDERATIONS IN DETERMINATION.—

"(i) IN GENERAL.—In determining which offer is the payment to be applied pursuant to this paragraph, the certified IDR entity, with respect to the determina-

tion for a qualified IDR air ambulance service shall consider—

"(I) the qualifying payment amounts (as defined in section 9816(a)(3)(E)) for the applicable year for items or services that are comparable to the qualified IDR air ambulance service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR air ambulance service; and

"(II) subject to clause (iii), information on any circumstance described in clause (ii), such information as requested in subparagraph (B)(i)(II), and any additional information provided in subparagraph (B)(ii).

"(ii) ADDITIONAL CIRCUMSTANCES.—For purposes of clause (i)(II), the circumstances described in this clause are, with respect to air ambulance services included in the notification submitted under paragraph (1)(B) of a nonparticipating

provider, or group health plan the following:

''(I) The quality and outcomes measurements of the provider that furnished such services.

''(II) The acuity of the individual receiving such services or the complexity of furnishing such services to such individual.

''(III) The training, experience, and quality of the medical personnel that furnished such services.

''(IV) Ambulance vehicle type, including the clinical capability level of such vehicle.

''(V) Population density of the pick up location (such as urban, suburban, rural, or frontier).

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

rates between the provider and the plan during the previous 4 plan years.

''(iii) PROHIBITION ON CONSIDERATION OF CERTAIN FACTORS.—In determining which offer is the payment amount to be applied with respect to qualified IDR air ambulance services furnished by a provider, the certified IDR entity with respect to such determination shall not consider usual and customary charges, the amount that would have been billed by such provider with respect to such services had the provisions of section 2799B–5 of the Public Health Service Act not applied, or the payment or reimbursement rate for such services furnished by such provider payable by a public payor, including under the Medicare program under title XVIII of the Social Security Act, under the Medicaid program under title XIX of such Act, under the Children's Health Insurance Program under title XXI of such Act, under the TRICARE program under chapter 55 of title 10, United States Code, or

under chapter 17 of title 38, United States Code.

''(D) EFFECTS OF DETERMINATION.—The provisions of section 9816(c)(5)(E)) shall apply with respect to a determination of a certified IDR entity under subparagraph (A), the notification submitted with respect to such determination, the services with respect to such notification, and the parties to such notification in the same manner as such provisions apply with respect to a determination of a certified IDR entity under section 9816(c)(5)(E), the notification submitted with respect to such determination, the items and services with respect to such notification, and the parties to such notification.

''(E) COSTS OF INDEPENDENT DISPUTE RESOLUTION PROCESS.—The provisions of section 9816(c)(5)(F) shall apply to a notification made under this subsection, the parties to such notification, and a determination under subparagraph (A) in the same manner and to the same extent such provisions apply to a notification under section 9816(c), the parties to such

notification and a determination made under section 9816(c)(5)(A).

''(6) TIMING OF PAYMENT.—The total plan payment required pursuant to subsection (a)(3), with respect to qualified IDR air ambulance services for which a determination is made under paragraph (5)(A) or with respect to air ambulance services for which a payment amount is determined under open negotiations under paragraph (1), shall be made directly to the nonparticipating provider not later than 30 days after the date on which such determination is made.

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

''(A) IN GENERAL.—For each calendar quarter in 2022 and each calendar quarter in a subsequent year, the Secretary shall publish on the public website of the Department of the Treasury—

''(i) the number of notifications submitted under the IDR process during such calendar quarter;

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

"(iii) the information described in subparagraph (B) with respect to each notification with respect to which such a determination was so made.

"(iv) the number of times the payment amount determined (or agreed to) under this subsection exceeds the qualifying payment amount;

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

"(vi) the total amount of fees paid under paragraph (8) during such calendar quarter; and

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

"(B) INFORMATION WITH RESPECT TO REQUESTS.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to a notification under the IDR process of a nonparticipating provider, or group health plan—

''(i) a description of each air ambulance service included in such notification;

''(ii) the geography in which the services included in such notification were provided;

''(iii) the amount of the offer submitted under paragraph (2) by the group health plan and by the nonparticipating provider expressed as a percentage of the qualifying payment amount;

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

''(v) ambulance vehicle type, including the clinical capability level of such vehicle;

''(vi) the identity of the group health plan or health insurance issuer or air ambulance provider with respect to such notification;

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

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

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

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

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

"(8) ADMINISTRATIVE FEE.—

"(A) IN GENERAL.—Each party to a determination under paragraph (5) to which an entity is selected under paragraph (4) in a year

shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a fee for participating in the IDR process with respect to such determination in an amount described in subparagraph (B) for such year.

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

''(9) WAIVER AUTHORITY.—The Secretary may modify any deadline or other timing requirement specified under this subsection (other than the establishment date for the IDR process under paragraph (2)(A) and other than under paragraph (6)) in cases of extenuating circumstances, as specified by the Secretary, or to ensure that all claims that occur during a 90-day period applied through paragraph (5)(D), but with respect to which a notification is not permitted by reason of such paragraph to be submitted under paragraph (1)(B) during such period, are eligible for the IDR process.

"(c) DEFINITIONS.—For purposes of this section:

"(1) AIR AMBULANCE SERVICES.—The term 'air ambulance service' means medical transport by helicopter or airplane for patients.

"(2) QUALIFYING PAYMENT AMOUNT.—The term 'qualifying payment amount' has the meaning given such term in section 9816(a)(3).

"(3) NONPARTICIPTING PROVIDER.—The term 'nonparticipating provider' has the meaning given such term in section 9816(a)(3).".

(B) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 102(c)(3), is further amended by inserting after the item relating to section 9816 the following new item:

"Sec. 9817. Ending surprise air ambulance bills.".

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

(b) AIR AMBULANCE PROVIDER BALANCE BILLING.—Part E of title XXVII of the Public Health Service Act, as added and amended by section 104, is further amended by adding at the end the following new section:

"SEC. 2799B–5. AIR AMBULANCE SERVICES.

"In the case of a participant, beneficiary, or enrollee with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who is furnished in a plan year beginning on or after January 1, 2022, air ambulance services (for which benefits are available under such plan or coverage) from a nonparticipating provider (as defined in section 2799A–1(a)(3)(G)) with respect to such plan or coverage, such provider shall not bill, and shall not hold liable, such participant, beneficiary, or enrollee for a payment amount for such service furnished by such provider that is more than the cost-sharing amount for such service (as determined in accordance with paragraphs (1) and (2) of section 2799A–2(a), section 717(a) of the Employee Retirement Income Security Act of 1974, or section 9817(a) of the Internal Revenue Code of 1986, as applicable).".

SEC. 106. REPORTING REQUIREMENTS REGARDING AIR AMBULANCE SERVICES.

(a) REPORTING REQUIREMENTS FOR PROVIDERS OF AIR AMBULANCE SERVICES.—

(1) IN GENERAL.—A provider of air ambulance services shall submit to the Secretary of Health and Human Services and the Secretary of Transportation—

(A) not later than the date that is 90 days after the last day of the first calendar 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—

(i)(I) group health plans;

(II) health insurance issuers; and

(III) State and Federal Government payors; and

(ii) uninsured individuals.

(E) The number of claims of such provider that have been denied payment by a group health plan or health insurance issuer and the reasons for any such denials.

(F) The number of emergency and non-emergency air ambulance transports, disaggregated by air ambulance base and type of aircraft.

(G) Such other information regarding air ambulance services as the Secretary of Health and Human Services may specify.

(b) REPORTING REQUIREMENTS FOR GROUP HEALTH PLANS AND HEALTH INSURANCE ISSUERS.—

(1) PHSA.—Part D of title XXVII of the Public Health Service Act, as added by section 102(a)(1), is amended by adding after section 2799A–7, as added by section 102(a)(2)(A) of this Act, the following new section:

"SEC. 2799A–8. AIR AMBULANCE REPORT REQUIREMENTS.

''(a) IN GENERAL.—Each group health plan and health insurance issuer offering group or individual health insurance coverage shall submit to the Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury—

''(1) not later than the date that is 90 days after the last day of the first calendar year beginning on or after the date on which a final rule is promulgated pursuant to the rulemaking described in section 106(d) of the No Surprises Act, the information described in subsection (b) with respect to such plan year; and

''(2) not later than the date that is 90 days after the last day of the calendar year immediately succeeding the plan year described in paragraph (1), such information with respect to such immediately succeeding plan year.

''(b) INFORMATION DESCRIBED.—For purposes of subsection (a), information described in this subsection, with respect to a group health plan or a health insurance issuer offering group or individual health insurance coverage, is each of the following:

''(1) Claims data for air ambulance services furnished by providers of such services, disaggregated by each of the following factors:

''(A) Whether such services were furnished on an emergent or nonemergent basis.

''(B) Whether the provider of such services is part of a hospital-owned or sponsored program, municipality-sponsored program, hospital independent partnership (hybrid) program, independent program, or tribally operated program in Alaska.

''(C) Whether the transport in which the services were furnished originated in a rural or urban area.

''(D) The type of aircraft (such as rotor transport or fixed wing transport) used to furnish such services.

''(E) Whether the provider of such services has a contract with the plan or issuer, as appli-

cable, to furnish such services under the plan or coverage, respectively.

''(2) Such other information regarding providers of air ambulance services as the Secretary may specify.''.

(2) ERISA.—

(A) IN GENERAL.—Subpart B of part 7 of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding after section 722, as added by section 102(b)(2)(A) of this Act, the following new section:

''SEC. 723. AIR AMBULANCE REPORT REQUIREMENTS.

''(a) IN GENERAL.—Each group health plan and health insurance issuer offering group health insurance coverage shall submit to the Secretary, jointly with the Secretary of Health and Human Services and the Secretary of the Treasury—

''(1) not later than the date that is 90 days after the last day of the first calendar year beginning on or after the date on which a final rule is promulgated pursuant to the rulemaking described in section 106(d) of the No Surprises Act, the information described in subsection (b) with respect to such plan year; and

''(2) not later than the date that is 90 days after the last day of the plan year immediately succeeding the calendar year described in paragraph (1), such information with respect to such immediately succeeding plan year.

''(b) INFORMATION DESCRIBED.—For purposes of subsection (a), information described in this subsection, with respect to a group health plan or a health insurance issuer offering group health insurance coverage, is each of the following:

''(1) Claims data for air ambulance services furnished by providers of such services, disaggregated by each of the following factors:

''(A) Whether such services were furnished on an emergent or nonemergent basis.

''(B) Whether the provider of such services is part of a hospital-owned or sponsored program, municipality-sponsored program, hospital independent partnership (hybrid) program, independent program, or tribally operated program in Alaska.

''(C) Whether the transport in which the services were furnished originated in a rural or urban area.

''(D) The type of aircraft (such as rotor transport or fixed wing transport) used to furnish such services.

''(E) Whether the provider of such services has a contract with the plan or issuer, as applicable, to furnish such services under the plan or coverage, respectively.

''(2) Such other information regarding providers of air ambulance services as the Secretary may specify.''.

(B) CLERICAL AMENDMENT.—The table of contents of the Employee Retirement Income Security Act of 1974 is amended by adding after the item relating to section 722, as added by section 102(b) the following:

''Sec. 723. Air ambulance report requirements.''.

(3) IRC.—

(A) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding after section 9822, as added by section 102(c)(2)(A) of this Act, the following new section:

''SEC. 9823. AIR AMBULANCE REPORT REQUIREMENTS.

''(a) IN GENERAL.—Each group health plan shall submit to the Secretary, jointly with the Secretary of Labor and the Secretary of Health and Human Services—

''(1) not later than the date that is 90 days after the last day of the first calendar year beginning on or after the date on which a final rule is promulgated pursuant to the rulemaking described in section 106(d) of the No Surprises Act, the information described in subsection (b) with respect to such plan year; and

''(2) not later than the date that is 90 days after the last day of the calendar year immediately succeeding the plan year described in paragraph (1), such information with respect to such immediately succeeding plan year.

''(b) INFORMATION DESCRIBED.—For purposes of subsection (a), information described in this subsection, with respect to a group health plan is each of the following:

''(1) Claims data for air ambulance services furnished by providers of such services, disaggregated by each of the following factors:

''(A) Whether such services were furnished on an emergent or nonemergent basis.

''(B) Whether the provider of such services is part of a hospital-owned or sponsored program, municipality-sponsored program, hospital independent partnership (hybrid) program,

independent program, or tribally operated program in Alaska.

"(C) Whether the transport in which the services were furnished originated in a rural or urban area.

"(D) The type of aircraft (such as rotor transport or fixed wing transport) used to furnish such services.

"(E) Whether the provider of such services has a contract with the plan or issuer, as applicable, to furnish such services under the plan or coverage, respectively.

"(2) Such other information regarding providers of air ambulance services as the Secretary may specify.".

(B) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding after the item relating to section 9822, as added by section 102(c), the following new item:

"Sec. 9823. Air ambulance report requirements.".

(c) PUBLICATION OF COMPREHENSIVE REPORT.—

(1) IN GENERAL.—Not later than the date that is one year after the date described in subsection (a)(2) of section 2799A–8 of the Public Health

Service Act, of section 723 of the Employee Retirement Income Security Act of 1974, and of section 9823 of the Internal Revenue Code of 1986, as such sections are added by subsection (b), the Secretary of Health and Human Services, in consultation with the Secretary of Transportation (referred to in this section as the ''Secretaries''), shall develop, and make publicly available (subject to paragraph (3)), a comprehensive report summarizing the information submitted under subsection (a) and the amendments made by subsection (b) and including each of the following:

(A) The percentage of providers of air ambulance services that are part of a hospital-owned or sponsored program, municipality-sponsored program, hospital-independent partnership (hybrid) program, or independent program.

(B) An assessment of the extent of competition among providers of air ambulance services on the basis of price and services offered, and any changes in such competition over time.

(C) An assessment of the average charges for air ambulance services, amounts paid by group health plans and health insurance issuers

offering group or individual health insurance coverage to providers of air ambulance services for furnishing such services, and amounts paid out-of-pocket by consumers, and any changes in such amounts paid over time.

(D) An assessment of the presence of air ambulance bases in, or with the capability to serve, rural areas, and the relative growth in air ambulance bases in rural and urban areas over time.

(E) Any evidence of gaps in rural access to providers of air ambulance services.

(F) The percentage of providers of air ambulance services that have contracts with group health plans or health insurance issuers offering group or individual health insurance coverage to furnish such services under such plans or coverage, respectively.

(G) An assessment of whether there are instances of unfair, deceptive, or predatory practices by providers of air ambulance services in collecting payments from patients to whom such services are furnished, such as referral of such patients to collections, lawsuits, and liens or wage garnishment actions.

(H) An assessment of whether there are, within the air ambulance industry, instances of unreasonable industry concentration, excessive market domination, or other conditions that would allow at least one provider of air ambulance services to unreasonably increase prices or exclude competition in air ambulance services in a given geographic region.

(I) An assessment of the frequency of patient balance billing, patient referrals to collections, lawsuits to collect balance bills, and liens or wage garnishment actions by providers of air ambulance services as part of a collections process across hospital-owned or sponsored programs, municipality-sponsored programs, hospital-independent partnership (hybrid) programs, tribally operated programs in Alaska, or independent programs, providers of air ambulance services operated by public agencies (such as a State or county health department), and other independent providers of air ambulance services.

(J) An assessment of the frequency of claims appeals made by providers of air ambulance services to group health plans or health

insurance issuers offering group or individual health insurance coverage with respect to air ambulance services furnished to enrollees of such plans or coverage, respectively.

(K) Any other cost, quality, or other data relating to air ambulance services or the air ambulance industry, as determined necessary and appropriate by the Secretaries.

(2) OTHER SOURCES OF INFORMATION.—The Secretaries may incorporate information from independent experts or third-party sources in developing the comprehensive report required under paragraph (1).

(3) PROTECTION OF PROPRIETARY INFORMATION.—The Secretaries may not make publicly available under this subsection any proprietary information.

(d) RULEMAKING.—Not later than the date that is one year after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with the Secretary of Transportation, shall, through notice and comment rulemaking, specify the form and manner in which reports described in subsection (a) and in the amendments made by subsection (b) shall be submitted to such Secretaries, taking into consideration (as applica-

ble and to the extent feasible) any recommendations included in the report submitted by the Advisory Committee on Air Ambulance and Patient Billing under section 418(e) of the FAA Reauthorization Act of 2018 (Public Law 115–254; 49 U.S.C. 42301 note prec.).

(e) CIVIL MONEY PENALTIES.—

(1) IN GENERAL.—Subject to paragraph (2), a provider of air ambulance services who fails to submit all information required under subsection (a)(2) by the date described in subparagraph (A) or (B) of subsection (a)(1), as applicable, shall be subject to a civil money penalty of not more than $10,000.

(2) EXCEPTION.—In the case of a provider of air ambulance services that submits only some of the information required under subsection (a)(2) by the date described in subparagraph (A) or (B) of subsection (a)(1), as applicable, the Secretary of Health and Human Services may waive the civil money penalty imposed under paragraph (1) if such provider demonstrates a good faith effort (as defined by the Secretary pursuant to regulation) in working with the Secretary to submit the remaining information required under subsection (a)(2).

(3) PROCEDURE.—The provisions of section 1128A of the Social Security Act (42 U.S.C. 1320a–

7a), other than subsections (a) and (b) and the first sentence of subsection (c)(1), shall apply to civil money penalties under this subsection in the same manner as such provisions apply to a penalty or proceeding under such section.

(f) UNFAIR AND DECEPTIVE PRACTICES AND UNFAIR METHODS OF COMPETITION.—The Secretary of Transportation may use any information submitted under subsection (a) in determining whether a provider of air ambulance services has violated section 41712(a) of title 49, United States Code.

(g) ADVISORY COMMITTEE ON AIR AMBULANCE QUALITY AND PATIENT SAFETY.—

(1) ESTABLISHMENT.—Not later than the date that is 60 days after the date of the enactment of this Act, the Secretary of Health and Human Services and the Secretary of Transportation, shall establish an Advisory Committee on Air Ambulance Quality and Patient Safety (referred to in this subsection as the ''Committee'') for the purpose of reviewing options to establish quality, patient safety, and clinical capability standards for each clinical capability level of air ambulances.

(2) MEMBERSHIP.—The Committee shall be composed of the following members:

(A) The Secretary of Health and Human Services, or a designee of the Secretary, who shall serve as the Chair of the Committee.

(B) The Secretary of Transportation, or a designee of the Secretary.

(C) One representative, to be appointed by the Secretary of Health and Human Services, of each of the following:

(i) State health insurance regulators.

(ii) Health care providers.

(iii) Group health plans and health insurance issuers offering group or individual health insurance coverage.

(iv) Patient advocacy groups.

(v) Accrediting bodies with experience in quality measures.

(D) Three representatives of the air ambulance industry, to be appointed by the Secretary of Transportation.

(E) Additional three representatives not covered under subparagraphs (A) through (D), as determined necessary and appropriate by the Secretary of Health and Human Services and Secretary of Transportation.

(3) FIRST MEETING.—Not later than the date that is 90 days after the date of the enactment of this Act, the Committee shall hold its first meeting.

(4) DUTIES.—The Committee shall study and make recommendations, as appropriate, to Congress regarding each of the following with respect to air ambulance services:

(A) Qualifications of different clinical capability levels and tiering of such levels.

(B) Patient safety and quality standards.

(C) Options for improving service reliability during poor weather, night conditions, or other adverse conditions.

(D) Differences between air ambulance vehicle types, services, and technologies, and other flight capability standards, and the impact of such differences on patient safety.

(E) Clinical triage criteria for air ambulances.

(5) REPORT.—Not later than the date that is 180 days after the date of the first meeting of the Committee, the Committee, in consultation with relevant experts and stakeholders, as appropriate, shall develop and make publicly available a report on any recommendations submitted to Congress under para-

graph (4). The Committee may update such report, as determined appropriate by the Committee.

(h) DEFINITIONS.—In this section, the terms ''group health plan'', ''health insurance coverage'', ''individual health insurance coverage'', ''group health insurance coverage'', and ''health insurance issuer'' have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).

SEC. 107. TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET LIMITATIONS.

(a) PHSA.—Section 2799A–1 of the Public Health Service Act, as added by section 102(a) and amended by section 103, is further amended by adding at the end the following new subsection:

''(e) TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET LIMITATIONS.—A group health plan or a health insurance issuer offering group or individual health insurance coverage and providing or covering any benefit with respect to items or services shall include, in clear writing, on any physical or electronic plan or insurance identification card issued to the participants, beneficiaries, or enrollees in the plan or coverage the following:

''(1) Any deductible applicable to such plan or coverage.

''(2) Any out-of-pocket maximum limitation applicable to such plan or coverage.

''(3) A telephone number and Internet website address through which such individual may seek consumer assistance information, such as information related to hospitals and urgent care facilities that have in effect a contractual relationship with such plan or coverage for furnishing items and services under such plan or coverage''.

(b) ERISA.—Section 716 of the Employee Retirement Income Security Act of 1974, as added by section 102(b) and amended by section 103, is further amended by adding at the end the following new subsection:

''(e) TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET LIMITATIONS.—A group health plan or a health insurance issuer offering group health insurance coverage and providing or covering any benefit with respect to items or services shall include, in clear writing, on any physical or electronic plan or insurance identification card issued to the participants or beneficiaries in the plan or coverage the following:

''(1) Any deductible applicable to such plan or coverage.

''(2) Any out-of-pocket maximum limitation applicable to such plan or coverage.

''(3) A telephone number and Internet website address through which such individual may seek consumer assistance information, such as information related to hospitals and urgent care facilities that have in effect a contractual relationship with such plan or coverage for furnishing items and services under such plan or coverage''.

(c) IRC.—Section 9816 of the Internal Revenue Code of 1986, as added by section 102(c) and amended by section 103, is further amended by adding at the end the following new subsection:

''(e) TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET LIMITATIONS.—A group health plan providing or covering any benefit with respect to items or services shall include, in clear writing, on any physical or electronic plan or insurance identification card issued to the participants or beneficiaries in the plan the following:

''(1) Any deductible applicable to such plan.

''(2) Any out-of-pocket maximum limitation applicable to such plan.

''(3) A telephone number and Internet website address through which such individual may seek consumer assistance information, such as information related to hospitals and urgent care facilities that have in effect a contractual relationship with such plan for furnishing items and services under such plan.''.

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

SEC. 108. IMPLEMENTING PROTECTIONS AGAINST PROVIDER DISCRIMINATION.

Not later than January 1, 2022, the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury shall issue a proposed rule implementing the protections of section 2706(a) of the Public Health Service Act (42 U.S.C. 300gg-5(a)). The Secretaries shall accept and consider public comments on any proposed rule issued pursuant to this subsection for a period of 60 days after the date of such issuance. Not later than 6 months after the date of the conclusion of the comment period, the Secretaries shall issue a final rule implementing the protections of section 2706(a) of the Public Health Service Act (42 U.S.C. 300gg-5(a)).

SEC. 109. REPORTS.

(a) REPORTS IN CONSULTATION WITH FTC AND AG.—Not later than January 1, 2023, and annually thereafter for each of the following 4 years, the Secretary of Health and Human Services, in consultation with the Federal Trade Commission and the Attorney General, shall—

(1) conduct a study on the effects of the provisions of, including amendments made by, this Act on—

(A) any patterns of vertical or horizontal integration of health care facilities, providers, group health plans, or health insurance issuers offering group or individual health insurance coverage;

(B) overall health care costs; and

(C) access to health care items and services, including specialty services, in rural areas and health professional shortage areas, as defined in section 332 of the Public Health Service Act (42 U.S.C. 254e);

(2) for purposes of the reports under paragraph (3), in consultation with the Secretary of Labor and the Secretary of the Treasury, make recommendations for the effective enforcement of subsections (a)(1)(C)(iv) and (b)(1)(C) of section 2799A–1 of

the Public Health Service Act, subsections (a)(1)(C)(iv) and (b)(1)(C) of section 716 of the Employee Retirement Income Security Act of 1974, and subsections (a)(1)(C)(iv) and (b)(1)(C) of section 9816 of the Internal Revenue Code of 1986, including with respect to potential challenges to addressing anti-competitive consolidation of health care facilities, providers, group health plans, or health insurance issuers offering group or individual health insurance coverage; and

(3) submit a report on such study and including such recommendations to the Committees on Energy and Commerce; on Education and Labor; on Ways and Means; and on the Judiciary of the House of Representatives and the Committees on Health, Education, Labor, and Pensions; on Commerce, Science, and Transportation; on Finance; and on the Judiciary of the Senate.

(b) GAO REPORT ON IMPACT OF SURPRISE BILLING PROVISIONS.—Not later than January 1, 2025, the Comptroller General of the United States shall submit to Congress a report summarizing the effects of the provisions of this Act, including the amendments made by such provisions, on changes during the period since the date on the enactment of this Act in health care provider networks of

group health plans and group and individual health insurance coverage offered by a health insurance issuer, in fee schedules and amounts for health care services, and to contracted rates under such plans or coverage. Such report shall—

(1) to the extent practicable, sample a statistically significant group of national health care providers;

(2) examine—

(A) provider network participation, including nonparticipating providers furnishing items and services at participating facilities;

(B) health care provider group network participation, including specialty, size, and ownership;

(C) the impact of State surprise billing laws and network adequacy standards on participation of health care providers and facilities in provider networks of group health plans and of group and individual health insurance coverage offered by health insurance issuers; and

(D) access to providers, including in rural and medically underserved communities and health professional shortage areas (as defined in section 332 of the Public Health Service

Act), and the extent of provider shortages in such communities and areas;

(3) to the extent practicable, sample a statistically significant group of national health insurance plans and issuers and examine—

(A) the effects of the provisions of, including amendments made by, this Act on premiums and out-of-pocket costs with respect to group health plans or group or individual health insurance coverage;

(B) the adequacy of provider networks with respect to such plans or coverage; and

(C) categories of providers of ancillary services, as defined in section 2799B–2(b)(2) of the Public Health Service Act, for which such plans have no or a limited number of in-network providers; and

(4) such other relevant effects of such provisions and amendments.

(c) GAO REPORT ON ADEQUACY OF PROVIDER NETWORKS.—Not later than January 1, 2023, the Comptroller General of the United States shall submit to Congress, and make publicly available, a report on the adequacy of provider networks in group health plans and group and individual health insurance coverage, including

legislative recommendations to improve the adequacy of such networks.

(d) GAO REPORT ON IDR PROCESS AND POTENTIAL FINANCIAL RELATIONSHIPS.—Not later than December 31, 2023, the Comptroller General of the United States shall conduct a study and submit to Congress a report on the IDR process established under this section. Such study and report shall include an analysis of potential financial relationships between providers and facilities that utilize the IDR process established by the amendments made by this Act and private equity investment firms.

SEC. 110. CONSUMER PROTECTIONS THROUGH APPLICATION OF HEALTH PLAN EXTERNAL REVIEW IN CASES OF CERTAIN SURPRISE MEDICAL BILLS.

(a) IN GENERAL.—In applying the provisions of section 2719(b) of the Public Health Service Act (42 U.S.C. 300gg–19(b)) to group health plans and health insurance issuers offering group or individual health insurance coverage, the Secretary of Health and Human Services, Secretary of Labor, and Secretary of the Treasury, shall require, beginning not later than January 1, 2022, the external review process described in paragraph (1) of such section to apply with respect to any adverse determination by such a plan or issuer under section 2799A-1 or 2799A-

2, section 716 or 717 of the Employee Retirement Income Security Act of 1974, or section 9816 or 9817 of the Internal Revenue Code of 1986, including with respect to whether an item or service that is the subject to such a determination is an item or service to which such respective section applies.

(b) DEFINITIONS.—The terms ''group health plan''; ''health insurance issuer''; ''group health insurance coverage'', and ''individual health insurance coverage'' have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91), section 733 of the Employee Retirement Income Security Act (29 U.S.C. 1191b), and section 9832 of the Internal Revenue Code, as applicable.

SEC. 111. CONSUMER PROTECTIONS THROUGH HEALTH PLAN REQUIREMENT FOR FAIR AND HONEST ADVANCE COST ESTIMATE.

(a) PHSA AMENDMENT.—Section 2799A–1 of the Public Health Service Act (42 U.S.C. 300gg–19a), as added by section 102 and as further amended by the previous provisions of this title, is further amended by adding at the end the following new subsection:

''(f) ADVANCED EXPLANATION OF BENEFITS.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2022, each group health

plan, or a health insurance issuer offering group or individual health insurance coverage shall, with respect to a notification submitted under section 2799B–6 by a health care provider or health care facility to the plan or issuer for a participant, beneficiary, or enrollee under plan or coverage scheduled to receive an item or service from the provider or facility (or authorized representative of such participant, beneficiary, or enrollee), not later than 1 business day (or, in the case such item or service was so scheduled at least 10 business days before such item or service is to be furnished (or in the case of a request made to such plan or coverage by such participant, beneficiary, or enrollee), 3 business days) after the date on which the plan or coverage receives such notification (or such request), provide to the participant, beneficiary, or enrollee (through mail or electronic means, as requested by the participant, beneficiary, or enrollee) a notification (in clear and understandable language) including the following:

''(A) Whether or not the provider or facility is a participating provider or a participating facility with respect to the plan or coverage

with respect to the furnishing of such item or service and—

''(i) in the case the provider or facility is a participating provider or facility with respect to the plan or coverage with respect to the furnishing of such item or service, the contracted rate under such plan or coverage for such item or service (based on the billing and diagnostic codes provided by such provider or facility); and

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

''(B) The good faith estimate included in the notification received from the provider or facility (if applicable) based on such codes.

''(C) A good faith estimate of the amount the plan or coverage is responsible for paying for items and services included in the estimate described in subparagraph (B).

"(D) A good faith estimate of the amount of any cost-sharing for which the participant, beneficiary, or enrollee would be responsible for such item or service (as of the date of such notification).

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

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

"(G) 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.

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

''(2) AUTHORITY TO MODIFY TIMING REQUIREMENTS IN THE CASE OF SPECIFIED ITEMS AND SERVICES.—

''(A) IN GENERAL.—In the case of a participant, beneficiary, or enrollee scheduled to receive an item or service that is a specified item or service (as defined in subparagraph (B)), the Secretary may modify any timing requirements relating to the provision of the notification described in paragraph (1) to such participant, beneficiary, or enrollee with respect to such item or service. Any modification made by the Secretary pursuant to the previous sentence may not result in the provision of such notification after such participant, beneficiary, or enrollee has been furnished such item or service.

''(B) SPECIFIED ITEM OR SERVICE DEFINED.—For purposes of subparagraph (A), the term 'specified item or service' means an item or service that has low utilization or significant variation in costs (such as when furnished as

part of a complex treatment), as specified by the Secretary.''.

(b) IRC AMENDMENTS.—Section 9816 of the Internal Revenue Code of 1986, as added by section 102 and further amended by the previous provisions of this title, is further amended by inserting after subsection (e) the following new subsection:

''(f) ADVANCED EXPLANATION OF BENEFITS.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2022, each group health plan shall, with respect to a notification submitted under section 2799B–6 of the Public Health Service Act by a health care provider or health care facility to the plan for a participant or beneficiary under plan scheduled to receive an item or service from the provider or facility (or authorized representative of such participant or beneficiary), not later than 1 business day (or, in the case such item or service was so scheduled at least 10 business days before such item or service is to be furnished (or in the case of a request made to such plan or coverage by such participant or beneficiary), 3 business days) after the date on which the plan receives such notification (or such request), 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:

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

"(i) in the case the provider or facility is a participating provider or facility with respect to the plan or coverage with respect to the furnishing of such item or service, the contracted rate under such plan for such item or service (based on the billing and diagnostic codes provided by such provider or facility); and

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

"(B) The good faith estimate included in the notification received from the provider or facility (if applicable) based on such codes.

"(C) A good faith estimate of the amount the plan is responsible for paying for items and services included in the estimate described in subparagraph (B).

"(D) A good faith estimate of the amount of any cost-sharing for which the participant or beneficiary would be responsible for such item or service (as of the date of such notification).

"(E) 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 plan (as of the date of such notification).

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

"(G) 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.

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

''(2) AUTHORITY TO MODIFY TIMING REQUIREMENTS IN THE CASE OF SPECIFIED ITEMS AND SERVICES.—

''(A) IN GENERAL.—In the case of a participant or beneficiary scheduled to receive an item or service that is a specified item or service (as defined in subparagraph (B)), the Secretary may modify any timing requirements relating to the provision of the notification described in paragraph (1) to such participant or beneficiary with respect to such item or service. Any modification made by the Secretary pursuant to the previous sentence may not result in the provision of such notification after such participant or beneficiary has been furnished such item or service.

''(B) SPECIFIED ITEM OR SERVICE DEFINED.—For purposes of subparagraph (A), the term 'specified item or service' means an item

or service that has low utilization or significant variation in costs (such as when furnished as part of a complex treatment), as specified by the Secretary.''.

(c) ERISA AMENDMENTS.—Section 716 of the Employee Retirement Income Security Act of 1974, as added by section 102 and further amended by the previous amendments of this title, is further amended by adding at the end the following new subsection:

''(f) ADVANCED EXPLANATION OF BENEFITS.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2022, each group health plan, or a health insurance issuer offering group health insurance coverage shall, with respect to a notification submitted under section 2799B–6 of the Public Health Service Act by a health care provider or health care facility to the plan or issuer for a participant or beneficiary under plan or coverage scheduled to receive an item or service from the provider or facility (or authorized representative of such participant or beneficiary), not later than 1 business day (or, in the case such item or service was so scheduled at least 10 business days before such item or service is to be furnished (or in the case of a request made to such plan or coverage by such partici-

pant or beneficiary), 3 business days) after the date on which the plan or coverage receives such notification (or such request), 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:

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

''(i) in the case the provider or facility is a participating provider or facility with respect to the plan or coverage with respect to the furnishing of such item or service, the contracted rate under such plan for such item or service (based on the billing and diagnostic codes provided by such provider or facility); and

''(ii) in the case the provider or facility is a nonparticipating provider or facility with respect to such plan or coverage, a description of how such individual may obtain information on providers and facilities

that, with respect to such plan or coverage, are participating providers and facilities, if any.

''(B) The good faith estimate included in the notification received from the provider or facility (if applicable) based on such codes.

''(C) A good faith estimate of the amount the health plan is responsible for paying for items and services included in the estimate described in subparagraph (B).

''(D) A good faith estimate of the amount of any cost-sharing for which the participant or beneficiary would be responsible for such item or service (as of the date of such notification).

''(E) 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 plan or coverage (as of the date of such notification).

''(F) 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 cov-

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

"(G) 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.

"(H) Any other information or disclaimer the plan or coverage determines appropriate that is consistent with information and disclaimers required under this section.

"(2) AUTHORITY TO MODIFY TIMING REQUIREMENTS IN THE CASE OF SPECIFIED ITEMS AND SERVICES.—

"(A) IN GENERAL.—In the case of a participant or beneficiary scheduled to receive an item or service that is a specified item or service (as defined in subparagraph (B)), the Secretary may modify any timing requirements relating to the provision of the notification described in paragraph (1) to such participant or beneficiary with respect to such item or service. Any modification made by the Secretary pursu-

ant to the previous sentence may not result in the provision of such notification after such participant or beneficiary has been furnished such item or service.

''(B) SPECIFIED ITEM OR SERVICE DEFINED.—For purposes of subparagraph (A), the term 'specified item or service' means an item or service that has low utilization or significant variation in costs (such as when furnished as part of a complex treatment), as specified by the Secretary.''.

SEC. 112. PATIENT PROTECTIONS THROUGH TRANSPARENCY AND PATIENT-PROVIDER DISPUTE RESOLUTION.

Part E of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as added by section 104 and further amended by the previous provisions of this title, is further amended by adding at the end the following new sections:

''SEC. 2799B–6. PROVISION OF INFORMATION UPON REQUEST AND FOR SCHEDULED APPOINTMENTS.

''Each health care provider and health care facility shall, beginning January 1, 2022, in the case of an individual who schedules an item or service to be furnished

to such individual by such provider or facility at least 3 business days before the date such item or service is to be so furnished, not later than 1 business day after the date of such scheduling (or, in the case of such an item or service scheduled at least 10 business days before the date such item or service is to be so furnished (or if requested by the individual), not later than 3 business days after the date of such scheduling or such request)—

''(1) inquire if such individual is enrolled in a group health plan, group or individual health insurance coverage offered by a health insurance issuer, or a Federal health care program (and if is so enrolled in such plan or coverage, seeking to have a claim for such item or service submitted to such plan or coverage); and

''(2) provide a notification (in clear and understandable language) of the good faith estimate of the expected charges for furnishing such item or service (including any item or service that is reasonably expected to be provided in conjunction with such scheduled item or service and such an item or service reasonably expected to be so provided by another health care provider or health care facility), with the expected billing and diagnostic codes for any such item or service, to—

''(A) in the case the individual is enrolled in such a plan or such coverage (and is seeking to have a claim for such item or service submitted to such plan or coverage), such plan or issuer of such coverage; and

''(B) in the case the individual is not described in subparagraph (A) and not enrolled in a Federal health care program, the individual.

''SEC. 2799B–7. PATIENT-PROVIDER DISPUTE RESOLUTION.

''(a) IN GENERAL.—Not later than January 1, 2022, the Secretary shall establish a process (in this subsection referred to as the 'patient-provider dispute resolution process') under which an uninsured individual, with respect to an item or service, who received, pursuant to section 2799B–6, from a health care provider or health care facility a good-faith estimate of the expected charges for furnishing such item or service to such individual and who after being furnished such item or service by such provider or facility is billed by such provider or facility for such item or service for charges that are substantially in excess of such estimate, may seek a determination from a selected dispute resolution entity for the charges to be paid by such individual (in lieu of such amount so billed) to such provider or facility for such item or service. For purposes of this subsection, the term 'uninsured individual'

means, with respect to an item or service, an individual who does not have benefits for such item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, Federal health care program (as defined in section 1128B(f) of the Social Security Act), or a health benefits plan under chapter 89 of title 5, United States Code (or an individual who has benefits for such item or service under a group health plan or individual or group health insurance coverage offered by a health insurance issuer, but who does not seek to have a claim for such item or service submitted to such plan or coverage).

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

''(1) a method to select to make such determination an entity certified under subsection (d) that—

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

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

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

''(2) the provision of a notification of such selection to the individual and the provider or facility (as applicable) party to such determination.

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

''(c) ADMINISTRATIVE FEE.—The Secretary shall establish a fee to participate in the patient-provider dispute resolution process in such a manner as to not create a barrier to an uninsured individual's access to such process.

''(d) CERTIFICATION.—The Secretary shall establish or recognize a process to certify entities under this subparagraph. Such process shall ensure that an entity so certified satisfies at least the criteria specified in section 2799A–1(c).''.

SEC. 113. ENSURING CONTINUITY OF CARE.

(a) PUBLIC HEALTH SERVICE ACT.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.)

is amended, in the part D, as added and amended by section 102(a) and further amended by the previous provisions of this title, by inserting after section 2799A–2 the following new section:

"SEC. 2799A-3. CONTINUITY OF CARE.

"(a) ENSURING CONTINUITY OF CARE WITH RESPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER NETWORK STATUS.—

"(1) IN GENERAL.—In the case of an individual with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer and with respect to a health care provider or facility that has a contractual relationship with such plan or such issuer (as applicable) for furnishing items and services under such plan or such coverage, if, while such individual is a continuing care patient (as defined in subsection (b)) with respect to such provider or facility—

"(A) such contractual relationship is terminated (as defined in subsection (b));

"(B) benefits provided under such plan or such health insurance coverage with respect to such provider or facility are terminated because of a change in the terms of the participation of

such provider or facility in such plan or coverage; or

''(C) a contract between such group health plan and a health insurance issuer offering health insurance coverage in connection with such plan is terminated, resulting in a loss of benefits provided under such plan with respect to such provider or facility;

the plan or issuer, respectively, shall meet the requirements of paragraph (2) with respect to such individual.

''(2) REQUIREMENTS.—The requirements of this paragraph are that the plan or issuer—

''(A) notify each individual enrolled under such plan or coverage who is a continuing care patient with respect to a provider or facility at the time of a termination described in paragraph (1) affecting such provider or facility on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility under this section;

''(B) provide such individual with an opportunity to notify the plan or issuer of the individual's need for transitional care; and

"(C) permit the patient to elect to continue to have benefits provided under such plan or such coverage, under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under such plan or coverage had such termination not occurred, with respect to the course of treatment furnished by such provider or facility relating to such individual's status as a continuing care patient during the period beginning on the date on which the notice under subparagraph (A) is provided and ending on the earlier of—

"(i) the 90-day period beginning on such date; or

"(ii) the date on which such individual is no longer a continuing care patient with respect to such provider or facility.

"(b) DEFINITIONS.—In this section:

"(1) CONTINUING CARE PATIENT.—The term 'continuing care patient' means an individual who, with respect to a provider or facility—

"(A) is undergoing a course of treatment for a serious and complex condition from the provider or facility;

''(B) is undergoing a course of institutional or inpatient care from the provider or facility;

''(C) is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;

''(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

''(E) is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

''(2) SERIOUS AND COMPLEX CONDITION.—The term 'serious and complex condition' means, with respect to a participant, beneficiary, or enrollee under a group health plan or group or individual health insurance coverage—

''(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

''(B) in the case of a chronic illness or condition, a condition that is—

''(i) is life-threatening, degenerative, potentially disabling, or congenital; and

''(ii) requires specialized medical care over a prolonged period of time.

''(3) TERMINATED.—The term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.''.

(b) INTERNAL REVENUE CODE.—

(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by sections 102(c) and 105(a)(3), is further amended by inserting after section 9817 the following new section:

''SEC. 9818. CONTINUITY OF CARE.

''(a) ENSURING CONTINUITY OF CARE WITH RESPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER NETWORK STATUS.—

''(1) IN GENERAL.—In the case of an individual with benefits under a group health plan and with respect to a health care provider or facility that has

a contractual relationship with such plan for furnishing items and services under such plan, if, while such individual is a continuing care patient (as defined in subsection (b)) with respect to such provider or facility—

"(A) such contractual relationship is terminated (as defined in paragraph (b));

"(B) benefits provided under such plan with respect to such provider or facility are terminated because of a change in the terms of the participation of such provider or facility in such plan; or

"(C) a contract between such group health plan and a health insurance issuer offering health insurance coverage in connection with such plan is terminated, resulting in a loss of benefits provided under such plan with respect to such provider or facility;

the plan shall meet the requirements of paragraph (2) with respect to such individual.

"(2) REQUIREMENTS.—The requirements of this paragraph are that the plan—

"(A) notify each individual enrolled under such plan who is a continuing care patient with respect to a provider or facility at the time of

a termination described in paragraph (1) affecting such provider on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility under this section;

"(B) provide such individual with an opportunity to notify the plan of the individual's need for transitional care; and

"(C) permit the patient to elect to continue to have benefits provided under such plan, under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under such plan had such termination not occurred, with respect to the course of treatment furnished by such provider or facility relating to such individual's status as a continuing care patient during the period beginning on the date on which the notice under subparagraph (A) is provided and ending on the earlier of—

"(i) the 90-day period beginning on such date; or

"(ii) the date on which such individual is no longer a continuing care patient with respect to such provider or facility.

''(b) DEFINITIONS.—In this section:

''(1) CONTINUING CARE PATIENT.—The term 'continuing care patient' means an individual who, with respect to a provider or facility—

''(A) is undergoing a course of treatment for a serious and complex condition from the provider or facility;

''(B) is undergoing a course of institutional or inpatient care from the provider or facility;

''(C) is scheduled to undergo nonelective surgery from the provider or facility, including receipt of postoperative care from such provider or facility with respect to such a surgery;

''(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

''(E) is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

''(2) SERIOUS AND COMPLEX CONDITION.—The term 'serious and complex condition' means, with re-

spect to a participant or beneficiary 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.''.

(2) CLERICAL AMENDMENT.—The table of sections for such subchapter, as amended by the previous sections, is further amended by inserting after the item relating to section 9817 the following new item:

''Sec. 9818. Continuity of care.''.

(c) EMPLOYEE RETIREMENT INCOME SECURITY ACT.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by section 102(c) and further amended by the previous provisions of this title, is further amended by inserting after section 717 the following new section:

"SEC. 718. CONTINUITY OF CARE.

''(a) ENSURING CONTINUITY OF CARE WITH RESPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER NETWORK STATUS.—

''(1) IN GENERAL.—In the case of an individual with benefits under a group health plan or group health insurance coverage offered by a health insurance issuer and with respect to a health care provider or facility that has a contractual relationship with such plan or such issuer (as applicable) for furnishing items and services under such plan or such coverage, if, while such individual is a continuing care patient (as defined in subsection (b)) with respect to such provider or facility—

''(A) such contractual relationship is terminated (as defined in paragraph (b));

''(B) benefits provided under such plan or such health insurance coverage with respect to such provider or facility are terminated because of a change in the terms of the participation of the provider or facility in such plan or coverage; or

''(C) a contract between such group health plan and a health insurance issuer offering health insurance coverage in connection with such plan is terminated, resulting in a loss of benefits provided under such plan with respect to such provider or facility;

the plan or issuer, respectively, shall meet the requirements of paragraph (2) with respect to such individual.

''(2) REQUIREMENTS.—The requirements of this paragraph are that the plan or issuer—

''(A) notify each individual enrolled under such plan or coverage who is a continuing care patient with respect to a provider or facility at the time of a termination described in paragraph (1) affecting such provider or facility on a timely basis of such termination and such individual's right to elect continued transitional

care from such provider or facility under this section;

"(B) provide such individual with an opportunity to notify the plan or issuer of the individual's need for transitional care; and

"(C) permit the patient to elect to continue to have benefits provided under such plan or such coverage, under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under such plan or coverage had such termination not occurred, with respect to the course of treatment furnished by such provider or facility relating to such individual's status as a continuing care patient during the period beginning on the date on which the notice under subparagraph (A) is provided and ending on the earlier of—

"(i) the 90-day period beginning on such date; or

"(ii) the date on which such individual is no longer a continuing care patient with respect to such provider or facility.

"(b) DEFINITIONS.—In this section:

''(1) CONTINUING CARE PATIENT.—The term 'continuing care patient' means an individual who, with respect to a provider or facility—

''(A) is undergoing a course of treatment for a serious and complex condition from the provider or facility;

''(B) is undergoing a course of institutional or inpatient care from the provider or facility;

''(C) is scheduled to undergo nonelective surgery from the provide or facility, including receipt of postoperative care from such provider or facility with respect to such a surgery;

''(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

''(E) is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

''(2) SERIOUS AND COMPLEX CONDITION.—The term 'serious and complex condition' means, with respect to a participant or beneficiary under a group health plan or group health insurance coverage—

''(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

''(B) in the case of a chronic illness or condition, a condition that—

''(i) is life-threatening, degenerative, potentially disabling, or congenital; and

''(ii) requires specialized medical care over a prolonged period of time.

''(3) TERMINATED.—The term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.''.

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 716 the following new item:

''Sec. 718. Continuity of care.''.

(d) PROVIDER REQUIREMENT.—Part E of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as added by section 104 and further amended by the previous provisions of this title, is further amended by adding at the end the following new section:

"SEC. 2799B–8. CONTINUITY OF CARE.

"A health care provider or health care facility shall, in the case of an individual furnished items and services by such provider or facility for which coverage is provided under a group health plan or group or individual health insurance coverage pursuant to section 2799A–3, section 9818 of the Internal Revenue Code of 1986, or section 718 of the Employee Retirement Income Security Act of 1974—

"(1) accept payment from such plan or such issuer (as applicable) (and cost-sharing from such individual, if applicable, in accordance with subsection (a)(2)(C) of such section 2799A–3, 9818, or 718) for such items and services as payment in full for such items and services; and

"(2) continue to adhere to all policies, procedures, and quality standards imposed by such plan or issuer with respect to such individual and such items and services in the same manner as if such termination had not occurred.".

(e) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (c) shall apply with respect to plan years beginning on or after January 1, 2022.

SEC. 114. MAINTENANCE OF PRICE COMPARISON TOOL.

(a) PUBLIC HEALTH SERVICE ACT.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.)

is amended, in part D, as added and amended by section 102 and further amended by the previous provisions of this title, by inserting after section 2799A–3 the following new section:

"SEC. 2799A–4. MAINTENANCE OF PRICE COMPARISON TOOL.

''A group health plan or a health insurance issuer offering group or individual health insurance coverage shall offer price comparison guidance by telephone and make available on the Internet website of the plan or issuer a price comparison tool that (to the extent practicable) allows an individual enrolled under such plan or coverage, with respect to such plan year, such geographic region, and participating providers with respect to such plan or coverage, to compare the amount of cost-sharing that the individual would be responsible for paying under such plan or coverage with respect to the furnishing of a specific item or service by any such provider.''.

(b) INTERNAL REVENUE CODE.—

(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by sections 102, 105, and 113, is further amended by inserting after section 9818 the following new section:

"SEC. 9819. MAINTENANCE OF PRICE COMPARISON TOOL.

''A group health plan shall offer price comparison guidance by telephone and make available on the Internet website of the plan or issuer a price comparison tool that (to the extent practicable) allows an individual enrolled under such plan, with respect to such plan year, such geographic region, and participating providers with respect to such plan or coverage, to compare the amount of cost-sharing that the individual would be responsible for paying under such plan with respect to the furnishing of a specific item or service by any such provider.''.

(2) CLERICAL AMENDMENT.—The table of sections for such subchapter, as amended by the previous sections, is further amended by inserting after the item relating to section 9818 the following new item:

''Sec. 9819. Maintenance of price comparison tool.''.

(c) EMPLOYEE RETIREMENT INCOME SECURITY ACT.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by sections 102, 105, and 113, is further amended by inserting after section 718 the following new section:

"SEC. 719. MAINTENANCE OF PRICE COMPARISON TOOL.

''A group health plan or a health insurance issuer offering group health insurance coverage shall offer price comparison guidance by telephone and make available on the Internet website of the plan or issuer a price comparison tool that (to the extent practicable) allows an individual enrolled under such plan or coverage, with respect to such plan year, such geographic region, and participating providers with respect to such plan or coverage, to compare the amount of cost-sharing that the individual would be responsible for paying under such plan or coverage with respect to the furnishing of a specific item or service by any such provider.''.

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974, as amended by the previous provisions of this title, is further amended by inserting after the item relating to section 716 the following new item:

''Sec. 719. Maintenance of price comparison tool.''.

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

SEC. 115. STATE ALL PAYER CLAIMS DATABASES.

(a) GRANTS TO STATES.—Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by adding at the end the following:

"SEC. 320B. STATE ALL PAYER CLAIMS DATABASES.

"(a) IN GENERAL.—The Secretary shall make one-time grants to eligible States for the purposes described in subsection (b).

"(b) USES.—A State may use a grant received under subsection (a) for one of the following purposes:

"(1) To establish a State All Payer Claims Database.

"(2) To improve an existing State All Payer Claims Databases.

"(c) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary specifies, including, with respect to a State All Payer Claims Database, at least specifics on how the State will ensure uniform data collection and the privacy and security of such data.

"(d) GRANT PERIOD AND AMOUNT.—Grants awarded under this section shall be for a period of 3-years, and in an amount of $2,500,000, of which $1,000,000 shall be made available to the State for each of the first 2 years

of the grant period, and $500,000 shall be made available to the State for the third year of the grant period.

''(e) AUTHORIZED USERS.—

''(1) APPLICATION.—An entity desiring authorization for access to a State All Payer Claims Database that has received a grant under this section shall submit to the State All Payer Claims Database an application for such access, which shall include—

''(A) in the case of an entity requesting access for research purposes—

''(i) a description of the uses and methodologies for evaluating health system performance using such data; and

''(ii) documentation of approval of the research by an institutional review board, if applicable for a particular plan of research; or

''(B) in the case of an entity such as an employer, health insurance issuer, third-party administrator, or health care provider, requesting access for the purpose of quality improvement or cost-containment, a description of the intended uses for such data.

''(2) REQUIREMENTS.—

''(A) ACCESS FOR RESEARCH PURPOSES.—Upon approval of an application for research purposes under paragraph (1)(A), the authorized user shall enter into a data use and confidentiality agreement with the State All Payer Claims Database that has received a grant under this subsection, which shall include a prohibition on attempts to reidentify and disclose individually identifiable health information and proprietary financial information.

''(B) CUSTOMIZED REPORTS.—Employers and employer organizations may request customized reports from a State All Payer Claims Database that has received a grant under this section, at cost, subject to the requirements of this section with respect to privacy, security, and proprietary financial information.

''(C) NON-CUSTOMIZED REPORTS.—A State All Payer Claims Database that has received a grant under this section shall make available to all authorized users aggregate data sets available through the State All Payer Claims Database, free of charge.

''(3) WAIVERS.—The Secretary may waive the requirements of this subsection of a State All Payer

Claims Database to provide access of entities to such database if such State All Payer Claims Database is substantially in compliance with this subsection.

''(f) EXPANDED ACCESS.—

''(1) MULTI-STATE APPLICATIONS.—The Secretary may prioritize applications submitted by a State whose application demonstrates that the State will work with other State All Payer Claims Databases to establish a single application for access to data by authorized users across multiple States.

''(2) EXPANSION OF DATA SETS.—The Secretary may prioritize applications submitted by a State whose application demonstrates that the State will implement the reporting format for self-insured group health plans described in section 735 of the Employee Retirement Income Security Act of 1974.

''(g) DEFINITIONS.—In this section—

''(1) the term 'individually identifiable health information' has the meaning given such term in section 1171(6) of the Social Security Act;

''(2) the term 'proprietary financial information' means data that would disclose the terms of a specific contract between an individual health care provider or facility and a specific group health plan, managed care entity (as defined in section

1932(a)(1)(B) of the Social Security Act) or other managed care organization, or health insurance issuer offering group or individual health insurance coverage; and

''(3) the term 'State All Payer Claims Database' means, with respect to a State, a database that may include medical claims, pharmacy claims, dental claims, and eligibility and provider files, which are collected from private and public payers.

''(h) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $50,000,000 for each of fiscal years 2022 and 2023, and $25,000,000 for fiscal year 2024, to remain available until expended.''.

(b) STANDARDIZED REPORTING FORMAT.—

Subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191 et seq.) is amended by adding at the end the following:

''SEC. 735. STANDARDIZED REPORTING FORMAT.

''(a) IN GENERAL.—Not later than 1 year after the date of enactment of this section, the Secretary shall establish (and periodically update) a standardized reporting format for the voluntary reporting, by group health plans to State All Payer Claims Databases, of medical claims,

pharmacy claims, dental claims, and eligibility and provider files that are collected from private and public payers, and shall provide guidance to States on the process by which States may collect such data from such plans in the standardized reporting format.

''(b) CONSULTATION.—

''(1) ADVISORY COMMITTEE.—Not later than 90 days after the date of enactment of this section, the Secretary shall convene an Advisory Committee (referred to in this section as the 'Committee'), consisting of 15 members to advise the Secretary regarding the format and guidance described in paragraph (1).

''(2) MEMBERSHIP.—

''(A) APPOINTMENT.—In accordance with subparagraph (B), not later than 90 days after the date of enactment this section, the Secretary, in coordination with the Secretary of Health and Human Services, shall appoint under subparagraph (B)(iii), and the Comptroller General of the United States shall appoint under subparagraph (B)(iv), members who have distinguished themselves in the fields of health services research, health economics, health informatics, data privacy and security, or

the governance of State All Payer Claims Databases, or who represent organizations likely to submit data to or use the database, including patients, employers, or employee organizations that sponsor group health plans, health care providers, health insurance issuers, or third-party administrators of group health plans. Such members shall serve 3-year terms on a staggered basis. Vacancies on the Committee shall be filled by appointment consistent with this paragraph not later than 3 months after the vacancy arises.

''(B) COMPOSITION.—The Committee shall be comprised of—

''(i) the Assistant Secretary of Employee Benefits and Security Administration of the Department of Labor, or a designee of such Assistant Secretary;

''(ii) the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services, or a designee of such Assistant Secretary;

''(iii) members appointed by the Secretary, in coordination with the Secretary

of Health and Human Services, including—

"(I) 1 member to serve as the chair of the Committee;

"(II) 1 representative of the Centers for Medicare & Medicaid Services;

"(III) 1 representative of the Agency for Healthcare Research and Quality;

"(IV) 1 representative of the Office for Civil Rights of the Department of Health and Human Services with expertise in data privacy and security;

"(V) 1 representative of the National Center for Health Statistics;

"(VI) 1 representative of the Office of the National Coordinator for Health Information Technology; and

"(VII) 1 representative of a State All-Payer Claims Database;

"(iv) members appointed by the Comptroller General of the United States, including—

"(I) 1 representative of an employer that sponsors a group health plan;

"(II) 1 representative of an employee organization that sponsors a group health plan;

"(III) 1 academic researcher with expertise in health economics or health services research;

"(IV) 1 consumer advocate; and

"(V) 2 additional members.

"(3) REPORT.—Not later than 180 days after the date of enactment of this section, the Committee shall report to the Secretary, the Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Energy and Commerce and the Committee on Education and Labor of the House of Representatives. Such report shall include recommendations on the establishment of the format and guidance described in subsection (a).

"(c) STATE ALL PAYER CLAIMS DATABASE.—In this section, the term 'State All Payer Claims Database' means, with respect to a State, a database that may include medical claims, pharmacy claims, dental claims, and

eligibility and provider files, which are collected from private and public payers.

''(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $5,000,000 for fiscal year 2021, to remain available until expended or, if sooner, until the date described in subsection (e).

''(e) SUNSET.—Beginning on the date on which the report is submitted under subsection (b)(3), subsection (b) shall have no force or effect.''.

SEC. 116. PROTECTING PATIENTS AND IMPROVING THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

(a) PHSA.—Part D of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as added and amended by section 102 and further amended by the previous provisions of this title, is further amended by inserting after section 2799A–4 the following:

''SEC. 2799A–5. PROTECTING PATIENTS AND IMPROVING THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

''(a) PROVIDER DIRECTORY INFORMATION REQUIREMENTS.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2022, each group health plan

and health insurance issuer offering group or individual health insurance coverage shall—

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

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

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

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

"(2) VERIFICATION PROCESS.—The verification process described in this paragraph is, with respect to a group health plan or a health insurance issuer offering group or individual health insurance coverage, a process—

"(A) under which, not less frequently than once every 90 days, such plan or such issuer (as applicable) verifies and updates the provider directory information included on the database described in paragraph (4) of such plan or issuer of each health care provider and health care facility included in such database;

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

''(C) that provides for the update of such database within 2 business days of such plan or issuer receiving from such a provider or facility information pursuant to section 2799B–9.

''(3) RESPONSE PROTOCOL.—The response protocol described in this paragraph is, in the case of an individual enrolled under a group health plan or group or individual health insurance coverage offered by a health insurance issuer who requests information through a telephone call or electronic, web-based, or Internet-based means on whether a health care provider or health care facility has a contractual relationship to furnish items and services under such plan or such coverage, a protocol under which such plan or such issuer (as applicable), in the case such request is made through a telephone call—

''(A) responds to such individual as soon as practicable and in no case later than 1 business day after such call is received, through a

written electronic or print (as requested by such individual) communication; and

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

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

"(A) a list of each health care provider and health care facility with which such plan or such issuer has a direct or indirect contractual relationship for furnishing items and services under such plan or such coverage; and

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

"(5) INFORMATION.—The information described in this paragraph is, with respect to a print directory containing provider directory information with respect to a group health plan or individual or group health insurance coverage offered by a health insurance issuer, a notification that such information contained in such directory was accurate as of

the date of publication of such directory and that an individual enrolled under such plan or such coverage should consult the database described in paragraph (4) with respect to such plan or such coverage or contact such plan or the issuer of such coverage to obtain the most current provider directory information with respect to such plan or such coverage.

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

''(7) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to preempt any provision of State law relating to health care provider directories.

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

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

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

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

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

''(A) The participant, beneficiary, or enrollee received through a database, provider directory, or response protocol described in subsection (a) information with respect to such item and service to be furnished and such information provided that the provider was a participating provider or facility was a participating facility, with respect to the plan for furnishing such item or service.

''(B) The information was not provided, in accordance with subsection (a), to the participant, beneficiary, or enrollee and the participant, beneficiary, or enrollee requested through the response protocol described in subsection (a)(3) of the plan or coverage information on whether the provider was a participating provider or facility was a participating facility with

respect to the plan for furnishing such item or service and was informed through such protocol that the provider was such a participating provider or facility was such a participating facility.

''(c) DISCLOSURE ON PATIENT PROTECTIONS AGAINST BALANCE BILLING.—For plan years beginning on or after January 1, 2022, each group health plan and health insurance issuer offering group or individual health insurance coverage shall make publicly available, post on a public website of such plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements under section 2799A–1 applies—

''(1) information in plain language on—

''(A) the requirements and prohibitions applied under sections 2799B–1 and 2799B–2 (relating to prohibitions on balance billing in certain circumstances);

''(B) if provided for under applicable State law, any other requirements on providers and facilities regarding the amounts such providers and facilities may, with respect to an item or service, charge a participant, beneficiary, or enrollee of such plan or coverage with respect to

which such a provider or facility does not have a contractual relationship for furnishing such item or service under the plan or coverage after receiving payment from the plan or coverage for such item or service and any applicable cost sharing payment from such participant, beneficiary, or enrollee; and

''(C) the requirements applied under section 2799A-1; and

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

(b) ERISA.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by sections 102, 105, 113, and 114, is further amended by inserting after section 719 the following:

''SEC. 720. PROTECTING PATIENTS AND IMPROVING THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

''(a) PROVIDER DIRECTORY INFORMATION REQUIREMENTS.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2022, each group health plan and health insurance issuer offering group health insurance coverage shall—

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

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

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

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

''(2) VERIFICATION PROCESS.—The verification process described in this paragraph is, with respect to a group health plan or a health insurance issuer offering group health insurance coverage, a process—

''(A) under which, not less frequently than once every 90 days, such plan or such issuer (as applicable) verifies and updates the provider directory information included on the database described in paragraph (4) of such plan or

issuer of each health care provider and health care facility included in such database;

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

"(C) that provides for the update of such database within 2 business days of such plan or issuer receiving from such a provider or facility information pursuant to section 2799B–9 of the Public Health Service Act.

"(3) RESPONSE PROTOCOL.—The response protocol described in this paragraph is, in the case of an individual enrolled under a group health plan or group health insurance coverage offered by a health insurance issuer who requests information through a telephone call or electronic, web-based, or Internet-based means on whether a health care provider or health care facility has a contractual relationship to furnish items and services under such plan or such coverage, a protocol under which such plan or such issuer (as applicable), in the case such request is made through a telephone call—

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

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

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

"(A) a list of each health care provider and health care facility with which such plan or such issuer has a direct or indirect contractual relationship for furnishing items and services under such plan or such coverage; and

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

"(5) INFORMATION.—The information described in this paragraph is, with respect to a print directory containing provider directory information with respect to a group health plan or group health insurance coverage offered by a health insurance

issuer, a notification that such information contained in such directory was accurate as of the date of publication of such directory and that an individual enrolled under such plan or such coverage should consult the database described in paragraph (4) with respect to such plan or such coverage or contact such plan or the issuer of such coverage to obtain the most current provider directory information with respect to such plan or such coverage.

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

''(7) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to preempt any provision of State law relating to health care provider directories, to the extent such State law applies to such plan, coverage, or issuer, subject to section 514.

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

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

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

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

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

''(A) The participant or beneficiary received through a database, provider directory, or response protocol described in subsection (a) information with respect to such item and service to be furnished and such information provided that the provider was a participating provider or facility was a participating facility, with respect to the plan for furnishing such item or service.

''(B) The information was not provided, in accordance with subsection (a), to the participant or beneficiary and the participant or beneficiary requested through the response protocol described in subsection (a)(3) of the plan or coverage information on whether the provider was a participating provider or facility was a participating facility with respect to the plan for furnishing such item or service and was in-

formed through such protocol that the provider was such a participating provider or facility was such a participating facility.

''(c) DISCLOSURE ON PATIENT PROTECTIONS AGAINST BALANCE BILLING.—For plan years beginning on or after January 1, 2022, each group health plan and health insurance issuer offering group health insurance coverage shall make publicly available, post on a public website of such plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements under section 716 applies—

''(1) information in plain language on—

''(A) the requirements and prohibitions applied under sections 2799B–1 and 2799B–2 of the Public Health Service 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 or coverage with respect to which such a provider or facility does not have a contractual relationship for furnishing such item or

service under the plan or coverage after receiving payment from the plan or coverage for such item or service and any applicable cost sharing payment from such participant or beneficiary; and

"(C) the requirements applied under section 716; and

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

(c) IRC.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by sections 102, 105, 113, and 114, is further amended by inserting after section 9819 the following:

"SEC. 9820. PROTECTING PATIENTS AND IMPROVING THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

"(a) PROVIDER DIRECTORY INFORMATION REQUIREMENTS.—

"(1) IN GENERAL.—For plan years beginning on or after January 1, 2022, each group health plan shall—

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

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

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

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

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

''(A) under which, not less frequently than once every 90 days, such plan verifies and updates the provider directory information included on the database described in paragraph (4) of such plan or issuer of each health care provider and health care facility included in such database;

''(B) that establishes a procedure for the removal of such a provider or facility with respect to which such plan or issuer has been un-

able to verify such information during a period specified by the plan or issuer; and

''(C) that provides for the update of such database within 2 business days of such plan or issuer receiving from such a provider or facility information pursuant to section 2799B–9 of the Public Health Service Act.

''(3) RESPONSE PROTOCOL.—The response protocol described in this paragraph is, in the case of an individual enrolled under a group health plan who requests information through a telephone call or electronic, web-based, or Internet-based means on whether a health care provider or health care facility has a contractual relationship to furnish items and services under such plan, a protocol under which such plan or such issuer (as applicable), in the case such request is made through a telephone call—

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

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

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

''(A) a list of each health care provider and health care facility with which such plan or such issuer has a direct or indirect contractual relationship for furnishing items and services under such plan; and

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

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

''(6) DEFINITION.—For purposes of this subsection, the term 'provider directory information' includes, with respect to a group health plan, the

name, address, specialty, telephone number, and digital contact information of each health care provider or health care facility with which such plan has a contractual relationship for furnishing items and services under such plan.

''(7) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to preempt any provision of State law relating to health care provider directories.

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

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

''(A) shall not impose on such participant or beneficiary a cost-sharing amount for such item or service so furnished that is greater than

the cost-sharing amount that would apply under such plan had such item or service been furnished by a participating provider; and

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

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

"(A) The participant or beneficiary received through a database, provider directory, or response protocol described in subsection (a) information with respect to such item and service to be furnished and such information provided that the provider was a participating provider or facility was a participating facility, with respect to the plan for furnishing such item or service.

"(B) The information was not provided, in accordance with subsection (a), to the participant or beneficiary and the participant or bene-

ficiary requested through the response protocol described in subsection (a)(3) of the plan information on whether the provider was a participating provider or facility was a participating facility with respect to the plan for furnishing such item or service and was informed through such protocol that the provider was such a participating provider or facility was such a participating facility.

''(c) DISCLOSURE ON PATIENT PROTECTIONS AGAINST BALANCE BILLING.—For plan years beginning on or after January 1, 2022, each group health plan shall make publicly available, post on a public website of such plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements under section 9816 applies—

''(1) information in plain language on—

''(A) the requirements and prohibitions applied under sections 2799B–1 and 2799B–2 of the Public Health Service 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 or facility does not have a contractual relationship for furnishing such item or service under the plan after receiving payment from the plan for such item or service and any applicable cost sharing payment from such participant or beneficiary; and

''(C) the requirements applied under section 9816; and

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

(d) CLERICAL AMENDMENTS.—

(1) ERISA.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), as amended by the previous provisions of this title, is further amended by inserting after the item relating to section 719 the following new item:

''720. Protecting patients and improving the accuracy of provider directory information.''.

(2) IRC.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by the previous provisions of this title, is further amended by inserting after the item relating to section 9819 the following new item:

"9820. Protecting patients and improving the accuracy of provider directory information.".

(e) PROVIDER REQUIREMENTS.—Part E of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as added by section 104 and as further amended by the previous provisions of this title, is further amended by adding at the end the following:

"SEC. 2799B–9. PROVIDER REQUIREMENTS TO PROTECT PATIENTS AND IMPROVE THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

"(a) PROVIDER BUSINESS PROCESSES.—Beginning not later than January 1, 2022, each health care provider and each health care facility shall have in place business processes to ensure the timely provision of provider directory information to a group health plan or a health insurance issuer offering group or individual health insurance coverage to support compliance by such plans or issuers with section 2799A–5(a)(1), section 720(a)(1) of the Employee Retirement Income Security Act of 1974, or section 9820(a)(1) of the Internal Revenue Code of 1986, as ap-

plicable. Such providers shall submit provider directory information to a plan or issuers, at a minimum—

''(1) when the provider or facility begins a network agreement with a plan or with an issuer with respect to certain coverage;

''(2) when the provider or facility terminates a network agreement with a plan or with an issuer with respect to certain coverage;

''(3) when there are material changes to the content of provider directory information of the provider or facility described in section 2799A–5(a)(1), section 720(a)(1) of the Employee Retirement Income Security Act of 1974, or section 9820(a)(1) of the Internal Revenue Code of 1986, as applicable; and

''(4) at any other time (including upon the request of such issuer or plan) determined appropriate by the provider, facility, or the Secretary.

''(b) REFUNDS TO ENROLLEES.—If a health care provider submits a bill to an enrollee based on cost-sharing for treatment or services provided by the health care provider that is in excess of the normal cost-sharing applied for such treatment or services provided in-network, as prohibited under section 2799A–5(b), section 720(b) of the Employee Retirement Income Security Act of 1974, or

section 9820(b) of the Internal Revenue Code of 1986, as applicable, and the enrollee pays such bill, the provider shall reimburse the enrollee for the full amount paid by the enrollee in excess of the in-network cost-sharing amount for the treatment or services involved, plus interest, at an interest rate determined by the Secretary.

''(c) LIMITATION.—Nothing in this section shall prohibit a provider from requiring in the terms of a contract, or contract termination, with a group health plan or health insurance issuer—

''(1) that the plan or issuer remove, at the time of termination of such contract, the provider from a directory of the plan or issuer described in section 2799A–5(a), section 720(a) of the Employee Retirement Income Security Act of 1974, or section 9820(a) of the Internal Revenue Code of 1986, as applicable; or

''(2) that the plan or issuer bear financial responsibility, including under section 2799A–5(b), section 720(b) of the Employee Retirement Income Security Act of 1974, or section 9820(b) of the Internal Revenue Code of 1986, as applicable, for providing inaccurate network status information to an enrollee.

''(d) DEFINITION.—For purposes of this section, the term 'provider directory information' includes the names, addresses, specialty, telephone numbers, and digital contact information of individual health care providers, and the names, addresses, telephone numbers, and digital contact information of each medical group, clinic, or facility contracted to participate in any of the networks of the group health plan or health insurance coverage involved.

''(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to preempt any provision of State law relating to health care provider directories.''.

SEC. 117. ADVISORY COMMITTEE ON GROUND AMBULANCE AND PATIENT BILLING.

(a) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary of Labor, Secretary of Health and Human Services, and the Secretary of the Treasury (the Secretaries) shall jointly establish an advisory committee for the purpose of reviewing options to improve the disclosure of charges and fees for ground ambulance services, better inform consumers of insurance options for such services, and protect consumers from balance billing.

(b) COMPOSITION OF THE ADVISORY COMMITTEE.—The advisory committee shall be composed of the following members:

(1) The Secretary of Labor, or the Secretary's designee.

(2) The Secretary of Health and Human Services, or the Secretary's designee.

(3) The Secretary of the Treasury, or the Secretary's designee.

(4) One representative, to be appointed jointly by the Secretaries, for each of the following:

(A) Each relevant Federal agency, as determined by the Secretaries.

(B) State insurance regulators.

(C) Health insurance providers.

(D) Patient advocacy groups.

(E) Consumer advocacy groups.

(F) State and local governments.

(G) Physician specializing in emergency, trauma, cardiac, or stroke.

(H) State Emergency Medical Services Officials.

(I) Emergency medical technicians, paramedics, and other emergency medical services personnel.

(5) Three representatives, to be appointed jointly by the Secretaries, to represent the various segments of the ground ambulance industry.

(6) Up to an additional 2 representatives otherwise not described in paragraphs (1) through (5), as determined necessary and appropriate by the Secretaries.

(c) CONSULTATION.—The advisory committee shall, as appropriate, consult with relevant experts and stakeholders, including those not otherwise included under subsection (b), while conducting the review described in subsection (a).

(d) RECOMMENDATIONS.—The advisory committee shall make recommendations with respect to disclosure of charges and fees for ground ambulance services and insurance coverage, consumer protection and enforcement authorities of the Departments of Labor, Health and Human Services, and the Treasury and State authorities, and the prevention of balance billing to consumers. The recommendations shall address, at a minimum—

(1) options, best practices, and identified standards to prevent instances of balance billing;

(2) steps that can be taken by State legislatures, State insurance regulators, State attorneys general, and other State officials as appropriate, consistent with current legal authorities regarding consumer protection; and

(3) legislative options for Congress to prevent balance billing.

(e) REPORT.—Not later than 180 days after the date of the first meeting of the advisory committee, the advisory committee shall submit to the Secretaries, and the Committees on Education and Labor, Energy and Commerce, and Ways and Means of the House of Representatives and the Committees on Finance and Health, Education, Labor, and Pensions a report containing the recommendations made under subsection (d).

SEC. 118. IMPLEMENTATION FUNDING.

(a) IN GENERAL.—For the purposes described in subsection (b), there are appropriated, out of amounts in the Treasury not otherwise appropriated, to the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury, $500,000,000 for fiscal year 2021, to remain available until expended through 2024.

(b) PERMITTED PURPOSES.—The purposes described in this subsection are limited to the following purposes, insofar as such purposes are to carry out the provisions of, including the amendments made by, this title and title II:

(1) Preparing, drafting, and issuing proposed and final regulations or interim regulations.

(2) Preparing, drafting, and issuing guidance and public information.

(3) Preparing and holding public meetings.

(4) Preparing, drafting, and publishing reports.

(5) Enforcement of such provisions.

(6) Reporting, collection, and analysis of data.

(7) Establishment and initial implementation of the processes for independent dispute resolution and implementation of patient-provider dispute resolution under such provisions.

(8) Conducting audits.

(9) Other administrative duties necessary for implementation of such provisions.

(c) TRANSPARENCY OF IMPLEMENTATION FUNDS.—Each Secretary described in subsection (a) shall annually submit to the Committees on Energy and Commerce, on Ways and Means, on Education and Labor, and on Appropriations of the House of Representatives and on the Committees on Health, Education, Labor, and Pensions and on Appropriations of the Senate a report on funds expended pursuant to funds appropriated under this section.

TITLE II—TRANSPARENCY

SEC. 201. INCREASING TRANSPARENCY BY REMOVING GAG CLAUSES ON PRICE AND QUALITY INFORMATION.

(a) PHSA.—Part D of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as added and amended by title I, is further amended by adding at the end the following:

"SEC. 2799A–9. INCREASING TRANSPARENCY BY REMOVING GAG CLAUSES ON PRICE AND QUALITY INFORMATION.

''(a) INCREASING PRICE AND QUALITY TRANSPARENCY FOR PLAN SPONSORS AND GROUP AND INDIVIDUAL MARKET CONSUMERS.—

''(1) GROUP HEALTH PLANS.—A group health plan or health insurance issuer offering group health insurance coverage may not enter into an agreement with a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict a group health plan or health insurance issuer offering such coverage from—

''(A) providing provider-specific cost or quality of care information or data, through a

consumer engagement tool or any other means, to referring providers, the plan sponsor, enrollees, or individuals eligible to become enrollees of the plan or coverage;

"(B) electronically accessing de-identified claims and encounter information or data for each enrollee in the plan or coverage, upon request and consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990, including, on a per claim basis—

"(i) financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract;

"(ii) provider information, including name and clinical designation;

"(iii) service codes; or

"(iv) any other data element included in claim or encounter transactions; or

"(C) sharing information or data described in subparagraph (A) or (B), or directing that

such data be shared, with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.

''(2) INDIVIDUAL HEALTH INSURANCE COVERAGE.—A health insurance issuer offering individual health insurance coverage may not enter into an agreement with a health care provider, network or association of providers, or other service provider offering access to a network of providers that would directly or indirectly restrict the health insurance issuer from—

''(A) providing provider-specific price or quality of care information, through a consumer engagement tool or any other means, to referring providers, enrollees, or individuals eligible to become enrollees of the plan or coverage; or

''(B) sharing, for plan design, plan administration, and plan, financial, legal, and quality

improvement activities, data described in subparagraph (A) with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.

''(3) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in paragraph (1)(A) or (2)(A) prevents a health care provider, network or association of providers, or other service provider from placing reasonable restrictions on the public disclosure of the information described in such paragraphs (1) and (2).

''(4) ATTESTATION.—A group health plan or a health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary an attestation that such plan or issuer of such coverage is in compliance with the requirements of this subsection.

''(5) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to modify or eliminate

existing privacy protections and standards under State and Federal law. Nothing in this subsection shall be construed to otherwise limit access by a group health plan, plan sponsor, or health insurance issuer to data as permitted under the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.''.

(b) ERISA.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by title I, is further amended by adding at the end the following:

''SEC. 724. INCREASING TRANSPARENCY BY REMOVING GAG CLAUSES ON PRICE AND QUALITY INFORMATION.

''(a) INCREASING PRICE AND QUALITY TRANSPARENCY FOR PLAN SPONSORS AND CONSUMERS.—

''(1) IN GENERAL.—A group health plan (or an issuer of health insurance coverage offered in connection with such a plan) may not enter into an agreement with a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network

of providers that would directly or indirectly restrict a group health plan or health insurance issuer offering such coverage from—

"(A) providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, participants or beneficiaries, or individuals eligible to become participants or beneficiaries of the plan or coverage;

"(B) electronically accessing de-identified claims and encounter information or data for each participant or beneficiary in the plan or coverage, upon request and consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990, including, on a per claim basis—

"(i) financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract;

"(ii) provider information, including name and clinical designation;

"(iii) service codes; or

"(iv) any other data element included in claim or encounter transactions; or

"(C) sharing information or data described in subparagraph (A) or (B), or directing that such data be shared, with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.

"(2) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in paragraph (1)(A) prevents a health care provider, network or association of providers, or other service provider from placing reasonable restrictions on the public disclosure of the information described in such paragraph (1).

''(3) ATTESTATION.—A group health plan (or health insurance coverage offered in connection with such a plan) shall annually submit to the Secretary an attestation that such plan or issuer of such coverage is in compliance with the requirements of this subsection.

''(4) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to modify or eliminate existing privacy protections and standards under State and Federal law. Nothing in this subsection shall be construed to otherwise limit access by a group health plan, plan sponsor, or health insurance issuer to data as permitted under the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.''.

(c) IRC.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by title I, is further amended by adding at the end the following:

"SEC. 9824. INCREASING TRANSPARENCY BY REMOVING GAG CLAUSES ON PRICE AND QUALITY INFORMATION.

"(a) INCREASING PRICE AND QUALITY TRANSPARENCY FOR PLAN SPONSORS AND CONSUMERS.—

"(1) IN GENERAL.—A group health plan may not enter into an agreement with a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict a group health plan from—

"(A) providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, participants or beneficiaries, or individuals eligible to become participants or beneficiaries of the plan;

"(B) electronically accessing de-identified claims and encounter information or data for each participant or beneficiary in the plan, upon request and consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Non-

discrimination Act of 2008, and the Americans with Disabilities Act of 1990, including, on a per claim basis—

''(i) financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract;

''(ii) provider information, including name and clinical designation;

''(iii) service codes; or

''(iv) any other data element included in claim or encounter transactions; or

''(C) sharing information or data described in subparagraph (A) or (B), or directing that such data be shared, with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.

''(2) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in paragraph (1)(A) prevents a health care provider, network or association of providers, or other service provider from placing reasonable restrictions on the public disclosure of the information described in such paragraph (1).

''(3) ATTESTATION.—A group health plan shall annually submit to the Secretary an attestation that such plan is in compliance with the requirements of this subsection.

''(4) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to modify or eliminate existing privacy protections and standards under State and Federal law. Nothing in this subsection shall be construed to otherwise limit access by a group health plan or plan sponsor to data as permitted under the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.''.

(d) CLERICAL AMENDMENTS.—

(1) ERISA.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), as amended by title I, is further amended by inserting after the item relating to section 723 the following new item:

''Sec. 724. Increasing transparency by removing gag clauses on price and quality information.''.

(2) IRC.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by title I, is further amended by adding at the end the following new item:

''Sec. 9824. Increasing transparency by removing gag clauses on price and quality information.''.

SEC. 202. DISCLOSURE OF DIRECT AND INDIRECT COMPENSATION FOR BROKERS AND CONSULTANTS TO EMPLOYER-SPONSORED HEALTH PLANS AND ENROLLEES IN PLANS ON THE INDIVIDUAL MARKET.

(a) GROUP HEALTH PLANS.—Section 408(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1108(b)(2)) is amended—

(1) by striking ''(2) Contracting or making'' and inserting ''(2)(A) Contracting or making''; and

(2) by adding at the end the following:

''(B)(i) No contract or arrangement for services between a covered plan and a covered service provider, and no extension or renewal of such a contract

or arrangement, is reasonable within the meaning of this paragraph unless the requirements of this clause are met.

''(ii)(I) For purposes of this subparagraph:

''(aa) The term 'covered plan' means a group health plan as defined section 733(a).

''(bb) The term 'covered service provider' means a service provider that enters into a contract or arrangement with the covered plan and reasonably expects $1,000 (or such amount as the Secretary may establish in regulations to account for inflation since the date of enactment of the Consolidated Appropriations Act, 2021, as appropriate) or more in compensation, direct or indirect, to be received in connection with providing one or more of the following services, pursuant to the contract or arrangement, regardless of whether such services will be performed, or such compensation received, by the covered service provider, an affiliate, or a subcontractor:

''(AA) Brokerage services, for which the covered service provider, an affiliate, or a subcontractor reasonably expects to receive indirect compensation or direct com-

pensation described in item (dd), provided to a covered plan with respect to selection of insurance products (including vision and dental), recordkeeping services, medical management vendor, benefits administration (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness services, transparency tools and vendors, group purchasing organization preferred vendor panels, disease management vendors and products, compliance services, employee assistance programs, or third party administration services.

''(BB) Consulting, for which the covered service provider, an affiliate, or a subcontractor reasonably expects to receive indirect compensation or direct compensation described in item (dd), related to the development or implementation of plan design, insurance or insurance product selection (including vision and dental), recordkeeping, medical management, benefits administration selection (including vision and dental), stop-loss insurance, pharmacy ben-

efit management services, wellness design and management services, transparency tools, group purchasing organization agreements and services, participation in and services from preferred vendor panels, disease management, compliance services, employee assistance programs, or third party administration services.

''(cc) The term 'affiliate', with respect to a covered service provider, means an entity that directly or indirectly (through one or more intermediaries) controls, is controlled by, or is under common control with, such provider, or is an officer, director, or employee of, or partner in, such provider.

''(dd)(AA) The term 'compensation' means anything of monetary value, but does not include non-monetary compensation valued at $250 (or such amount as the Secretary may establish in regulations to account for inflation since the date of enactment of the Consolidated Appropriations Act, 2021, as appropriate) or less, in the aggregate, during the term of the contract or arrangement.

"(BB) The term 'direct compensation' means compensation received directly from a covered plan.

"(CC) The term 'indirect compensation' means compensation received from any source other than the covered plan, the plan sponsor, the covered service provider, or an affiliate. Compensation received from a subcontractor is indirect compensation, unless it is received in connection with services performed under a contract or arrangement with a subcontractor.

"(ee) The term 'responsible plan fiduciary' means a fiduciary with authority to cause the covered plan to enter into, or extend or renew, the contract or arrangement.

"(ff) The term 'subcontractor' means any person or entity (or an affiliate of such person or entity) that is not an affiliate of the covered service provider and that, pursuant to a contract or arrangement with the covered service provider or an affiliate, reasonably expects to receive $1,000 (or such amount as the Secretary may establish in regulations to account for inflation since the date of enactment of the Consolidated Appropriations Act, 2021, as ap-

propriate) or more in compensation for performing one or more services described in item (bb) under a contract or arrangement with the covered plan.

''(II) For purposes of this subparagraph, a description of compensation or cost may be expressed as a monetary amount, formula, or a per capita charge for each enrollee or, if the compensation or cost cannot reasonably be expressed in such terms, by any other reasonable method, including a disclosure that additional compensation may be earned but may not be calculated at the time of contract if such a disclosure includes a description of the circumstances under which the additional compensation may be earned and a reasonable and good faith estimate if the covered service provider cannot otherwise readily describe compensation or cost and explains the methodology and assumptions used to prepare such estimate. Any such description shall contain sufficient information to permit evaluation of the reasonableness of the compensation or cost.

''(III) No person or entity is a 'covered service provider' within the meaning of subclause (I)(bb) solely on the basis of providing services as an affiliate or a subcontractor that is performing one or

more of the services described in subitem (AA) or (BB) of such subclause under the contract or arrangement with the covered plan.

''(iii) A covered service provider shall disclose to a responsible plan fiduciary, in writing, the following:

''(I) A description of the services to be provided to the covered plan pursuant to the contract or arrangement.

''(II) If applicable, a statement that the covered service provider, an affiliate, or a subcontractor will provide, or reasonably expects to provide, services pursuant to the contract or arrangement directly to the covered plan as a fiduciary (within the meaning of section 3(21)).

''(III) A description of all direct compensation, either in the aggregate or by service, that the covered service provider, an affiliate, or a subcontractor reasonably expects to receive in connection with the services described in subclause (I).

''(IV)(aa) A description of all indirect compensation that the covered service provider, an affiliate, or a subcontractor reasonably expects

to receive in connection with the services described in subclause (I)—

"(AA) including compensation from a vendor to a brokerage firm based on a structure of incentives not solely related to the contract with the covered plan; and

"(BB) not including compensation received by an employee from an employer on account of work performed by the employee.

"(bb) A description of the arrangement between the payer and the covered service provider, an affiliate, or a subcontractor, as applicable, pursuant to which such indirect compensation is paid.

"(cc) Identification of the services for which the indirect compensation will be received, if applicable.

"(dd) Identification of the payer of the indirect compensation.

"(V) A description of any compensation that will be paid among the covered service provider, an affiliate, or a subcontractor, in connection with the services described in subclause (I) if such compensation is set on a transaction

basis (such as commissions, finder's fees, or other similar incentive compensation based on business placed or retained), including identification of the services for which such compensation will be paid and identification of the payers and recipients of such compensation (including the status of a payer or recipient as an affiliate or a subcontractor), regardless of whether such compensation also is disclosed pursuant to subclause (III) or (IV).

''(VI) A description of any compensation that the covered service provider, an affiliate, or a subcontractor reasonably expects to receive in connection with termination of the contract or arrangement, and how any prepaid amounts will be calculated and refunded upon such termination.

''(iv) A covered service provider shall disclose to a responsible plan fiduciary, in writing a description of the manner in which the compensation described in clause (iii), as applicable, will be received.

''(v)(I) A covered service provider shall disclose the information required under clauses (iii) and (iv) to the responsible plan fiduciary not later than the date that is reasonably in advance of the date on

which the contract or arrangement is entered into, and extended or renewed.

''(II) A covered service provider shall disclose any change to the information required under clause (iii) and (iv) as soon as practicable, but not later than 60 days from the date on which the covered service provider is informed of such change, unless such disclosure is precluded due to extraordinary circumstances beyond the covered service provider's control, in which case the information shall be disclosed as soon as practicable.

''(vi)(I) Upon the written request of the responsible plan fiduciary or covered plan administrator, a covered service provider shall furnish any other information relating to the compensation received in connection with the contract or arrangement that is required for the covered plan to comply with the reporting and disclosure requirements under this Act.

''(II) The covered service provider shall disclose the information required under clause (iii)(I) reasonably in advance of the date upon which such responsible plan fiduciary or covered plan administrator states that it is required to comply with the applicable reporting or disclosure requirement, unless such disclosure is precluded due to extraordinary cir-

cumstances beyond the covered service provider's control, in which case the information shall be disclosed as soon as practicable.

''(vii) No contract or arrangement will fail to be reasonable under this subparagraph solely because the covered service provider, acting in good faith and with reasonable diligence, makes an error or omission in disclosing the information required pursuant to clause (iii) (or a change to such information disclosed pursuant to clause (v)(II)) or clause (vi), provided that the covered service provider discloses the correct information to the responsible plan fiduciary as soon as practicable, but not later than 30 days from the date on which the covered service provider knows of such error or omission.

''(viii)(I) Pursuant to subsection (a), subparagraphs (C) and (D) of section 406(a)(1) shall not apply to a responsible plan fiduciary, notwithstanding any failure by a covered service provider to disclose information required under clause (iii), if the following conditions are met:

''(aa) The responsible plan fiduciary did not know that the covered service provider failed or would fail to make required disclosures and reasonably believed that the covered service

provider disclosed the information required to be disclosed.

''(bb) The responsible plan fiduciary, upon discovering that the covered service provider failed to disclose the required information, requests in writing that the covered service provider furnish such information.

''(cc) If the covered service provider fails to comply with a written request described in subclause (II) within 90 days of the request, the responsible plan fiduciary notifies the Secretary of the covered service provider's failure, in accordance with subclauses (II) and (III).

''(II) A notice described in subclause (I)(cc) shall contain—

''(aa) the name of the covered plan;

''(bb) the plan number used for the annual report on the covered plan;

''(cc) the plan sponsor's name, address, and employer identification number;

''(dd) the name, address, and telephone number of the responsible plan fiduciary;

''(ee) the name, address, phone number, and, if known, employer identification number of the covered service provider;

"(ff) a description of the services provided to the covered plan;

"(gg) a description of the information that the covered service provider failed to disclose;

"(hh) the date on which such information was requested in writing from the covered service provider; and

"(ii) a statement as to whether the covered service provider continues to provide services to the plan.

"(III) A notice described in subclause (I)(cc) shall be filed with the Department not later than 30 days following the earlier of—

"(aa) The covered service provider's refusal to furnish the information requested by the written request described in subclause (I)(bb); or

"(bb) 90 days after the written request referred to in subclause (I)(cc) is made.

"(IV) If the covered service provider fails to comply with the written request under subclause (I)(bb) within 90 days of such request, the responsible plan fiduciary shall determine whether to terminate or continue the contract or arrangement under section 404. If the requested information re-

lates to future services and is not disclosed promptly after the end of the 90-day period, the responsible plan fiduciary shall terminate the contract or arrangement as expeditiously as possible, consistent with such duty of prudence.

''(ix) Nothing in this subparagraph shall be construed to supersede any provision of State law that governs disclosures by parties that provide the services described in this section, except to the extent that such law prevents the application of a requirement of this section.''.

(b) APPLICABILITY OF EXISTING REGULATIONS.—Nothing in the amendments made by subsection (a) shall be construed to affect the applicability of section 2550.408b–2 of title 29, Code of Federal Regulations (or any successor regulations), with respect to any applicable entity other than a covered plan or a covered service provider (as defined in section 408(b)(2)(B)(ii) of the Employee Retirement Income Security Act of 1974, as amended by subsection (a)).

(c) INDIVIDUAL MARKET COVERAGE.—Subpart 1 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–41 et seq.) is amended by adding at the end the following:

"SEC. 2746. DISCLOSURE TO ENROLLEES OF INDIVIDUAL MARKET COVERAGE.

''(a) IN GENERAL.—A health insurance issuer offering individual health insurance coverage or a health insurance issuer offering short-term limited duration insurance coverage shall make disclosures to enrollees in such coverage, as described in subsection (b), and reports to the Secretary, as described in subsection (c), regarding direct or indirect compensation provided by the issuer to an agent or broker associated with enrolling individuals in such coverage.

''(b) DISCLOSURE.—A health insurance issuer described in subsection (a) shall disclose to an enrollee the amount of direct or indirect compensation provided to an agent or broker for services provided by such agent or broker associated with plan selection and enrollment. Such disclosure shall be—

''(1) made prior to the individual finalizing plan selection; and

''(2) included on any documentation confirming the individual's enrollment.

''(c) REPORTING.—A health insurance issuer described in subsection (a) shall annually report to the Secretary, prior to the beginning of open enrollment, any direct or indirect compensation provided to an agent or

broker associated with enrolling individuals in such coverage.

''(d) RULEMAKING.—Not later than 1 year after the date of enactment of the Consolidated Appropriations Act, 2021, the Secretary shall finalize, through notice-and-comment rulemaking, the timing, form, and manner in which issuers described in subsection (a) are required to make the disclosures described in subsection (b) and the reports described in subsection (c). Such rulemaking may also include adjustments to notice requirements to reflect the different processes for plan renewals, in order to provide enrollees with full, timely information.''.

(d) TRANSITION RULE.—No contract executed prior to the effective date described in subsection (e) by a group health plan subject to the requirements of section 408(b)(2)(B) of the Employee Retirement Income Security Act of 1974 (as amended by subsection (a)) or by a health insurance issuer subject to the requirements of section 2746 of the Public Health Service Act (as added by subsection (c)) shall be subject to the requirements of such section 408(b)(2)(B) or such section 2746, as applicable.

(e) APPLICATION.—The amendments made by subsections (a) and (c) shall apply beginning 1 year after the date of enactment of this Act.

SEC. 203. STRENGTHENING PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.

(a) IN GENERAL.—

(1) PHSA.—Section 2726(a) of the Public Health Service Act (42 U.S.C. 300gg–26(a)) is amended by adding at the end the following:

''(8) COMPLIANCE REQUIREMENTS.—

''(A) NONQUANTITATIVE TREATMENT LIMITATION (NQTL) REQUIREMENTS.—In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits and that imposes nonquantitative treatment limitations (referred to in this section as 'NQTLs') on mental health or substance use disorder benefits, such plan or issuer shall perform and document comparative analyses of the design and application of NQTLs and, beginning 45 days after the date of enactment of the Consolidated Appropriations Act, 2021, make available to the applicable State authority (or, as applicable, to the Secretary of Labor or the Secretary of Health and Human Services), upon request, the comparative analyses and the following information:

''(i) The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification.

''(ii) The factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits.

''(iii) The evidentiary standards used for the factors identified in clause (ii), when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits.

''(iv) The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to,

and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.

''(v) The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses described in this subparagraph that indicate that the plan or coverage is or is not in compliance with this section.

''(B) SECRETARY REQUEST PROCESS.—

''(i) SUBMISSION UPON REQUEST.—The Secretary shall request that a group health plan or a health insurance issuer offering group or individual health insurance coverage submit the comparative analyses described in subparagraph (A) for plans that involve potential violations of this section or complaints regarding noncompliance with this section that concern NQTLs and any other instances in which the Secretary determines appropriate. The Sec-

retary shall request not fewer than 20 such analyses per year.

''(ii) ADDITIONAL INFORMATION.—In instances in which the Secretary has concluded that the group health plan or health insurance issuer with respect to health insurance coverage has not submitted sufficient information for the Secretary to review the comparative analyses described in subparagraph (A), as requested under clause (i), the Secretary shall specify to the plan or issuer the information the plan or issuer must submit to be responsive to the request under clause (i) for the Secretary to review the comparative analyses described in subparagraph (A) for compliance with this section. Nothing in this paragraph shall require the Secretary to conclude that a group health plan or health insurance issuer is in compliance with this section solely based upon the inspection of the comparative analyses described in subparagraph (A), as requested under clause (i).

''(iii) REQUIRED ACTION.—

"(I) IN GENERAL.—In instances in which the Secretary has reviewed the comparative analyses described in subparagraph (A), as requested under clause (i), and determined that the group health plan or health insurance issuer is not in compliance with this section, the plan or issuer—

"(aa) shall specify to the Secretary the actions the plan or issuer will take to be in compliance with this section and provide to the Secretary additional comparative analyses described in subparagraph (A) that demonstrate compliance with this section not later than 45 days after the initial determination by the Secretary that the plan or issuer is not in compliance; and

"(bb) following the 45-day corrective action period under item (aa), if the Secretary makes a final determination that the plan or issuer still is not in com-

pliance with this section, not later than 7 days after such determination, shall notify all individuals enrolled in the plan or applicable health insurance coverage offered by the issuer that the plan or issuer, with respect to such coverage, has been determined to be not in compliance with this section.

''(II) EXEMPTION FROM DISCLOSURE.—Documents or communications produced in connection with the Secretary's recommendations to a group health plan or health insurance issuer shall not be subject to disclosure pursuant to section 552 of title 5, United States Code.

''(iv) REPORT.—Not later than 1 year after the date of enactment of this paragraph, and not later than October 1 of each year thereafter, the Secretary shall submit to Congress, and make publicly available, a report that contains—

''(I) a summary of the comparative analyses requested under clause (i), including the identity of each group health plan or health insurance issuer, with respect to particular health insurance coverage that is determined to be not in compliance after the final determination by the Secretary described in clause (iii)(I)(bb);

''(II) the Secretary's conclusions as to whether each group health plan or health insurance issuer submitted sufficient information for the Secretary to review the comparative analyses requested under clause (i) for compliance with this section;

''(III) for each group health plan or health insurance issuer that did submit sufficient information for the Secretary to review the comparative analyses requested under clause (i), the Secretary's conclusions as to whether and why the plan or issuer is in compliance with the requirements under this section;

"(IV) the Secretary's specifications described in clause (ii) for each group health plan or health insurance issuer that the Secretary determined did not submit sufficient information for the Secretary to review the comparative analyses requested under clause (i) for compliance with this section; and

"(V) the Secretary's specifications described in clause (iii) of the actions each group health plan or health insurance issuer that the Secretary determined is not in compliance with this section must take to be in compliance with this section, including the reason why the Secretary determined the plan or issuer is not in compliance.

"(C) COMPLIANCE PROGRAM GUIDANCE DOCUMENT UPDATE PROCESS.—

"(i) IN GENERAL.—The Secretary shall include instances of noncompliance that the Secretary discovers upon reviewing the comparative analyses requested

under subparagraph (B)(i) in the compliance program guidance document described in paragraph (6), as it is updated every 2 years, except that such instances shall not disclose any protected health information or individually identifiable information.

''(ii) GUIDANCE AND REGULATIONS.—Not later than 18 months after the date of enactment of this paragraph, the Secretary shall finalize any draft or interim guidance and regulations relating to mental health parity under this section. Such draft guidance shall include guidance to clarify the process and timeline for current and potential participants and beneficiaries (and authorized representatives and health care providers of such participants and beneficiaries) with respect to plans to file complaints of such plans or issuers being in violation of this section, including guidance, by plan type, on the relevant State, regional, or national office with which such complaints should be filed.

''(iii) STATE.—The Secretary shall share information on findings of compliance and noncompliance discovered upon reviewing the comparative analyses requested under subparagraph (B)(i) shall be shared with the State where the group health plan is located or the State where the health insurance issuer is licensed to do business for coverage offered by a health insurance issuer in the group market, in accordance with paragraph (6)(B)(iii)(II).''.

(2) ERISA.—Section 712(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a(a)) is amended by adding at the end the following:

''(6) COMPLIANCE PROGRAM GUIDANCE DOCUMENT.—

''(A) IN GENERAL.—The Secretary, the Secretary of Health and Human Services, and the Secretary of the Treasury, in consultation with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the

Treasury, shall issue a compliance program guidance document to help improve compliance with this section, section 2726 of the Public Health Service Act, and section 9812 of the Internal Revenue Code of 1986, as applicable. In carrying out this paragraph, the Secretaries may take into consideration the 2016 publication of the Department of Health and Human Services and the Department of Labor, entitled 'Warning Signs - Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance'.

''(B) EXAMPLES ILLUSTRATING COMPLIANCE AND NONCOMPLIANCE.—

''(i) IN GENERAL.—The compliance program guidance document required under this paragraph shall provide illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and noncompliance with this section, section 2726 of the Public Health Service Act, or section 9812 of the Internal Revenue Code of

1986, as applicable, based on investigations of violations of such sections, including—

"(I) examples illustrating requirements for information disclosures and nonquantitative treatment limitations; and

"(II) descriptions of the violations uncovered during the course of such investigations.

"(ii) NONQUANTITATIVE TREATMENT LIMITATIONS.—To the extent that any example described in clause (i) involves a finding of compliance or noncompliance with regard to any requirement for nonquantitative treatment limitations, the example shall provide sufficient detail to fully explain such finding, including a full description of the criteria involved for approving medical and surgical benefits and the criteria involved for approving mental health and substance use disorder benefits.

"(iii) ACCESS TO ADDITIONAL INFORMATION REGARDING COMPLIANCE.—In developing and issuing the compliance pro-

gram guidance document required under this paragraph, the Secretaries specified in subparagraph (A)—

"(I) shall enter into interagency agreements with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury to share findings of compliance and noncompliance with this section, section 2726 of the Public Health Service Act, or section 9812 of the Internal Revenue Code of 1986, as applicable; and

"(II) shall seek to enter into an agreement with a State to share information on findings of compliance and noncompliance with this section, section 2726 of the Public Health Service Act, or section 9812 of the Internal Revenue Code of 1986, as applicable.

"(C) RECOMMENDATIONS.—The compliance program guidance document shall include

recommendations to advance compliance with this section, section 2726 of the Public Health Service Act, or section 9812 of the Internal Revenue Code of 1986, as applicable, and encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. Such internal controls may include illustrative examples of nonquantitative treatment limitations on mental health and substance use disorder benefits, which may fail to comply with this section, section 2726 of the Public Health Service Act, or section 9812 of the Internal Revenue Code of 1986, as applicable, in relation to nonquantitative treatment limitations on medical and surgical benefits.

''(D) UPDATING THE COMPLIANCE PROGRAM GUIDANCE DOCUMENT.—The Secretary, the Secretary of Health and Human Services, and the Secretary of the Treasury, in consultation with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury, shall update the compliance pro-

gram guidance document every 2 years to include illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and noncompliance with this section, section 2726 of the Public Health Service Act, or section 9812 of the Internal Revenue Code of 1986, as applicable.

''(7) ADDITIONAL GUIDANCE.—

''(A) IN GENERAL.—The Secretary, the Secretary of Health and Human Services, and the Secretary of the Treasury shall issue guidance to group health plans and health insurance issuers offering group health insurance coverage to assist such plans and issuers in satisfying the requirements of this section, section 2726 of the Public Health Service Act, or section 9812 of the Internal Revenue Code of 1986, as applicable.

''(B) DISCLOSURE.—

''(i) GUIDANCE FOR PLANS AND ISSUERS.—The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods that group health plans and health insur-

ance issuers offering group or individual health insurance coverage may use for disclosing information to ensure compliance with the requirements under this section, section 2726 of the Public Health Service Act, or section 9812 of the Internal Revenue Code of 1986, as applicable, (and any regulations promulgated pursuant to such sections, as applicable).

''(ii) DOCUMENTS FOR PARTICIPANTS, BENEFICIARIES, CONTRACTING PROVIDERS, OR AUTHORIZED REPRESENTATIVES.—The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods that group health plans and health insurance issuers offering group health insurance coverage may use to provide any participant, beneficiary, contracting provider, or authorized representative, as applicable, with documents containing information that the health plans or issuers are required to disclose to participants, beneficiaries, contracting providers, or authorized representatives to ensure compliance with this sec-

tion, section 2726 of the Public Health Service Act, or section 9812 of the Internal Revenue Code of 1986, as applicable, compliance with any regulation issued pursuant to such respective section, or compliance with any other applicable law or regulation. Such guidance shall include information that is comparative in nature with respect to—

"(I) nonquantitative treatment limitations for both medical and surgical benefits and mental health and substance use disorder benefits;

"(II) the processes, strategies, evidentiary standards, and other factors used to apply the limitations described in subclause (I); and

"(III) the application of the limitations described in subclause (I) to ensure that such limitations are applied in parity with respect to both medical and surgical benefits and mental health and substance use disorder benefits.

"(C) NONQUANTITATIVE TREATMENT LIMITATIONS.—The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods, processes, strategies, evidentiary standards, and other factors that group health plans and health insurance issuers offering group health insurance coverage may use regarding the development and application of nonquantitative treatment limitations to ensure compliance with this section, section 2726 of the Public Health Service Act, or section 9812 of the Internal Revenue Code of 1986, as applicable, (and any regulations promulgated pursuant to such respective section), including—

"(i) examples of methods of determining appropriate types of nonquantitative treatment limitations with respect to both medical and surgical benefits and mental health and substance use disorder benefits, including nonquantitative treatment limitations pertaining to—

"(I) medical management standards based on medical necessity or ap-

propriateness, or whether a treatment is experimental or investigative;

''(II) limitations with respect to prescription drug formulary design; and

''(III) use of fail-first or step therapy protocols;

''(ii) examples of methods of determining—

''(I) network admission standards (such as credentialing); and

''(II) factors used in provider reimbursement methodologies (such as service type, geographic market, demand for services, and provider supply, practice size, training, experience, and licensure) as such factors apply to network adequacy;

''(iii) examples of sources of information that may serve as evidentiary standards for the purposes of making determinations regarding the development and application of nonquantitative treatment limitations;

''(iv) examples of specific factors, and the evidentiary standards used to evaluate such factors, used by such plans or issuers in performing a nonquantitative treatment limitation analysis;

''(v) examples of how specific evidentiary standards may be used to determine whether treatments are considered experimental or investigative;

''(vi) examples of how specific evidentiary standards may be applied to each service category or classification of benefits;

''(vii) examples of methods of reaching appropriate coverage determinations for new mental health or substance use disorder treatments, such as evidence-based early intervention programs for individuals with a serious mental illness and types of medical management techniques;

''(viii) examples of methods of reaching appropriate coverage determinations for which there is an indirect relationship between the covered mental health or substance use disorder benefit and a tradi-

tional covered medical and surgical benefit, such as residential treatment or hospitalizations involving voluntary or involuntary commitment; and

"(ix) additional illustrative examples of methods, processes, strategies, evidentiary standards, and other factors for which the Secretary determines that additional guidance is necessary to improve compliance with this section, section 2726 of the Public Health Service Act, or section 9812 of the Internal Revenue Code of 1986, as applicable.

"(D) PUBLIC COMMENT.—Prior to issuing any final guidance under this paragraph, the Secretary shall provide a public comment period of not less than 60 days during which any member of the public may provide comments on a draft of the guidance.

"(8) COMPLIANCE REQUIREMENTS.—

"(A) NONQUANTITATIVE TREATMENT LIMITATION (NQTL) REQUIREMENTS.—In the case of a group health plan or a health insurance issuer offering group health insurance coverage that provides both medical and surgical benefits

and mental health or substance use disorder benefits and that imposes nonquantitative treatment limitations (referred to in this section as 'NQTLs') on mental health or substance use disorder benefits, such plan or issuer shall perform and document comparative analyses of the design and application of NQTLs and, beginning 45 days after the date of enactment of the Consolidated Appropriations Act, 2021, make available to the Secretary, upon request, the comparative analyses and the following information:

''(i) The specific plan or coverage terms or other relevant terms regarding the NQTLs, that applies to such plan or coverage, and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification.

''(ii) The factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits.

''(iii) The evidentiary standards used for the factors identified in clause (ii), when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits.

''(iv) The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.

''(v) The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses described in this subparagraph that indicate that the plan

or coverage is or is not in compliance with this section.

''(B) SECRETARY REQUEST PROCESS.—

''(i) SUBMISSION UPON REQUEST.—The Secretary shall request that a group health plan or a health insurance issuer offering group health insurance coverage submit the comparative analyses described in subparagraph (A) for plans that involve potential violations of this section or complaints regarding noncompliance with this section that concern NQTLs and any other instances in which the Secretary determines appropriate. The Secretary shall request not fewer than 20 such analyses per year.

''(ii) ADDITIONAL INFORMATION.—In instances in which the Secretary has concluded that the group health plan or health insurance issuer with respect to group health insurance coverage has not submitted sufficient information for the Secretary to review the comparative analyses described in subparagraph (A), as requested under clause (i), the Secretary

shall specify to the plan or issuer the information the plan or issuer must submit to be responsive to the request under clause (i) for the Secretary to review the comparative analyses described in subparagraph (A) for compliance with this section. Nothing in this paragraph shall require the Secretary to conclude that a group health plan or health insurance issuer is in compliance with this section solely based upon the inspection of the comparative analyses described in subparagraph (A), as requested under clause (i).

''(iii) REQUIRED ACTION.—

''(I) IN GENERAL.—In instances in which the Secretary has reviewed the comparative analyses described in subparagraph (A), as requested under clause (i), and determined that the group health plan or health insurance issuer is not in compliance with this section, the plan or issuer—

''(aa) shall specify to the Secretary the actions the plan or issuer will take to be in compli-

ance with this section and provide to the Secretary additional comparative analyses described in subparagraph (A) that demonstrate compliance with this section not later than 45 days after the initial determination by the Secretary that the plan or issuer is not in compliance; and

''(bb) following the 45-day corrective action period under item (aa), if the Secretary makes a final determination that the plan or issuer still is not in compliance with this section, not later than 7 days after such determination, shall notify all individuals enrolled in the plan or applicable health insurance coverage offered by the issuer that the plan or issuer, with respect to such coverage, has been determined to be not in compliance with this section.

''(II) EXEMPTION FROM DISCLOSURE.—Documents or communications produced in connection with the Secretary's recommendations to a group health plan or health insurance issuer shall not be subject to disclosure pursuant to section 552 of title 5, United States Code.

''(iv) REPORT.—Not later than 1 year after the date of enactment of this paragraph, and not later than October 1 of each year thereafter, the Secretary shall submit to Congress, and make publicly available, a report that contains—

''(I) a summary of the comparative analyses requested under clause (i), including the identity of each group health plan or health insurance issuer, with respect to certain health insurance coverage that is determined to be not in compliance after the final determination by the Secretary described in clause (iii)(I)(bb);

''(II) the Secretary's conclusions as to whether each group health plan

or health insurance issuer submitted sufficient information for the Secretary to review the comparative analyses requested under clause (i) for compliance with this section;

''(III) for each group health plan or health insurance issuer that did submit sufficient information for the Secretary to review the comparative analyses requested under clause (i), the Secretary's conclusions as to whether and why the plan or issuer is in compliance with the disclosure requirements under this section;

''(IV) the Secretary's specifications described in clause (ii) for each group health plan or health insurance issuer that the Secretary determined did not submit sufficient information for the Secretary to review the comparative analyses requested under clause (i) for compliance with this section; and

''(V) the Secretary's specifications described in clause (iii) of the

actions each group health plan or health insurance issuer that the Secretary determined is not in compliance with this section must take to be in compliance with this section, including the reason why the Secretary determined the plan or issuer is not in compliance.

''(C) COMPLIANCE PROGRAM GUIDANCE DOCUMENT UPDATE PROCESS.—

''(i) IN GENERAL.—The Secretary shall include instances of noncompliance that the Secretary discovers upon reviewing the comparative analyses requested under subparagraph (B)(i) in the compliance program guidance document described in paragraph (6), as it is updated every 2 years, except that such instances shall not disclose any protected health information or individually identifiable information.

''(ii) GUIDANCE AND REGULATIONS.—Not later than 18 months after the date of enactment of this paragraph, the Secretary shall finalize any draft or interim guidance

and regulations relating to mental health parity under this section. Such draft guidance shall include guidance to clarify the process and timeline for current and potential participants and beneficiaries (and authorized representatives and health care providers of such participants and beneficiaries) with respect to plans to file complaints of such plans or issuers being in violation of this section, including guidance, by plan type, on the relevant State, regional, or national office with which such complaints should be filed.

''(iii) STATE.—The Secretary shall share information on findings of compliance and noncompliance discovered upon reviewing the comparative analyses requested under subparagraph (B)(i) shall be shared with the State where the group health plan is located or the State where the health insurance issuer is licensed to do business for coverage offered by a health insurance issuer in the group market, in accordance with paragraph (6)(B)(iii)(II).''.

(3) IRC.—Section 9812(a) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''(6) COMPLIANCE PROGRAM GUIDANCE DOCUMENT.—

''(A) IN GENERAL.—The Secretary, the Secretary of Health and Human Services, and the Secretary of Labor, in consultation with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury, shall issue a compliance program guidance document to help improve compliance with this section, section 2726 of the Public Health Service Act, and section 712 of the Employee Retirement Income Security Act of 1974, as applicable. In carrying out this paragraph, the Secretaries may take into consideration the 2016 publication of the Department of Health and Human Services and the Department of Labor, entitled 'Warning Signs - Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance'.

''(B) EXAMPLES ILLUSTRATING COMPLIANCE AND NONCOMPLIANCE.—

''(i) IN GENERAL.—The compliance program guidance document required under this paragraph shall provide illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and noncompliance with this section, section 2726 of the Public Health Service Act, or section 712 of the Employee Retirement Income Security Act of 1974, as applicable, based on investigations of violations of such sections, including—

''(I) examples illustrating requirements for information disclosures and nonquantitative treatment limitations; and

''(II) descriptions of the violations uncovered during the course of such investigations.

''(ii) NONQUANTITATIVE TREATMENT LIMITATIONS.—To the extent that any example described in clause (i) involves a

finding of compliance or noncompliance with regard to any requirement for non-quantitative treatment limitations, the example shall provide sufficient detail to fully explain such finding, including a full description of the criteria involved for approving medical and surgical benefits and the criteria involved for approving mental health and substance use disorder benefits.

''(iii) ACCESS TO ADDITIONAL INFORMATION REGARDING COMPLIANCE.—In developing and issuing the compliance program guidance document required under this paragraph, the Secretaries specified in subparagraph (A)—

''(I) shall enter into interagency agreements with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury to share findings of compliance and noncompliance with this section, section 2726 of the Public Health Service Act, or section

712 of the Employee Retirement Income Security Act of 1974, as applicable; and

"(II) shall seek to enter into an agreement with a State to share information on findings of compliance and noncompliance with this section, section 2726 of the Public Health Service Act, or section 712 of the Employee Retirement Income Security Act of 1974, as applicable.

"(C) RECOMMENDATIONS.—The compliance program guidance document shall include recommendations to advance compliance with this section, section 2726 of the Public Health Service Act, or section 712 of the Employee Retirement Income Security Act of 1974, as applicable, and encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. Such internal controls may include illustrative examples of nonquantitative treatment limitations on mental health and substance use disorder benefits, which may fail to comply with this section, section 2726 of the

Public Health Service Act, or section 712 of the Employee Retirement Income Security Act of 1974, as applicable, in relation to nonquantitative treatment limitations on medical and surgical benefits.

''(D) UPDATING THE COMPLIANCE PROGRAM GUIDANCE DOCUMENT.—The Secretary, the Secretary of Health and Human Services, and the Secretary of Labor, in consultation with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury, shall update the compliance program guidance document every 2 years to include illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and noncompliance with this section, section 2726 of the Public Health Service Act, or section 712 of the Employee Retirement Income Security Act of 1974, as applicable.

''(7) ADDITIONAL GUIDANCE.—

"(A) IN GENERAL.—The Secretary, the Secretary of Health and Human Services, and the Secretary of Labor shall issue guidance to group health plans to assist such plans in satisfying the requirements of this section, section 2726 of the Public Health Service Act, or section 712 of the Employee Retirement Income Security Act of 1974, as applicable.

"(B) DISCLOSURE.—

"(i) GUIDANCE FOR PLANS.—The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods that group health plans may use for disclosing information to ensure compliance with the requirements under this section, section 2726 of the Public Health Service Act, or section 712 of the Employee Retirement Income Security Act of 1974, as applicable, (and any regulations promulgated pursuant to such sections, as applicable).

"(ii) DOCUMENTS FOR PARTICIPANTS, BENEFICIARIES, CONTRACTING PROVIDERS, OR AUTHORIZED REPRESENTATIVES.—The guidance issued under this paragraph shall

include clarifying information and illustrative examples of methods that group health plans may use to provide any participant, beneficiary, contracting provider, or authorized representative, as applicable, with documents containing information that the health plans are required to disclose to participants, beneficiaries, contracting providers, or authorized representatives to ensure compliance with this section, section 2726 of the Public Health Service Act, or section 712 of the Employee Retirement Income Security Act of 1974, as applicable, compliance with any regulation issued pursuant to such respective section, or compliance with any other applicable law or regulation. Such guidance shall include information that is comparative in nature with respect to—

''(I) nonquantitative treatment limitations for both medical and surgical benefits and mental health and substance use disorder benefits;

''(II) the processes, strategies, evidentiary standards, and other fac-

tors used to apply the limitations described in subclause (I); and

"(III) the application of the limitations described in subclause (I) to ensure that such limitations are applied in parity with respect to both medical and surgical benefits and mental health and substance use disorder benefits.

"(C) NONQUANTITATIVE TREATMENT LIMITATIONS.—The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods, processes, strategies, evidentiary standards, and other factors that group health plans may use regarding the development and application of nonquantitative treatment limitations to ensure compliance with this section, section 2726 of the Public Health Service Act, or section 712 of the Employee Retirement Income Security Act of 1974, as applicable, (and any regulations promulgated pursuant to such respective section), including—

"(i) examples of methods of determining appropriate types of nonquantita-

tive treatment limitations with respect to both medical and surgical benefits and mental health and substance use disorder benefits, including nonquantitative treatment limitations pertaining to—

''(I) medical management standards based on medical necessity or appropriateness, or whether a treatment is experimental or investigative;

''(II) limitations with respect to prescription drug formulary design; and

''(III) use of fail-first or step therapy protocols;

''(ii) examples of methods of determining—

''(I) network admission standards (such as credentialing); and

''(II) factors used in provider reimbursement methodologies (such as service type, geographic market, demand for services, and provider supply, practice size, training, experience, and licensure) as such factors apply to network adequacy;

"(iii) examples of sources of information that may serve as evidentiary standards for the purposes of making determinations regarding the development and application of nonquantitative treatment limitations;

"(iv) examples of specific factors, and the evidentiary standards used to evaluate such factors, used by such plans in performing a nonquantitative treatment limitation analysis;

"(v) examples of how specific evidentiary standards may be used to determine whether treatments are considered experimental or investigative;

"(vi) examples of how specific evidentiary standards may be applied to each service category or classification of benefits;

"(vii) examples of methods of reaching appropriate coverage determinations for new mental health or substance use disorder treatments, such as evidence-based early intervention programs for indi-

viduals with a serious mental illness and types of medical management techniques;

''(viii) examples of methods of reaching appropriate coverage determinations for which there is an indirect relationship between the covered mental health or substance use disorder benefit and a traditional covered medical and surgical benefit, such as residential treatment or hospitalizations involving voluntary or involuntary commitment; and

''(ix) additional illustrative examples of methods, processes, strategies, evidentiary standards, and other factors for which the Secretary determines that additional guidance is necessary to improve compliance with this section, section 2726 of the Public Health Service Act, or section 712 of the Employee Retirement Income Security Act of 1974, as applicable.

''(D) PUBLIC COMMENT.—Prior to issuing any final guidance under this paragraph, the Secretary shall provide a public comment period of not less than 60 days during which any

member of the public may provide comments on a draft of the guidance.

''(8) COMPLIANCE REQUIREMENTS.—

''(A) NONQUANTITATIVE TREATMENT LIMITATION (NQTL) REQUIREMENTS.—In the case of a group health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits and that imposes nonquantitative treatment limitations (referred to in this section as 'NQTLs') on mental health or substance use disorder benefits, such plan shall perform and document comparative analyses of the design and application of NQTLs and, beginning 45 days after the date of enactment of the Consolidated Appropriations Act, 2021, make available to the Secretary, upon request, the comparative analyses and the following information:

''(i) The specific plan terms or other relevant terms regarding the NQTLs and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification.

"(ii) The factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits.

"(iii) The evidentiary standards used for the factors identified in clause (ii), when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits.

"(iv) The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.

"(v) A disclosure of the specific findings and conclusions reached by the group

health plan, including any results of the analyses described in this subparagraph that indicate that the plan is or is not in compliance with this section.

''(B) SECRETARY REQUEST PROCESS.—

''(i) SUBMISSION UPON REQUEST.—The Secretary shall request that a group health plan submit the comparative analyses described in subparagraph (A) for plans that involve potential violations of this section or complaints regarding noncompliance with this section that concern NQTLs and any other instances in which the Secretary determines appropriate. The Secretary shall request not fewer than 20 such analyses per year.

''(ii) ADDITIONAL INFORMATION.—In instances in which the Secretary has concluded that the group health plan has not submitted sufficient information for the Secretary to review the comparative analyses described in subparagraph (A), as requested under clause (i), the Secretary shall specify to the plan the information the plan must submit to be responsive to

the request under clause (i) for the Secretary to review the comparative analyses described in subparagraph (A) for compliance with this section. Nothing in this paragraph shall require the Secretary to conclude that a group health plan is in compliance with this section solely based upon the inspection of the comparative analyses described in subparagraph (A), as requested under clause (i).

''(iii) REQUIRED ACTION.—

''(I) IN GENERAL.—In instances in which the Secretary has reviewed the comparative analyses described in subparagraph (A), as requested under clause (i), and determined that the group health plan is not in compliance with this section, the plan—

''(aa) shall specify to the Secretary the actions the plan will take to be in compliance with this section and provide to the Secretary additional comparative analyses described in subparagraph (A) that demonstrate com-

pliance with this section not later than 45 days after the initial determination by the Secretary that the plan is not in compliance; and

''(bb) following the 45-day corrective action period under item (aa), if the Secretary makes a final determination that the plan still is not in compliance with this section, not later than 7 days after such determination, shall notify all individuals enrolled in the plan that the plan has been determined to be not in compliance with this section.

''(II) EXEMPTION FROM DISCLOSURE.—Documents or communications produced in connection with the Secretary's recommendations to a group health plan shall not be subject to disclosure pursuant to section 552 of title 5, United States Code.

''(iv) REPORT.—Not later than 1 year after the date of enactment of this para-

graph, and not later than October 1 of each year thereafter, the Secretary shall submit to Congress, and make publicly available, a report that contains—

"(I) a summary of the comparative analyses requested under clause (i), including the identity of each group plan that is determined to be not in compliance after the final determination by the Secretary described in clause (iii)(I)(bb);

"(II) the Secretary's conclusions as to whether each group health plan submitted sufficient information for the Secretary to review the comparative analyses requested under clause (i) for compliance with this section;

"(III) for each group health plan that did submit sufficient information for the Secretary to review the comparative analyses requested under clause (i), the Secretary's conclusions as to whether and why the plan is in compliance with the disclosure requirements under this section;

"(IV) the Secretary's specifications described in clause (ii) for each group health plan that the Secretary determined did not submit sufficient information for the Secretary to review the comparative analyses requested under clause (i) for compliance with this section; and

"(V) the Secretary's specifications described in clause (iii) of the actions each group health plan that the Secretary determined is not in compliance with this section must take to be in compliance with this section, including the reason why the Secretary determined the plan is not in compliance.

"(C) COMPLIANCE PROGRAM GUIDANCE DOCUMENT UPDATE PROCESS.—

"(i) IN GENERAL.—The Secretary shall include instances of noncompliance that the Secretary discovers upon reviewing the comparative analyses requested under subparagraph (B)(i) in the compliance program guidance document de-

scribed in paragraph (6), as it is updated every 2 years, except that such instances shall not disclose any protected health information or individually identifiable information.

''(ii) GUIDANCE AND REGULATIONS.—Not later than 18 months after the date of enactment of this paragraph, the Secretary shall finalize any draft or interim guidance and regulations relating to mental health parity under this section. Such draft guidance shall include guidance to clarify the process and timeline for current and potential participants and beneficiaries (and authorized representatives and health care providers of such participants and beneficiaries) with respect to plans to file complaints of such plans being in violation of this section, including guidance, by plan type, on the relevant State, regional, or national office with which such complaints should be filed.

''(iii) STATE.—The Secretary shall share information on findings of compliance and noncompliance discovered upon

reviewing the comparative analyses requested under subparagraph (B)(i) shall be shared with the State where the group health plan is located, in accordance with paragraph (6)(B)(iii)(II).''.

(4) MEDICAID AND CHIP COMPLIANCE.—

(A) MEDICAID MANAGED CARE ORGANIZATIONS.—Section 1932(b)(8) of the Social Security Act (42 U.S.C. 1396u–2(b)(8)) is amended by adding at the end the following new sentence: ''In applying the previous sentence with respect to requirements under paragraph (8) of section 2726(a) of the Public Health Service Act, a Medicaid managed care organization (or a prepaid inpatient health plan (as defined by the Secretary) or prepaid ambulatory health plan (as defined by the Secretary) that offers services to enrollees of a Medicaid managed care organization) shall be treated as in compliance with such requirements if the Medicaid managed care organization (or prepaid inpatient health plan or prepaid ambulatory health plan) is in compliance with subpart K of part 438 of title 42, Code of Federal Regulations,

and section 438.3(n) of such title, or any successor regulation.''.

(B) OTHER BENCHMARK BENEFIT PACKAGES OR BENCHMARK EQUIVALENT COVERAGE.—Section 1937(b)(6)(A) of such Act (42 U.S.C. 1396u–7(b)(6)(A)) is amended—

(i) by striking ''section 2705(a)'' and inserting ''section 2726(a)''; and

(ii) by adding at the end the following new sentence: ''In applying the previous sentence with respect to requirements under paragraph (8) of section 2726(a) of the Public Health Service Act, a benchmark benefit package or benchmark equivalent coverage described in such sentence shall be treated as in compliance with such requirements if the State plan under this title or the benchmark benefit package or benefit equivalent coverage, as applicable, is in compliance with subpart C of part 440 of title 42, Code of Federal Regulations, or any successor regulation.''.

(C) STATE CHILD HEALTH PLANS.—Section 2103(c)(7)(A) of the Social Security Act (42 U.S.C. 1397cc(c)(7)(A)) is amended—

(i) by striking ''section 2705(a)'' and inserting ''section 2726(a)''; and

(ii) by adding at the end the following new sentence: ''In applying the previous sentence with respect to requirements under paragraph (8) of section 2726(a) of the Public Health Service Act, a State child health plan described in such sentence shall be treated as in compliance with such requirements if the State child health plan is in compliance with section 457.496 of title 42, Code of Federal Regulations, or any successor regulation.''.

(b) GUIDANCE.—The Secretary of Health and Human Services, jointly with the Secretary of Labor and the Secretary of the Treasury, shall issue guidance to carry out the amendments made by paragraphs (1), (2), and (3) of subsection (a).

SEC. 204. REPORTING ON PHARMACY BENEFITS AND DRUG COSTS.

(a) PHSA.—Part D of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as amended by section 201, is further amended by adding at the end the following:

"SEC. 2799A–10. REPORTING ON PHARMACY BENEFITS AND DRUG COSTS.

"(a) IN GENERAL.—Not later than 1 year after the date of enactment of the Consolidated Appropriations Act, 2021, and not later than June 1 of each year thereafter, a group health plan or health insurance issuer offering group or individual health insurance coverage (except for a church plan) shall submit to the Secretary, the Secretary of Labor, and the Secretary of the Treasury the following information with respect to the health plan or coverage in the previous plan year:

"(1) The beginning and end dates of the plan year.

"(2) The number of enrollees.

"(3) Each State in which the plan or coverage is offered.

"(4) The 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid by the plan or coverage, and the total number of paid claims for each such drug.

"(5) The 50 most costly prescription drugs with respect to the plan or coverage by total annual spending, and the annual amount spent by the plan or coverage for each such drug.

"(6) The 50 prescription drugs with the greatest increase in plan expenditures over the plan year

preceding the plan year that is the subject of the report, and, for each such drug, the change in amounts expended by the plan or coverage in each such plan year.

''(7) Total spending on health care services by such group health plan or health insurance coverage, broken down by—

''(A) the type of costs, including—

''(i) hospital costs;

''(ii) health care provider and clinical service costs, for primary care and specialty care separately;

''(iii) costs for prescription drugs; and

''(iv) other medical costs, including wellness services; and

''(B) spending on prescription drugs by—

''(i) the health plan or coverage; and

''(ii) the enrollees.

''(8) The average monthly premium—

''(A) paid by employers on behalf of enrollees, as applicable; and

''(B) paid by enrollees.

''(9) Any impact on premiums by rebates, fees, and any other remuneration paid by drug manufacturers to the plan or coverage or its administrators

or service providers, with respect to prescription drugs prescribed to enrollees in the plan or coverage, including—

''(A) the amounts so paid for each therapeutic class of drugs; and

''(B) the amounts so paid for each of the 25 drugs that yielded the highest amount of rebates and other remuneration under the plan or coverage from drug manufacturers during the plan year.

''(10) Any reduction in premiums and out-of-pocket costs associated with rebates, fees, or other remuneration described in paragraph (9).

''(b) REPORT.—Not later than 18 months after the date on which the first report is required under subsection (a) and biannually thereafter, the Secretary, acting through the Assistant Secretary of Planning and Evaluation and in coordination with the Inspector General of the Department of Health and Human Services, shall make available on the internet website of the Department of Health and Human Services a report on prescription drug reimbursements under group health plans and group and individual health insurance coverage, prescription drug pricing trends, and the role of prescription drug costs in contributing to premium increases or decreases under such

plans or coverage, aggregated in such a way as no drug or plan specific information will be made public.

''(c) PRIVACY PROTECTIONS.—No confidential or trade secret information submitted to the Secretary under subsection (a) shall be included in the report under subsection (b).''.

(b) ERISA.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by section 201, is further amended by adding at the end the following:

''SEC. 725. REPORTING ON PHARMACY BENEFITS AND DRUG COSTS.

''(a) IN GENERAL.—Not later than 1 year after the date of enactment of the Consolidated Appropriations Act, 2021, and not later than June 1 of each year thereafter, a group health plan (or health insurance coverage offered in connection with such a plan) shall submit to the Secretary, the Secretary of Health and Human Services, and the Secretary of the Treasury the following information with respect to the health plan or coverage in the previous plan year:

''(1) The beginning and end dates of the plan year.

''(2) The number of participants and beneficiaries.

''(3) Each State in which the plan or coverage is offered.

''(4) The 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid by the plan or coverage, and the total number of paid claims for each such drug.

''(5) The 50 most costly prescription drugs with respect to the plan or coverage by total annual spending, and the annual amount spent by the plan or coverage for each such drug.

''(6) The 50 prescription drugs with the greatest increase in plan expenditures over the plan year preceding the plan year that is the subject of the report, and, for each such drug, the change in amounts expended by the plan or coverage in each such plan year.

''(7) Total spending on health care services by such group health plan or health insurance coverage, broken down by—

''(A) the type of costs, including—

''(i) hospital costs;

''(ii) health care provider and clinical service costs, for primary care and specialty care separately;

''(iii) costs for prescription drugs; and

''(iv) other medical costs, including wellness services; and

''(B) spending on prescription drugs by—

''(i) the health plan or coverage; and

''(ii) the participants and beneficiaries.

''(8) The average monthly premium—

''(A) paid by employers on behalf of participants and beneficiaries, as applicable; and

''(B) paid by participants and beneficiaries.

''(9) Any impact on premiums by rebates, fees, and any other remuneration paid by drug manufacturers to the plan or coverage or its administrators or service providers, with respect to prescription drugs prescribed to participants or beneficiaries in the plan or coverage, including—

''(A) the amounts so paid for each therapeutic class of drugs; and

''(B) the amounts so paid for each of the 25 drugs that yielded the highest amount of re-

bates and other remuneration under the plan or coverage from drug manufacturers during the plan year.

''(10) Any reduction in premiums and out-of-pocket costs associated with rebates, fees, or other remuneration described in paragraph (9).

''(b) REPORT.—Not later than 18 months after the date on which the first report is required under subsection (a) and biannually thereafter, the Secretary, acting in coordination with the Inspector General of the Department of Labor, shall make available on the internet website of the Department of Labor a report on prescription drug reimbursements under group health plans (or health insurance coverage offered in connection with such a plan), prescription drug pricing trends, and the role of prescription drug costs in contributing to premium increases or decreases under such plans or coverage, aggregated in such a way as no drug or plan specific information will be made public.

''(c) PRIVACY PROTECTIONS.—No confidential or trade secret information submitted to the Secretary under subsection (a) shall be included in the report under subsection (b).''.

(c) IRC.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 201, is further amended by adding at the end the following:

"SEC. 9825. REPORTING ON PHARMACY BENEFITS AND DRUG COSTS.

''(a) IN GENERAL.—Not later than 1 year after the date of enactment of the Consolidated Appropriations Act, 2021, and not later than June 1 of each year thereafter, a group health plan shall submit to the Secretary, the Secretary of Health and Human Services, and the Secretary of Labor the following information with respect to the health plan in the previous plan year:

''(1) The beginning and end dates of the plan year.

''(2) The number of participants and beneficiaries.

''(3) Each State in which the plan is offered.

''(4) The 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid by the plan, and the total number of paid claims for each such drug.

''(5) The 50 most costly prescription drugs with respect to the plan by total annual spending, and the annual amount spent by the plan for each such drug.

''(6) The 50 prescription drugs with the greatest increase in plan expenditures over the plan year preceding the plan year that is the subject of the report, and, for each such drug, the change in amounts expended by the plan in each such plan year.

''(7) Total spending on health care services by such group health plan, broken down by—

''(A) the type of costs, including—

''(i) hospital costs;

''(ii) health care provider and clinical service costs, for primary care and specialty care separately;

''(iii) costs for prescription drugs; and

''(iv) other medical costs, including wellness services; and

''(B) spending on prescription drugs by—

''(i) the health plan; and

''(ii) the participants and beneficiaries.

''(8) The average monthly premium—

''(A) paid by employers on behalf of participants and beneficiaries, as applicable; and

''(B) paid by participants and beneficiaries.

''(9) Any impact on premiums by rebates, fees, and any other remuneration paid by drug manufacturers to the plan or its administrators or service providers, with respect to prescription drugs prescribed to participants or beneficiaries in the plan, including—

''(A) the amounts so paid for each therapeutic class of drugs; and

''(B) the amounts so paid for each of the 25 drugs that yielded the highest amount of rebates and other remuneration under the plan from drug manufacturers during the plan year.

''(10) Any reduction in premiums and out-of-pocket costs associated with rebates, fees, or other remuneration described in paragraph (9).

''(b) REPORT.—Not later than 18 months after the date on which the first report is required under subsection (a) and biannually thereafter, the Secretary, acting in coordination with the Inspector General of the Department of the Treasury, shall make available on the internet website of the Department of the Treasury a report on prescription drug reimbursements under group health plans, prescription drug pricing trends, and the role of prescription drug costs in contributing to premium increases or decreases under such plans, aggregated in such

a way as no drug or plan specific information will be made public.

''(c) PRIVACY PROTECTIONS.—No confidential or trade secret information submitted to the Secretary under subsection (a) shall be included in the report under subsection (b).''.

(d) CLERICAL AMENDMENTS.—

(1) ERISA.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), as amended by section 201, is further amended by inserting after the item relating to section 724 the following new item:

''Sec. 725. Reporting on pharmacy benefits and drug costs.''.

(2) IRC.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 201, is further amended by adding at the end the following new item:

''Sec. 9825. Reporting on pharmacy benefits and drug costs.''.

TITLE III—PUBLIC HEALTH PROVISIONS

Subtitle A—Extenders Provisions

SEC. 301. EXTENSION FOR COMMUNITY HEALTH CENTERS, THE NATIONAL HEALTH SERVICE CORPS, AND TEACHING HEALTH CENTERS THAT OPERATE GME PROGRAMS.

(a) COMMUNITY HEALTH CENTERS.—Section 10503(b)(1)(F) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b–2(b)(1)(F)) is amended by striking '', $4,000,000,000 for fiscal year 2019, $4,000,000,000 for fiscal year 2020, and $865,753,425 for the period beginning on October 1, 2020, and ending on December 18, 2020'' and inserting ''and $4,000,000,000 for each of fiscal years 2019 through 2023''.

(b) NATIONAL HEALTH SERVICE CORPS.—Section 10503(b)(2)(H) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b–2(b)(2)(H)) is amended by striking '' $67,095,890 for the period beginning on October 1, 2020, and ending on December 18, 2020'' and inserting '' $310,000,000 for each of fiscal years 2021 through 2023''.

(c) TEACHING HEALTH CENTERS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.—Section

340H(g)(1) of the Public Health Service Act (42 U.S.C. 256h(g)(1)) is amended—

(1) by inserting ''and'' after ''2017,''; and

(2) by striking ''fiscal year 2020, and $27,379,452 for the period beginning on October 1, 2020, and ending on December 18, 2020'' and inserting ''2023''.

(d) APPLICATION OF PROVISIONS.—Amounts appropriated pursuant to the amendments made by this section for fiscal years 2021 through 2023 shall be subject to the requirements contained in Public Law 116–94 for funds for programs authorized under sections 330 through 340 of the Public Health Service Act.

(e) CONFORMING AMENDMENTS.—Paragraph (4) of section 3014(h) of title 18, United States Code, as amended by section 1201(e) of the Further Continuing Appropriations Act, 2021, and Other Extensions Act, is amended by striking ''and section 1201(d) of the Further Continuing Appropriations Act, 2021, and Other Extensions Act'' and inserting '', section 1201(d) of the Further Continuing Appropriations Act, 2021, and Other Extensions Act, and section 301(d) of division BB of the Consolidated Appropriations Act, 2021.''.

SEC. 302. DIABETES PROGRAMS.

(a) TYPE I.—Section 330B(b)(2)(D) of the Public Health Service Act (42 U.S.C. 254c–2(b)(2)(D)) is amended by striking ''2020, and $32,465,753 for the period beginning on October 1, 2020, and ending on December 18, 2020'' and inserting ''2023''.

(b) INDIANS.—Section 330C(c)(2)(D) of the Public Health Service Act (42 U.S.C. 254c–3(c)(2)(D)) is amended by striking ''2020, and $32,465,753 for the period beginning on October 1, 2020, and ending on December 18, 2020'' and inserting ''2023''.

Subtitle B—Strengthening Public Health

SEC. 311. IMPROVING AWARENESS OF DISEASE PREVENTION.

(a) IN GENERAL.—The Public Health Service Act is amended by striking section 313 of such Act (42 U.S.C. 245) and inserting the following:

''SEC. 313. PUBLIC AWARENESS CAMPAIGN ON THE IMPORTANCE OF VACCINATIONS.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in coordination with other offices and agencies, as appropriate, shall award competitive grants or contracts to one or more public or private entities to carry out a national, evidence-based campaign to increase

awareness and knowledge of the safety and effectiveness of vaccines for the prevention and control of diseases, combat misinformation about vaccines, and disseminate scientific and evidence-based vaccine-related information, with the goal of increasing rates of vaccination across all ages, as applicable, particularly in communities with low rates of vaccination, to reduce and eliminate vaccine-preventable diseases.

''(b) CONSULTATION.—In carrying out the campaign under this section, the Secretary shall consult with appropriate public health and medical experts, including the National Academy of Medicine and medical and public health associations and nonprofit organizations, in the development, implementation, and evaluation of the evidence-based public awareness campaign.

''(c) REQUIREMENTS.—The campaign under this section shall—

''(1) be a nationwide, evidence-based media and public engagement initiative;

''(2) include the development of resources for communities with low rates of vaccination, including culturally and linguistically appropriate resources, as applicable;

''(3) include the dissemination of vaccine information and communication resources to public

health departments, health care providers, and health care facilities, including such providers and facilities that provide prenatal and pediatric care;

''(4) be complementary to, and coordinated with, any other Federal, State, local, or Tribal efforts, as appropriate; and

''(5) assess the effectiveness of communication strategies to increase rates of vaccination.

''(d) ADDITIONAL ACTIVITIES.—The campaign under this section may—

''(1) include the use of television, radio, the internet, and other media and telecommunications technologies;

''(2) include the use of in-person activities;

''(3) be focused to address specific needs of communities and populations with low rates of vaccination; and

''(4) include the dissemination of scientific and evidence-based vaccine-related information, such as—

''(A) advancements in evidence-based research related to diseases that may be prevented by vaccines and vaccine development;

''(B) information on vaccinations for individuals and communities, including individuals

for whom vaccines are not recommended by the Advisory Committee for Immunization Practices, and the effects of low vaccination rates within a community on such individuals;

''(C) information on diseases that may be prevented by vaccines; and

''(D) information on vaccine safety and the systems in place to monitor vaccine safety.

''(e) EVALUATION.—The Secretary shall—

''(1) establish benchmarks and metrics to quantitatively measure and evaluate the awareness campaign under this section;

''(2) conduct qualitative assessments regarding the awareness campaign under this section; and

''(3) prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and Committee on Energy and Commerce of the House of Representatives an evaluation of the awareness campaign under this section.

''(f) SUPPLEMENT NOT SUPPLANT.—Funds appropriated under this section shall be used to supplement and not supplant other Federal, State, and local public funds provided for activities described in this section.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section

and subsections (k) and (n) of section 317, $15,000,000 for each of fiscal years 2021 through 2025.''.

(b) GRANTS TO ADDRESS VACCINE-PREVENTABLE DISEASES.—Section 317 of the Public Health Service Act (42 U.S.C. 247b) is amended—

(1) in subsection (k)(1)—

(A) in subparagraph (C), by striking ''; and'' and inserting a semicolon;

(B) in subparagraph (D), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

''(E) planning, implementation, and evaluation of activities to address vaccine-preventable diseases, including activities to—

''(i) identify communities at high risk of outbreaks related to vaccine-preventable diseases, including through improved data collection and analysis;

''(ii) pilot innovative approaches to improve vaccination rates in communities and among populations with low rates of vaccination;

''(iii) reduce barriers to accessing vaccines and evidence-based information about the health effects of vaccines;

''(iv) partner with community organizations and health care providers to develop and deliver evidence-based interventions, including culturally and linguistically appropriate interventions, to increase vaccination rates;

''(v) improve delivery of evidence-based vaccine-related information to parents and others; and

''(vi) improve the ability of State, local, Tribal, and territorial public health departments to engage communities at high risk for outbreaks related to vaccine-preventable diseases, including, as appropriate, with local educational agencies, as defined in section 8101 of the Elementary and Secondary Education Act of 1965; and

''(F) research related to strategies for improving awareness of scientific and evidence-based vaccine-related information, including for communities with low rates of vaccination, in order to understand barriers to vaccination, improve vaccination rates, and assess the public health outcomes of such strategies.''; and

(2) by adding at the end the following:

''(n) VACCINATION DATA.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall expand and enhance, and, as appropriate, establish and improve, programs and conduct activities to collect, monitor, and analyze vaccination coverage data to assess levels of protection from vaccine-preventable diseases, including by assessing factors contributing to underutilization of vaccines and variations of such factors, and identifying communities at high risk of outbreaks associated with vaccine-preventable diseases.''.

(c) SUPPLEMENTAL GRANT FUNDS.—Section 330(d)(1) of the Public Health Service Act (42 U.S.C. 254b) is amended—

(1) in subparagraph (F), by striking ''and'' at the end;

(2) in subparagraph (G), by striking the period and inserting ''; and''; and

(3) by adding at the end the following:

''(H) improving access to recommended immunizations.''.

(d) UPDATE OF 2015 NVAC REPORT.—The National Vaccine Advisory Committee established under section 2105 of the Public Health Service Act (42 U.S.C. 300aa–5) shall, as appropriate, update the report entitled, ''Assessing the State of Vaccine Confidence in the United

States: Recommendations from the National Vaccine Advisory Committee'', approved by the National Vaccine Advisory Committee on June 10, 2015, with respect to factors affecting childhood vaccination.

SEC. 312. GUIDE ON EVIDENCE-BASED STRATEGIES FOR PUBLIC HEALTH DEPARTMENT OBESITY PREVENTION PROGRAMS.

(a) DEVELOPMENT AND DISSEMINATION OF AN EVIDENCE-BASED STRATEGIES GUIDE.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the Centers for Disease Control and Prevention, not later than 2 years after the date of enactment of this Act, may—

(1) develop a guide on evidence-based strategies for State, territorial, and local health departments to use to build and maintain effective obesity prevention and reduction programs, and, in consultation with Indian Tribes, Tribal organizations, and urban Indian organizations, a guide on such evidence-based strategies with respect to Indian Tribes and Tribal organizations for such Indian Tribes and Tribal organizations to use for such purpose, both of which guides shall—

(A) describe an integrated program structure for implementing interventions proven to

be effective in preventing and reducing the incidence of obesity; and

(B) recommend—

(i) optimal resources, including staffing and infrastructure, for promoting nutrition and obesity prevention and reduction; and

(ii) strategies for effective obesity prevention programs for State, territorial, and local health departments, Indian Tribes, and Tribal organizations, including strategies related to—

(I) the application of evidence-based and evidence-informed practices to prevent and reduce obesity rates;

(II) the development, implementation, and evaluation of obesity prevention and reduction strategies for specific communities and populations;

(III) demonstrated knowledge of obesity prevention practices that reduce associated preventable diseases, health conditions, death, and health care costs;

(IV) best practices for the coordination of efforts to prevent and reduce obesity and related chronic diseases;

(V) addressing the underlying risk factors and social determinants of health that impact obesity rates; and

(VI) interdisciplinary coordination between relevant public health officials specializing in fields such as nutrition, physical activity, epidemiology, communications, and policy implementation, and collaboration between public health officials, community-based organizations, and others, as appropriate; and

(2) disseminate the guides and current research, evidence-based practices, tools, and educational materials related to obesity prevention, consistent with the guides, to State, territorial, and local health departments, Indian Tribes, and Tribal organizations.

(b) TECHNICAL ASSISTANCE.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall provide technical assistance to State,

territorial, and local health departments, Indian Tribes, and Tribal organizations to support such health departments in implementing the guide developed under subsection (a)(1).

(c) INDIAN TRIBES; TRIBAL ORGANIZATIONS; URBAN INDIAN ORGANIZATIONS.—In this section—

(1) the terms ''Indian Tribe'' and ''Tribal organization'' have the meanings given the terms ''Indian tribe'' and ''tribal organization'', respectively, in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304); and

(2) the term ''urban Indian organization'' has the meaning given such term in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

SEC. 313. EXPANDING CAPACITY FOR HEALTH OUTCOMES.

Title III of the Public Health Service Act is amended by inserting after section 330M (42 U.S.C. 254c–19) the following:

''SEC. 330N. EXPANDING CAPACITY FOR HEALTH OUTCOMES.

''(a) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means an entity that provides, or supports the provision of, health care services in rural areas, fron-

tier areas, health professional shortage areas, or medically underserved areas, or to medically underserved populations or Native Americans, including Indian Tribes, Tribal organizations, and urban Indian organizations, and which may include entities leading, or capable of leading, a technology-enabled collaborative learning and capacity building model or engaging in technology-enabled collaborative training of participants in such model.

''(2) HEALTH PROFESSIONAL SHORTAGE AREA.—The term 'health professional shortage area' means a health professional shortage area designated under section 332.

''(3) INDIAN TRIBE.—The terms 'Indian Tribe' and 'Tribal organization' have the meanings given the terms 'Indian tribe' and 'tribal organization' in section 4 of the Indian Self-Determination and Education Assistance Act.

''(4) MEDICALLY UNDERSERVED POPULATION.—The term 'medically underserved population' has the meaning given the term in section 330(b)(3).

''(5) NATIVE AMERICANS.—The term 'Native Americans' has the meaning given the term in sec-

tion 736 and includes Indian Tribes and Tribal organizations.

''(6) TECHNOLOGY-ENABLED COLLABORATIVE LEARNING AND CAPACITY BUILDING MODEL.—The term 'technology-enabled collaborative learning and capacity building model' means a distance health education model that connects health care professionals, and particularly specialists, with multiple other health care professionals through simultaneous interactive videoconferencing for the purpose of facilitating case-based learning, disseminating best practices, and evaluating outcomes.

''(7) URBAN INDIAN ORGANIZATION.—The term 'urban Indian organization' has the meaning given the term in section 4 of the Indian Health Care Improvement Act.

''(b) PROGRAM ESTABLISHED.—The Secretary shall, as appropriate, award grants to evaluate, develop, and, as appropriate, expand the use of technology-enabled collaborative learning and capacity building models, to improve retention of health care providers and increase access to health care services, such as those to address chronic diseases and conditions, infectious diseases, mental health, substance use disorders, prenatal and maternal health, pediatric care, pain management, palliative care, and other

specialty care in rural areas, frontier areas, health professional shortage areas, or medically underserved areas and for medically underserved populations or Native Americans.

"(c) USE OF FUNDS.—

"(1) IN GENERAL.—Grants awarded under subsection (b) shall be used for—

"(A) the development and acquisition of instructional programming, and the training of health care providers and other professionals that provide or assist in the provision of services through models described in subsection (b), such as training on best practices for data collection and leading or participating in such technology-enabled activities consistent with technology-enabled collaborative learning and capacity-building models;

"(B) information collection and evaluation activities to study the impact of such models on patient outcomes and health care providers, and to identify best practices for the expansion and use of such models; or

"(C) other activities consistent with achieving the objectives of the grants awarded under this section, as determined by the Secretary.

''(2) OTHER USES.—In addition to any of the uses under paragraph (1), grants awarded under subsection (b) may be used for—

''(A) equipment to support the use and expansion of technology-enabled collaborative learning and capacity building models, including for hardware and software that enables distance learning, health care provider support, and the secure exchange of electronic health information; or

''(B) support for health care providers and other professionals that provide or assist in the provision of services through such models.

''(d) LENGTH OF GRANTS.—Grants awarded under subsection (b) shall be for a period of up to 5 years.

''(e) GRANT REQUIREMENTS.—The Secretary may require entities awarded a grant under this section to collect information on the effect of the use of technology-enabled collaborative learning and capacity building models, such as on health outcomes, access to health care services, quality of care, and provider retention in areas and populations described in subsection (b). The Secretary may award a grant or contract to assist in the coordination of such models, including to assess outcomes associated with the use of such models in grants awarded under

subsection (b), including for the purpose described in subsection (c)(1)(B).

''(f) APPLICATION.—An eligible entity that seeks to receive a grant under subsection (b) shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require. Such application shall include plans to assess the effect of technology-enabled collaborative learning and capacity building models on patient outcomes and health care providers.

''(g) ACCESS TO BROADBAND.—In administering grants under this section, the Secretary may coordinate with other agencies to ensure that funding opportunities are available to support access to reliable, high-speed internet for grantees.

''(h) TECHNICAL ASSISTANCE.—The Secretary shall provide (either directly through the Department of Health and Human Services or by contract) technical assistance to eligible entities, including recipients of grants under subsection (b), on the development, use, and evaluation of technology-enabled collaborative learning and capacity building models in order to expand access to health care services provided by such entities, including for medically underserved areas and to medically underserved populations or Native Americans.

''(i) RESEARCH AND EVALUATION.—The Secretary, in consultation with stakeholders with appropriate expertise in such models, shall develop a strategic plan to research and evaluate the evidence for such models. The Secretary shall use such plan to inform the activities carried out under this section.

''(j) REPORT BY SECRETARY.—Not later than 4 years after the date of enactment of this section, the Secretary shall prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives, and post on the internet website of the Department of Health and Human Services, a report including, at minimum—

''(1) a description of any new and continuing grants awarded to entities under subsection (b) and the specific purpose and amounts of such grants;

''(2) an overview of—

''(A) the evaluations conducted under subsections (b);

''(B) technical assistance provided under subsection (h); and

''(C) activities conducted by entities awarded grants under subsection (b); and

''(3) a description of any significant findings or developments related to patient outcomes or health care providers and best practices for eligible entities expanding, using, or evaluating technology-enabled collaborative learning and capacity building models, including through the activities described in subsection (h).

''(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $10,000,000 for each of fiscal years 2022 through 2026.''.

SEC. 314. PUBLIC HEALTH DATA SYSTEM MODERNIZATION.

Subtitle C of title XXVIII of the Public Health Service Act (42 U.S.C. 300hh–31 et seq.) is amended by adding at the end the following:

''SEC. 2823. PUBLIC HEALTH DATA SYSTEM MODERNIZATION.

''(a) EXPANDING CDC AND PUBLIC HEALTH DEPARTMENT CAPABILITIES.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall—

''(A) conduct activities to expand, modernize, improve, and sustain applicable public health data systems used by the Centers for Disease Control and Prevention, including with

respect to the interoperability and improvement of such systems (including as it relates to preparedness for, prevention and detection of, and response to public health emergencies); and

''(B) award grants or cooperative agreements to State, local, Tribal, or territorial public health departments for the expansion and modernization of public health data systems, to assist public health departments and public health laboratories in—

''(i) assessing current data infrastructure capabilities and gaps to—

''(I) improve and increase consistency in data collection, storage, and analysis; and

''(II) as appropriate, improve dissemination of public health-related information;

''(ii) improving secure public health data collection, transmission, exchange, maintenance, and analysis, including with respect to demographic data, as appropriate;

''(iii) improving the secure exchange of data between the Centers for Disease

Control and Prevention, State, local, Tribal, and territorial public health departments, public health laboratories, public health organizations, and health care providers, including by public health officials in multiple jurisdictions within such State, as appropriate, and by simplifying and supporting reporting by health care providers, as applicable, pursuant to State law, including through the use of health information technology;

''(iv) enhancing the interoperability of public health data systems (including systems created or accessed by public health departments) with health information technology, including with health information technology certified under section 3001(c)(5);

''(v) supporting and training data systems, data science, and informatics personnel;

''(vi) supporting earlier disease and health condition detection, such as through near real-time data monitoring, to support rapid public health responses;

"(vii) supporting activities within the applicable jurisdiction related to the expansion and modernization of electronic case reporting; and

"(viii) developing and disseminating information related to the use and importance of public health data.

"(2) DATA STANDARDS.—In carrying out paragraph (1), the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall, as appropriate and in consultation with the Office of the National Coordinator for Health Information Technology, designate data and technology standards (including standards for interoperability) for public health data systems, with deference given to standards published by consensus-based standards development organizations with public input and voluntary consensus-based standards bodies.

"(3) PUBLIC-PRIVATE PARTNERSHIPS.—The Secretary may develop and utilize public-private partnerships for technical assistance, training, and related implementation support for State, local, Tribal, and territorial public health departments, and the Centers for Disease Control and Prevention,

on the expansion and modernization of electronic case reporting and public health data systems, as applicable.

''(b) REQUIREMENTS.—

''(1) HEALTH INFORMATION TECHNOLOGY STANDARDS.—The Secretary may not award a grant or cooperative agreement under subsection (a)(1)(B) unless the applicant uses or agrees to use standards endorsed by the National Coordinator for Health Information Technology pursuant to section 3001(c)(1) or adopted by the Secretary under section 3004.

''(2) WAIVER.—The Secretary may waive the requirement under paragraph (1) with respect to an applicant if the Secretary determines that the activities under subsection (a)(1)(B) cannot otherwise be carried out within the applicable jurisdiction.

''(3) APPLICATION.—A State, local, Tribal, or territorial health department applying for a grant or cooperative agreement under this section shall submit an application to the Secretary at such time and in such manner as the Secretary may require. Such application shall include information describing—

''(A) the activities that will be supported by the grant or cooperative agreement; and

''(B) how the modernization of the public health data systems involved will support or impact the public health infrastructure of the health department, including a description of remaining gaps, if any, and the actions needed to address such gaps.

''(c) STRATEGY AND IMPLEMENTATION PLAN.—Not later than 180 days after the date of enactment of this section, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a coordinated strategy and an accompanying implementation plan that identifies and demonstrates the measures the Secretary will utilize to—

''(1) update and improve applicable public health data systems used by the Centers for Disease Control and Prevention; and

''(2) carry out the activities described in this section to support the improvement of State, local, Tribal, and territorial public health data systems.

''(d) CONSULTATION.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall consult with State, local, Tribal, and

territorial health departments, professional medical and public health associations, associations representing hospitals or other health care entities, health information technology experts, and other appropriate public or private entities regarding the plan and grant program to modernize public health data systems pursuant to this section. Activities under this subsection may include the provision of technical assistance and training related to the exchange of information by such public health data systems used by relevant health care and public health entities at the local, State, Federal, Tribal, and territorial levels, and the development and utilization of public-private partnerships for implementation support applicable to this section.

''(e) REPORT TO CONGRESS.—Not later than 1 year after the date of enactment of this section, the Secretary shall submit a report to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives that includes—

''(1) a description of any barriers to—

''(A) public health authorities implementing interoperable public health data systems and electronic case reporting;

"(B) the exchange of information pursuant to electronic case reporting;

"(C) reporting by health care providers using such public health data systems, as appropriate, and pursuant to State law; or

"(D) improving demographic data collection or analysis;

"(2) an assessment of the potential public health impact of implementing electronic case reporting and interoperable public health data systems; and

"(3) a description of the activities carried out pursuant to this section.

"(f) ELECTRONIC CASE REPORTING.—In this section, the term 'electronic case reporting' means the automated identification, generation, and bilateral exchange of reports of health events among electronic health record or health information technology systems and public health authorities.

"(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $100,000,000 for each of fiscal years 2021 through 2025.".

SEC. 315. NATIVE AMERICAN SUICIDE PREVENTION.

Section 520E(b) of the Public Health Service Act (42 U.S.C. 290bb–36(b) is amended by inserting after paragraph (3) the following:

''(4) CONSULTATION.—An entity described in paragraph (1)(A) or (1)(B) that applies for a grant or cooperative agreement under this section shall agree to consult or confer with entities described in paragraph (1)(C) and Native Hawaiian Health Care Systems, as applicable, in the applicable State with respect to the development and implementation of a statewide early intervention strategy.''.

SEC. 316. REAUTHORIZATION OF THE YOUNG WOMEN'S BREAST HEALTH EDUCATION AND AWARENESS REQUIRES LEARNING YOUNG ACT OF 2009.

Section 399NN(h) of the Public Health Service Act (42 U.S.C. 280m(h)) is amended by striking '' $4,900,000 for each of fiscal years 2015 through 2019'' and inserting '' $9,000,000 for each of fiscal years 2022 through 2026''.

SEC. 317. REAUTHORIZATION OF SCHOOL-BASED HEALTH CENTERS.

Section 399Z–1(l) of the Public Health Service Act (42 U.S.C. 280h–5(l)) is amended by striking ''2010 through 2014'' and inserting ''2022 through 2026''.

Subtitle C—FDA Amendments

SEC. 321. RARE PEDIATRIC DISEASE PRIORITY REVIEW VOUCHER EXTENSION.

Section 529(b)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360ff(b)(5)) is amended—

(1) by striking ''December 18, 2020'' each place it appears and inserting ''September 30, 2024''; and

(2) in subparagraph (B), by striking ''December 18, 2022'' and inserting ''September 30, 2026''.

SEC. 322. CONDITIONS OF USE FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

Section 351(k)(2)(A)(iii) of the Public Health Service Act (42 U.S.C. 262(k)(2)(A)(iii)) is amended—

(1) in subclause (I), by striking ''; and'' and inserting a semicolon;

(2) in subclause (II), by striking the period and inserting ''; and''; and

(3) by adding at the end the following:

''(III) may include information to show that the conditions of use prescribed, recommended, or suggested in the labeling proposed for the biological product have been previously approved for the reference product.''.

SEC. 323. ORPHAN DRUG CLARIFICATION.

Section 527(c) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360cc(c)) is amended by adding at the end the following:

''(3) APPLICABILITY.—This subsection applies to any drug designated under section 526 for which an application was approved under section 505 of this Act or licensed under section 351 of the Public Health Service Act after the date of enactment of the FDA Reauthorization Act of 2017, regardless of the date on which such drug was designated under section 526.''.

SEC. 324. MODERNIZING THE LABELING OF CERTAIN GENERIC DRUGS.

Chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amended by inserting after section 503C the following:

''SEC. 503D. PROCESS TO UPDATE LABELING FOR CERTAIN GENERIC DRUGS.

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

''(1) The term 'covered drug' means a drug approved under section 505(c)—

''(A) for which there are no unexpired patents included in the list under section 505(j)(7) and no unexpired period of exclusivity;

''(B) for which the approval of the application has been withdrawn for reasons other than safety or effectiveness; and

''(C) for which—

''(i)(I) there is new scientific evidence available pertaining to new or existing conditions of use that is not reflected in the approved labeling;

''(II) the approved labeling does not reflect current legal and regulatory requirements for content or format; or

''(III) there is a relevant accepted use in clinical practice that is not reflected in the approved labeling; and

''(ii) updating the approved labeling would benefit the public health.

''(2) The term 'period of exclusivity', with respect to a drug approved under section 505(c), means any period of exclusivity under clause (ii), (iii), or (iv) of section 505(c)(3)(E), clause (ii), (iii), or (iv) of section 505(j)(5)(F), or section 505A, 505E, or 527.

''(3) The term 'generic version' means a drug approved under section 505(j) whose reference listed drug is a covered drug.

''(4) The term 'relevant accepted use' means a use for a drug in clinical practice that is supported by scientific evidence that appears to the Secretary to meet the standards for approval under section 505.

''(5) The term 'selected drug' means a covered drug for which the Secretary has determined through the process under subsection (c) that the labeling should be changed.

''(b) IDENTIFICATION OF COVERED DRUGS.—The Secretary may identify covered drugs for which labeling updates would provide a public health benefit. To assist in identifying covered drugs, the Secretary may do one or both of the following:

''(1) Enter into cooperative agreements or contracts with public or private entities to review the available scientific evidence concerning such drugs.

''(2) Seek public input concerning such drugs, including input on whether there is a relevant accepted use in clinical practice that is not reflected in the approved labeling of such drugs or whether new scientific evidence is available regarding the conditions of use for such drug, by—

''(A) holding one or more public meetings;

''(B) opening a public docket for the submission of public comments; or

''(C) other means, as the Secretary determines appropriate.

''(c) SELECTION OF DRUGS FOR UPDATING.—If the Secretary determines, with respect to a covered drug, that the available scientific evidence meets the standards under section 505 for adding or modifying information to the labeling or providing supplemental information to the labeling regarding the use of the covered drug, the Secretary may initiate the process under subsection (d).

''(d) INITIATION OF THE PROCESS OF UPDATING.—If the Secretary determines that labeling changes are appropriate for a selected drug pursuant to subsection (c), the Secretary shall provide notice to the holders of approved applications for a generic version of such drug that—

''(1) summarizes the findings supporting the determination of the Secretary that the available scientific evidence meets the standards under section 505 for adding or modifying information or providing supplemental information to the labeling of the covered drug pursuant to subsection (c);

''(2) provides a clear statement regarding the additional, modified, or supplemental information for

such labeling, according to the determination by the Secretary (including, as applicable, modifications to add the relevant accepted use to the labeling of the drug as an additional indication for the drug); and

''(3) states whether the statement under paragraph (2) applies to the selected drug as a class of covered drugs or only to a specific drug product.

''(e) RESPONSE TO NOTIFICATION.—Within 30 days of receipt of notification provided by the Secretary pursuant to subsection (d), the holder of an approved application for a generic version of the selected drug shall—

''(1) agree to change the approved labeling to reflect the additional, modified, or supplemental information the Secretary has determined to be appropriate; or

''(2) notify the Secretary that the holder of the approved application does not believe that the requested labeling changes are warranted and submit a statement detailing the reasons why such changes are not warranted.

''(f) REVIEW OF APPLICATION HOLDER'S RESPONSE.—

''(1) IN GENERAL.—Upon receipt of the application holder's response, the Secretary shall promptly review each statement received under subsection

(e)(2) and determine which labeling changes pursuant to the Secretary's notice under subsection (d) are appropriate, if any. If the Secretary disagrees with the reasons why such labeling changes are not warranted, the Secretary shall provide opportunity for discussions with the application holders to reach agreement on whether the labeling for the covered drug should be updated to reflect available scientific evidence, and if so, the content of such labeling changes.

''(2) CHANGES TO LABELING.—After considering all responses from the holder of an approved application under paragraph (1) or (2) of subsection (e), and any discussion under paragraph (1), the Secretary may order such holder to make the labeling changes the Secretary determines are appropriate. Such holder of an approved application shall—

''(A) update its paper labeling for the drug at the next printing of that labeling;

''(B) update any electronic labeling for the drug within 30 days of such order; and

''(C) submit the revised labeling through the form, 'Supplement—Changes Being Effected'.

''(g) VIOLATION.—If the holder of an approved application for the generic version of the selected drug does not comply with the requirements of subsection (f)(2), such generic version of the selected drug shall be deemed to be misbranded under section 502.

''(h) LIMITATIONS; GENERIC DRUGS.—

''(1) IN GENERAL.—With respect to any labeling change required under this section, the generic version shall be deemed to have the same conditions of use and the same labeling as its reference listed drug for purposes of clauses (i) and (v) of section 505(j)(2)(A). Any labeling change so required shall not have any legal effect for the applicant that is different than the legal effect that would have resulted if a supplemental application had been submitted and approved to conform the labeling of the generic version to a change in the labeling of the reference drug.

''(2) SUPPLEMENTAL APPLICATIONS.—Changes to labeling made in accordance with this section shall not be eligible for an exclusivity period under this Act.

''(3) SELECTION OF DRUGS.—The Secretary shall not identify a drug as a covered drug or select a drug label for updating under subsection (b) or (c)

solely based on the availability of new safety information. Upon identification of a drug as a covered drug under subsection (b), the Secretary may then consider the availability of new safety information (as defined in section 505–1(b)) in determining whether the drug is a selected drug and in determining what labeling changes are appropriate.

''(i) RULES OF CONSTRUCTION.—

''(1) APPROVAL STANDARDS.—This section shall not be construed as altering the applicability of the standards for approval of an application under section 505. No order shall be issued under this subsection unless the scientific evidence supporting the changed labeling meets the standards for approval applicable to any change to labeling under section 505.

''(2) REMOVAL OF INFORMATION.—Nothing in this section shall be construed to give the Secretary additional authority to remove approved indications for drugs, other than the authority described in this section.

''(3) SECRETARY AUTHORITY.—Nothing in this section shall be construed to limit the authority of the Secretary to require labeling changes under section 505(o).

''(4) MAINTENANCE OF LABELING.—Nothing in this section shall be construed to affect the responsibility of the holder of an approved application under section 505(j) to maintain its labeling in accordance with existing requirements, including subpart B of part 201 and sections 314.70 and 314.97 of title 21, Code of Federal Regulations (or any successor regulations).

''(j) REPORTS.—Not later than 4 years after the date of the enactment of this section, and every 4 years thereafter, the Secretary shall prepare and submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate, a report that—

''(1) describes the actions of the Secretary under this section, including—

''(A) the number of covered drugs and description of the types of drugs the Secretary has selected for labeling changes and the rationale for such recommended changes; and

''(B) the number of times the Secretary entered into discussions concerning a disagreement with an application holder or holders and a summary of the decision regarding a labeling change, if any; and

''(2) includes any recommendations of the Secretary for modifying the program under this section.''.

SEC. 325. BIOLOGICAL PRODUCT PATENT TRANSPARENCY.

(a) IN GENERAL.—Section 351(k) of the Public Health Service Act (42 U.S.C. 262(k)) is amended by adding at the end the following:

''(9) PUBLIC LISTING.—

''(A) IN GENERAL.—

''(i) INITIAL PUBLICATION.—Not later than 180 days after the date of enactment of this paragraph, the Secretary shall publish and make available to the public in a searchable, electronic format—

''(I) a list of each biological product, by nonproprietary name (proper name), for which, as of such date of enactment, a biologics license under subsection (a) or this subsection is in effect, or that, as of such date of enactment, is deemed to be licensed under this section pursuant to section 7002(e)(4) of the Biologics Price Competition and Innovation Act of 2009;

"(II) the date of licensure of the marketing application and the application number; and

"(III) with respect to each biological product described in subclause (I), the licensure status, and, as available, the marketing status.

"(ii) REVISIONS.—Every 30 days after the publication of the first list under clause (i), the Secretary shall revise the list to include each biological product which has been licensed under subsection (a) or this subsection during the 30-day period or deemed licensed under this section pursuant to section 7002(e)(4) of the Biologics Price Competition and Innovation Act of 2009.

"(iii) PATENT INFORMATION.—Not later than 30 days after a list of patents under subsection (l)(3)(A), or a supplement to such list under subsection (l)(7), has been provided by the reference product sponsor to the subsection (k) applicant respecting a biological product included on the list published under this subparagraph,

the reference product sponsor shall provide such list of patents (or supplement thereto) and their corresponding expiry dates to the Secretary, and the Secretary shall, in revisions made under clause (ii), include such information for such biological product. Within 30 days of providing any subsequent or supplemental list of patents to any subsequent subsection (k) applicant under subsection (l)(3)(A) or (l)(7), the reference product sponsor shall update the information provided to the Secretary under this clause with any additional patents from such subsequent or supplemental list and their corresponding expiry dates.

''(iv) LISTING OF EXCLUSIVITIES.—For each biological product included on the list published under this subparagraph, the Secretary shall specify each exclusivity period under paragraph (6) or paragraph (7) for which the Secretary has determined such biological product to be eligible and that has not concluded.

''(B) REVOCATION OR SUSPENSION OF LICENSE.—If the license of a biological product is

determined by the Secretary to have been revoked or suspended for safety, purity, or potency reasons, it may not be published in the list under subparagraph (A). If such revocation or suspension occurred after inclusion of such biological product in the list published under subparagraph (A), the reference product sponsor shall notify the Secretary that—

''(i) the biological product shall be immediately removed from such list for the same period as the revocation or suspension; and

''(ii) a notice of the removal shall be published in the Federal Register.''.

(b) REVIEW AND REPORT ON TYPES OF INFORMATION TO BE LISTED.—Not later than 3 years after the date of enactment of this Act, the Secretary of Health and Human Services shall—

(1) solicit public comment regarding the type of information, if any, that should be added to or removed from the list required by paragraph (9) of section 351(k) of the Public Health Service Act (42 U.S.C. 262(k)), as added by subsection (a); and

(2) transmit to Congress an evaluation of such comments, including any recommendations about the

types of information that should be added to or removed from the list.

Subtitle D—Technical Corrections

SEC. 331. TECHNICAL CORRECTIONS.

(a) EDUCATION AND TRAINING RELATING TO GERIATRICS.—Section 753(a)(7)(B) of the Public Health Service Act (42 U.S.C. 294c(a)(7)(B)) is amended, in the matter preceding clause (i), by striking ''Title VII Health Care Workforce Reauthorization Act of 2019'' and inserting ''Coronavirus Aid, Relief, and Economic Security Act''.

(b) NURSING.—Section 851(d)(3) of the Public Health Service Act (42 U.S.C. 297t(d)(3)) is amended by striking ''Title VIII Nursing Reauthorization Act'' and inserting ''Coronavirus Aid, Relief, and Economic Security Act''.

(c) CITATION.—Section 3404(a)(9) of the Coronavirus Aid, Relief, and Economic Security Act (Public Law 116–136) is amended by striking ''section 846A (42 U.S.C. 247n–1)'' and inserting ''section 846A (42 U.S.C. 297n–1)''.

(d) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (c) shall take effect as if included in the enactment of the Coronavirus Aid, Relief, and Economic Security Act (Public Law 116–136).