

Summary: HR. 133 Consolidated Appropriations Act, 2021

Division BB: Health Plan Provisions

February 22, 2021

Title I: No Surprises Act

Sections/ Applicability/Effective Dates	Provisions
Sec. 101: Short Title	No Surprises Act
	<p>Sec 101 Short title.</p> <p>Sec 102 Health insurance requirements regarding surprise medical billing.</p> <p>Sec 103 Determination of out-of-network rates to be paid by health plans; Independent dispute resolution process.</p> <p>Sec 104 Health care provider requirements regarding surprise medical billing.</p> <p>Sec 105 Ending surprise air ambulance bills.</p> <p>Sec 106 Reporting requirements regarding air ambulance services.</p> <p>Sec 107 Transparency regarding in-network and out-of-network deductibles and out-of-pocket limitations.</p> <p>Sec 108 Implementing protections against provider discrimination. N/A</p> <p>Sec 109 Reports. N/A</p> <p>Sec 110 Consumer protections through application of health plan external review in cases of certain surprise medical bills.</p> <p>Sec 111 Consumer protections through health plan requirement for fair and honest advance cost estimate.</p> <p>Sec 112 Patient protections through transparency and patient-provider dispute resolution.</p> <p>Sec 113 Ensuring continuity of care.</p> <p>Sec 114 Maintenance of price comparison tool.</p> <p>Sec 115 State All Payer Claims Databases. N/A (unless we/clients want access to the Database)</p> <p>Sec 116 Protecting patients and improving the accuracy of provider directory information.</p> <p>Sec 117 Advisory committee on ground ambulance and patient billing. N/A</p> <p>Sec 118 Implementation funding. N/A</p>

<p>Sections 102 - 106.</p> <p>Applicability: ERISA and non-ERISA (non-federal governmental, and church plans) self-funded group health plans and fully insured group and individual insurers (insurers); Also applies to grandfathered plans.</p> <p>Effective: plan years beginning on or after January 1, 2022.</p>	<p>PREVENTING SURPRISE MEDICAL BILLS</p> <p>High level summary – Amounts paid for out of network emergency care are treated as in-network for calculating reimbursement and the patient’s obligations up until the individual is stabilized and certain conditions are met (notice and consent). Amounts paid for non-emergency care provided at an in-network facility by an out of network provider are treated as in-network when the provider does not follow the patient notice and written consent requirements described below.</p> <p>No prior authorization can be applied to emergency care provided by emergency departments and freestanding emergency care facilities, and the cost-sharing the plan participant must pay for out of network services cannot exceed the amount for which an in-network provider or facility would charge and must be applied to the in-network cost-sharing amounts (i.e. deductible, out of pocket max).</p> <p>Written Disclosure (Notice) and Consent Before providing services (after the individual is stabilized in the case of prior emergency services), and before planned non-emergency care, an out of network provider must notify the plan participant and obtain prior written consent from the patient. The provider must disclose:</p> <ol style="list-style-type: none"> 1) their out-of-network status, 2) provide a good faith estimate of the costs of the services to the participant, 3) a list of participating providers at the facility that could provide the services, and 4) whether prior authorization is required for any of the items or services. <p>After receiving the notice, the individual must consent in writing to be treated by the nonparticipating provider or facility. The consent form must meet certain criteria.</p> <p>Calculating Cost Share for Out of network Emergency Services or Non-emergency services by Non-Participating Providers at In-network Facilities when no Written Notice and Consent For emergency services provided by an out of network provider or for non-emergency services provided by a out of network provider at an in-network facility where the notice and consent is not obtained from the participant, a claim must be denied or initially paid in part within 30 days of submission by the health care provider and the cost-sharing requirement is calculated, at the qualifying payment amount (median of the contracted rates, unless an applicable state law requires another method) consistent with the methodology established by the Secretaries. Regulations to implement the new law are due by July 1, 2021.</p>
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Open Negotiation Period

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 initiate **open negotiations** between such provider or facility and plan or coverage for purposes of determining, 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.

Dispute Resolution Process

As a recap, a claim must be denied or initially paid in part within 30 days of submission by the health care provider or facility and ultimately decided after the amount of the payment is determined through the new dispute resolution process, unless there is an applicable state law that determines the payment amount.

The dispute resolution process will be operated by a certified independent dispute resolution (IDR) entity, which will determine the amount to be paid. This new process also applies to air ambulance services. **Not later than December 27, 2021**, the Secretaries must establish by regs one independent dispute resolution process.

The group health plan or health insurer and the nonparticipating provider or the nonparticipating emergency facility (as applicable) involved in a notification jointly select a certified IDR entity, **not later than 3-business days following the date of the initiation of the process**.

Not later than 10 days after the date of selection of the certified IDR entity each party must submit to the certified IDR entity-

- (a) an offer for a payment amount for such item or service furnished by such provider or facility; and
- (b) such information as requested by the certified IDR entity relating to such offer; and
- (c) **may** each submit to the certified IDR entity, the following:
 - (1) 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 42 U.S.C.A. § 1395aaa (such as the National Quality Forum).
 - (2) 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.
 - (3) The acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual.
 - (4) The teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service.

(5) 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.

Prohibition on consideration of certain factors. In determining which offer is the payment to be applied, the **certified IDR entity cannot 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 balance bill prohibitions (section 2799B-1 or 2799B-2 Balance Billing prohibited) (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 Medicare, Medicaid, the Children's Health Insurance Program, or TRICARE.

Timing of IDR Decision

Not later than 30 days after the date of selection of the certified IDR entity, the certified IDR entity must select one of the offers submitted and notify the provider or facility and the group health plan or health insurer the decision.

Timing of Payment

The total plan or coverage payment required under an IDR determination or under open negotiations must be made directly to the nonparticipating provider or facility not later than 30 days after the date on which such determination is made.

Ending Surprise Air Ambulance Bills

A group health plan or group or individual health insurance coverage with participants who receive air ambulance (medical transport by helicopter or airplane) for patients services from a nonparticipating provider (if such services would otherwise be covered if provided by a participating provider) -

- (1) the cost-sharing requirement must be the same requirement had services been provided in network, and any coinsurance or deductible must be based on rates that would apply had the services been provided in network;
- (2) the cost-sharing amounts must be applied towards the in-network deductible and in-network out-of-pocket maximum amount and the in-network deductible must be applied as if the cost-sharing payments were for 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, directly to such provider furnishing such services to such participant, beneficiary, or enrollee that is, with application of any initial payment, equal to the amount by which the out-of-network rate (determined under applicable state law or the IDR entity) 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)).

Balance Billing Prohibited

Out-of-network emergency service providers and air ambulance providers are prohibited from balance billing a participant in excess of the participant's in-network cost-sharing amount under the plan. A nonparticipating provider or facility providing non-emergency services is prohibited from balance billing a participant for a payment that is more than the in-network cost-sharing requirement under the plan if the provider failed to provide the required disclosure and obtain the required consent.

Audit Process

By October 1, 2021, federal regulators must establish, through rules, a process for auditing group health plans and health insurers by the federal regulators or applicable State authority to ensure that such plans and coverage are in compliance with the requirement of applying a **qualifying payment amount** under this section.

There is coordination regarding the reporting of emergency care and billing violations to the applicable federal agencies for identifying patterns of noncompliance by health care providers with the notice requirement and prohibition on balance billing. The complaint and enforcement process for the emergency room/facility surprise billing also applies with respect to surprise air ambulance billing.

OTHER PATIENT PROTECTIONS.

(a) Choice of Health Care Professional. If a group health plan, or a health insurer requires or provides for designation by a participant of a participating primary care provider, then the plan or insurer must permit each participant to designate **any** participating primary care provider who is available to accept such individual.

(b) Access to Pediatric Care.-

In the case of a person who has a child who is covered under a group health plan, or group or individual health insurance coverage offered, if the plan or insurer requires or provides for the designation of a participating primary care provider for the child, the plan or insurer must 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 insurer.

	<p>(c) Patient Access to Obstetrical and Gynecological Care.-</p> <p>(1) General rights.</p> <p>(A) Direct access. A group health plan, or health insurance issuer offering group or individual health insurance coverage may not require authorization or referral by the plan, insurer, or any person (including a primary care provider) in the case of a female participant 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 insurer'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 insurer.</p> <p>(B) Obstetrical and gynecological care. A group health plan or health insurer shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.</p>
<p>Sec. 107 and 111</p> <p>Applicability: ERISA and non-ERISA (non-federal governmental, except FEHB, and church plans) self-funded group health plans and fully insured group and individual insurers (insurers)</p> <p>Effective: plan years beginning on or after January 1, 2022</p>	<p>ID CARDS AND PLAN DOCS</p> <p>Group health plans and health insurers (group or individual) must include, in clear writing, on any physical or electronic plan or insurance identification card the following:</p> <p>(1) Any deductible applicable to such plan or coverage.</p> <p>(2) Any out-of-pocket maximum limitation applicable to such plan or coverage.</p> <p>(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.</p> <p>EXTERNAL REVIEW PROCESS APPLIES TO SURPRISE MEDICAL BILLS</p> <p>The external review process applies to any adverse determination under the surprise medical bills provisions of the federal law no later than January 1, 2022 as determined by the federal regulators (including air ambulance provisions), including with respect to whether such respective section applies.</p> <p>ADVANCED EOBs</p> <p>(1) Group health plans and health insurers must provide an advance EOB, in clear and understandable language, to a participant (through mail or electronic means, as requested by the participant) , not later than:</p> <p>- 1 business day or,</p>

	<p>- 3 business days (in the case such item or service was scheduled at least 10 business days before such item or service is to be furnished (or in the case of a request made by a participant)),</p> <p>of receiving notification from a provider or facility.</p> <p>The advance EOB must include the following:</p> <ul style="list-style-type: none"> (A) Whether or not the provider or facility is a participating provider/facility (B) The contracted rate of a participating provider/facility (C) How the participant can obtain information on in network providers and facilities (if the claim is out of network) (D) The good faith estimate of expected charges included in the notification received from the provider or facility (C) A good faith estimate of the amount the plan or coverage is responsible for paying (D) A good faith estimate of the amount of any cost-sharing (E) A good faith estimate of the amount that the participant has incurred toward meeting the participants' cost share limits (including deductibles and out-of-pocket maximums) (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, 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 (H) Any other information or disclaimer the plan or coverage determines appropriate that is consistent with information and disclaimers required under this section. <p>(2) There is regulatory authority to modify timing requirements in the case of items and services with low utilization or significant variation in costs.</p>
<p>Section 112 Provider/Facility Good Faith Estimate of Expected Charges</p> <p>Applicability: Health care providers and facilities</p>	<p>Starting January 1, 2022, each health care provider and facility:</p> <ul style="list-style-type: none"> - within 1 business day after the date of scheduling if scheduled at least 3 business days before the item/service is to be furnished; - within 3 business days after the date of scheduling if scheduled at least 10 business days before the item/service is to be furnished (or if requested by the individual). <p>(1) inquire if such individual is enrolled in a group health plan, group or individual health insurance coverage, or a Federal health care program; and</p>

<p>Effective: January 1, 2022</p>	<p>(2) provide a notification (in clear and understandable language) of the good faith estimate of the expected charges (including any item or service that is reasonably expected to be provided by another health care provider/facility), with the expected billing and diagnostic codes for any such item or service, to-</p> <ul style="list-style-type: none"> (A) the plan or insurer, if the individual is enrolled in such a plan or such coverage; and (B) the individual, if the individual is does not have insurance coverage and not enrolled in a Federal health care program.
<p>Sect 113 Ensuring Continuity of Care With Respect to Terminations of Certain Contractual Relationships Resulting in Changes in Provider Network Status.-</p> <p>Applicability: ERISA and non-ERISA (non-federal governmental, and church plans) self-funded group health plans and fully insured group and individual insurers (insurers)</p> <p>Effective: plan years beginning on or after January 1, 2022</p>	<p>(1) If a person is receiving care from a contracted provider/facility while such individual is a continuing care patient</p> <ul style="list-style-type: none"> (A) such contractual relationship is terminated, (B) benefits provided under the group health plan or health insurance coverage with respect to such provider or facility are terminated; or (C) a contract between a group health plan and a health insurer is terminated, resulting in a loss of benefits provided under such plan with respect to such provider or facility; <p>(2) The plan or insurer must do the following.</p> <ul style="list-style-type: none"> (A) notify each individual enrolled under such plan or coverage who is a continuing care patient of such individual's right to elect continued transitional care from such provider or facility; (B) 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 is provided and ending on the earlier of- <ul style="list-style-type: none"> (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. <p>Definitions. In this section:</p> <ul style="list-style-type: none"> (1) The term 'continuing care patient' means an individual who, with respect to a provider or facility- <ul style="list-style-type: none"> (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 and is receiving treatment for such illness from such provider or facility. (2) The term 'serious and complex condition' means -

	<p>(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</p> <p>(B) in the case of a chronic illness or condition, a condition that is-</p> <p style="padding-left: 40px;">(i) is life-threatening, degenerative, potentially disabling, or congenital; and</p> <p style="padding-left: 40px;">(ii) requires specialized medical care over a prolonged period of time.</p> <p>(3) 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.</p>
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<p>SEC. 114 MAINTENANCE OF PRICE COMPARISON TOOL</p> <p>Applicability: ERISA and non-ERISA (non-federal governmental, and church plans) self-funded group health plans and fully insured group and individual insurers (insurers)</p> <p>Effective: plan years beginning on or after January 1, 2022</p>	<p>Price Comparison Tool</p> <p>A group health plan or a health insurer must offer price comparison guidance by telephone and make available on the Internet website of the plan or insurer:</p> <p>a price comparison tool that (to the extent practicable) allows a participant, with respect to such plan year, geographic region, and participating providers, to compare the amount of cost-sharing that the participant would be responsible for paying under the plan/coverage with respect to the furnishing of a specific item or service by any such provider.</p>
<p>SEC. 116. PROTECTING PATIENTS AND IMPROVING THE ACCURACY OF PROVIDER DIRECTORY</p>	<p>Provider Directory Information Requirements</p> <p>(1) Each group health plan and health insurance insurer must -</p> <p style="padding-left: 40px;">(A) establish a verification process on the accuracy of providers in the network directory, checking at least once every 90 days, and updating the network directory within 2 business days from hearing from a provider/facility;</p> <p style="padding-left: 40px;">(B) establish a response protocol that includes responding to a member who requests information via a</p>

<p>INFORMATION (2799A-5)</p> <p>Applicability: ERISA and non-ERISA (non-federal governmental, and church plans) self-funded group health plans and fully insured group and individual insurers (insurers)</p> <p>Effective: plan years beginning on or after January 1, 2022</p>	<p>a telephone call or electronic, web-based, or Internet-based means on whether a health care provider or facility has a contractual relationship to furnish items and services under such plan or such coverage. In the case such request is made through a telephone call-</p> <p>(i) responds to such individual as soon as practicable and no later than 1 business day after such call is received, through a written electronic or print (as requested by such individual) communication; and</p> <p>(ii) retains such communication in such individual's file for at least 2 years following such response.</p> <p>(C) establish a database on the public website of such plan or insurer that contains-</p> <p>(i) a list of each health care provider and health care facility with which such plan or insurer has a direct or indirect contractual relationship for furnishing items and services under such plan or such coverage; and</p> <p>(ii) provider directory information with respect to each such provider and facility. 'Provider directory information' includes the name, address, specialty, telephone number, and digital contact information of each health care provider or health care facility with which such plan or insurer has a contractual relationship for furnishing items and services under such plan or such coverage.</p> <p>(D) include in any provider directory (other than the database) a disclaimer that the information contained in the directory was accurate as of the date of publication of such directory and that the person should consult the database to obtain the most current provider directory.</p> <p>(b) Cost-sharing for Services Provided Based on Reliance on Incorrect Provider Network Information.-</p> <p>(1) For items or services furnished to a participant of a group health plan or an insurer by a nonparticipating provider or 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 participant received information through a database, provider directory or response protocol that the provider was a participating provider/facility, the plan or coverage-</p> <p>(A) must not impose on such participant a cost-sharing amount that is greater than the cost-sharing amount that would apply had such item or service been furnished by a participating provider; and</p> <p>(B) must apply the deductible or out-of-pocket maximum, if any, that would apply if such services were furnished by a participating provider facility.</p> <p>(c) Disclosure on Patient Protections Against Balance Billing. Each group health plan and health insurer must make publicly available, post on a public website of such plan or insurer, and include on each explanation of benefits for an item or service with respect to which the requirements under section Section 102 Surprise Medical Billing; applies-</p> <p>(1) information in plain language on-</p> <p>(A) the requirements regarding balance billing prohibited on emergency services (2799B-1) and balance billing prohibited for non-emergency services performed by a non-participating provider at a participating facility in certain circumstances (2799B-2);</p>
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	<p>(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 when such provider/facility does not have a contractual relationship for furnishing such item or service after receiving payment from the plan or coverage and any applicable cost sharing payment from such participant; and</p> <p>(C) the requirements applied under Section 102 Surprise Medical Billing; and</p> <p>(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.</p>
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<p>PROVIDER REQUIREMENTS TO PROTECT PATIENTS AND IMPROVE THE ACCURACY OF PROVIDER DIRECTORY INFORMATION (2799B-9)</p> <p>Applicability: Health care providers and facilities</p> <p>Effective: January 1, 2022</p>	<p>(a) Each health care provider and facility must have in place business processes to ensure the timely provision of provider directory information (defined below) to a group health plan or a health insurance insurer to support compliance by such plans or issuers with the prior section. Such providers must submit provider directory information to a plan or insurers at a minimum-</p> <ul style="list-style-type: none"> (1) when the provider or facility begins a network agreement with a plan or insurer; (2) when the provider or facility terminates a network agreement with a plan or insurer; (3) when there are material changes to the content of provider directory information of the provider or facility and (4) at any other time (including upon the request of such insurer or plan) determined appropriate by the provider, facility, or the federal regulators. <p>(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 above (prior section) 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 federal regulators.</p> <p>(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 insurer-</p> <ul style="list-style-type: none"> (1) that the plan or insurer remove, at the time of termination of such contract, the provider from a directory of the plan or insurer; or (2) that the plan or insurer bear financial responsibility, including under Provider Directory Information Requirements (section 2799A-5(b) above), for providing inaccurate network status information to an enrollee.
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	<p>(d) 'Provider directory information' includes the names, addresses, specialty (as regards providers), telephone numbers, and digital contact information of individual health care providers, and each medical group, clinic, or facility contracted to participate in any of the networks of the group health plan or health insurance coverage involved.</p>

<p>Sec. 102. Surprise Medical Billing (2799A-1)</p> <p>Applicability: ERISA and non-ERISA (non-federal governmental, except FEHB, and church plans) self-funded group health plans and fully insured group and individual insurers (insurers); Also applies to grandfathered plans.</p>	<p>Detailed Summary –</p> <p>(a) Coverage of Emergency Services.-</p> <p>(1) If a group health plan, or a health insurer provides or covers any benefits for services in an emergency department of a hospital or emergency services in an independent freestanding emergency department, the plan or insurer must cover emergency services -</p> <ul style="list-style-type: none"> (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; (C) if such services are provided by a nonparticipating provider or a nonparticipating emergency facility- <ul style="list-style-type: none"> (i) plans and insurers cannot impose any limitation on coverage that is more restrictive than if 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 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 below but generally, the median of the contracted rates and subject to forthcoming regs) for such services, plan or coverage, and year; (iv) the group health plan or health insurance issuer, respectively- <ul style="list-style-type: none"> (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
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Effective: plan years beginning on or after January 1, 2022

(II) pays a total plan or coverage payment directly to such provider or facility, respectively (in accordance, if applicable, with application of any initial payment), **equal to the amount by which the out-of-network rate for such services exceeds the cost-sharing amount for such services** (as determined in accordance with clauses (ii) and (iii)) and year; and

(v) any cost-sharing payments made by the participant, beneficiary, or enrollee for emergency services must be counted toward any in-network deductible or out-of-pocket maximums applied under the plan/coverage (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 for in-network services; 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, and other than applicable cost-sharing).

(2) Audit process and regulations for qualifying payment amounts.

(A) Audit process.-

By October 1, 2021, the Secretaries of HHS, Labor and Treasury must establish through rulemaking a process, under which group health plans and health insurers are audited (beginning with 2022) 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 with respect to the year involved.

(B) Reports. Beginning for 2022, the Secretaries must annually submit to Congress a report on the number of plans and insurers with respect to which audits were conducted during such year pursuant to this subparagraph.

(C) Rulemaking. Not later than July 1, 2021, the Secretaries of HHS, Labor and Treasury, must establish through rulemaking-

- (i) the methodology the group health plan or health insurers offering group or individual health insurance coverage use to determine **the qualifying payment amount**;
- (ii) the information such plan or insurer, respectively, must 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; and

(iv) a process to receive complaints of violations of the requirements by group health plans and health insurers.

Such rulemaking shall take into account payments that are made by such plan or insurer, 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.

(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 covered by a group health plan or health insurer and provided by a nonparticipating provider (and who, with respect to such items and services, has not satisfied the notice and consent criteria of section **2799B-2(d)**), the plan or coverage must -

(A) not impose any cost-sharing greater than in-network cost sharing;

(B) 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** (defined below);

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

(D) pay a total plan or coverage payment directly, in accordance, if applicable, within 30 days of an IDR determination, to such provider furnishing such items and services to such participant that is, with application of any initial payment under subparagraph (C), equal to the amount by which the out-of-network rate for such items and services involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such items and services (as determined in accordance with subparagraphs (A) and (B)) and year; and

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

Defined Terms for the above Sections:

The term '**emergency services**', with respect to an emergency medical condition, means-

(I) a medical screening examination 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 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. 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. With respect to a participant or beneficiary who is stabilized and furnished additional items and services described in subclause (I) after such stabilization include 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 disclosure and consent 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 disclosure 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.

The term **qualifying payment amount** means, subject to clauses (ii) and (iii), -

- (I) for an item or service furnished during 2022, ***the median of the contracted rates recognized by the plan or insurer***, respectively (determined with respect to all such plans of such sponsor or all such coverage offered by such insurer 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 Secretaries (under forthcoming rules), 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.

(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 in 2019 (or, in the case of a newly covered item or service, in the first coverage year (as defined in clause (v)(I)) for such item or service with respect to such plan or coverage) for an item or service (including with respect to provider type, or amount, of claims for items or services (as determined by the Secretary) provided in a particular geographic region (other than in a case with respect to which clause (ii) applies)) the term '**qualifying payment amount**'-

(I) for an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for such item or service with respect to such plan or coverage), means such rate for such item or service determined by the sponsor or issuer, respectively, through use of any database that is determined, in accordance with rulemaking 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 for such item or service with respect to such plan or coverage), means the rate determined under subclause (I) or this subclause, as applicable, for such item or service for the year previous to such subsequent year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year;

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

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

For purposes of clause (i)(I), a **health insurance market** 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.

First coverage year means, an item or service for which coverage is not offered in 2019 under a 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.

First sufficient information year means -

(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.

The term '**newly covered item or service**' means 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.

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 insurer, respectively; such a nonparticipating provider or nonparticipating emergency facility; and such an item or service, the amount that is **the qualifying payment amount** for such year and determined in *accordance with new rules promulgated by the Secretaries*; 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 (Medicare and Medicaid Innovation- applies to Medicare and Medicaid recipients), the amount that the State approves under such system for such item or service so furnished.

OTHER PATIENT PROTECTIONS.

(a) Choice of Health Care Professional. If a group health plan, or a health insurance insurer requires or provides for designation by a participant of a participating primary care provider, then the plan or insurer must permit each participant 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 covered under a group health plan, or group or individual health insurance coverage offered, if the plan or insurer requires or provides for the designation of a participating primary care provider for the child, the plan or insurer must 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 insurer.

(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 may not require authorization or referral by the plan, insurer, or any person (including a primary care provider) in the case of a female participant 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 insurer'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 insurer.

	<p>(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.</p> <p>(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-</p> <p>(A) provides coverage for obstetric or gynecologic care; and</p> <p>(B) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.</p> <p>(3) Construction. Nothing in paragraph (1) shall be construed to-</p> <p>(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</p> <p>(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.</p> <p>High Deductible Plans</p> <p>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 the law or any State law providing similar protections to individuals, prior to the satisfaction of the deductible.</p>
<p>Sec 103 Determination of out-of-network rates to be paid by health plans; Independent dispute resolution process.</p>	<p>(c) Determination of Out-of-network Rates to Be Paid by Health Plans; Independent Dispute Resolution Process.-</p> <p>(1) Determination through open negotiation.</p> <p>(A) In general. With respect to an item or service furnished by a nonparticipating provider or a nonparticipating facility, in a State that does not have a law that applies to determine the out of network payment for which a payment is required to be made by the plan or coverage pursuant to subsection (a)(1) or (b)(1) (emergency services provided out of network or non-emergency provided out of network but no notice to and consent by the patient as required), 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</p>

<p>Applicability: ERISA and non-ERISA (non-federal governmental, except FEHB, and church plans) self-funded group health plans and fully insured group and individual insurers (insurers); Also applies to FEHB and grandfathered plans.</p> <p>Effective: plan years beginning on or after January 1, 2022.</p>	<p>between such provider or facility and plan or coverage for purposes of determining, 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 is the 30-day period beginning on the date of initiation of the negotiations with respect to an item or service.</p> <p>(B) Accessing independent dispute resolution process in case of failed negotiations. In the case of open negotiations, 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, the provider or facility (as applicable) or group health plan or health insurer 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 by submission to the other party and to the Secretary of a notification (containing such information as specified by the Secretary) and, 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.</p> <p>(2) Independent dispute resolution process available in case of failed open negotiations.</p> <p>(A) Establishment. Not later than December 27, 2022, the Secretaries of HHS, Labor and Treasury, shall establish by regulation one independent dispute resolution process (referred to in this subsection as the 'IDR process') under which, a provider or facility (as applicable) or group health plan or health insurance issuer 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), the amount of payment under the plan or coverage for such item or service furnished by such provider or facility.</p> <p>(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 makes such determination, such amount shall be treated 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 IDR entity.</p> <p>(C) Clarification. A nonparticipating provider may not, with respect to an item or service furnished by such provider, submit a notification to initiate the independent dispute resolution process if such provider is exempt</p>
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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 insurer;
- (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 Secretaries of HHS, Labor and 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 shall be for a 5-year period.

(C) Revocation. A certification of an entity under this paragraph may be revoked 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 for certification must 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 for certification must 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 **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 to make a determination 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**, the **certified IDR entity** shall-

(i) select one of the offers submitted under subparagraph (B) to be the amount of payment for such item or service; 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.

(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** (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) below, such information as requested by the certified IR entity relating to the offer, 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 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 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 cannot 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 balance bill prohibitions (section 2799B-1 or 2799B-2 Balance Billing prohibited) (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 Medicare, Medicaid, the Children's Health Insurance Program, or TRICARE.

(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 where the award was procured by fraud, corruption, misconduct, evident partiality, or the arbiter exceeded its powers (described in any of paragraphs (1) through (4) of 9 U.S.C.A. § 10.)

(ii) **Suspension of certain subsequent idr requests.** In the case of a determination of a certified IDR entity, the party that submitted the initial notification may not submit during the 90-day period following such determination, a

subsequent notification 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 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 and submitted to a certified IDR entity-

(i) if such entity makes a determination, the party whose offer is not chosen 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 a determination or for which a payment amount is determined under open negotiations, must 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.**

	<p>(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 HHS website various information and data arising from the IDR process during the prior year.</p> <p>(8) Administrative fee.</p> <p>(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 the time and manner as specified in regs, a fee for participating in the IDR process.</p> <p>(B) Amount of fee. The amount is established by the Secretary and will be 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.</p> <p>(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) and other than 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.</p>
<p>Sec 104 Health care provider requirements regarding surprise medical billing (SEC. 2799B-1)</p> <p>Applicability: ERISA and non-ERISA (non-federal governmental, except FEHB, and church plans) self-funded group health plans and fully insured group and individual insurers (insurers); Also</p>	<p>BALANCE BILLING IN CASES OF EMERGENCY SERVICES.</p> <p>(a) In General. In the case of a participant, with benefits under a group health plan or group or individual health insurance coverage, who is furnished during a plan year beginning on or after January 1, 2022, emergency services (for which benefits are provided under the plan or coverage) with respect to an emergency medical condition with respect to a visit at an emergency department of a hospital or an independent freestanding emergency department-</p> <p>(1) the nonparticipating emergency facility, emergency department of a hospital or independent freestanding emergency department or a nonparticipating provider shall not bill, and shall not hold liable, the participant for a payment amount for such emergency services so furnished that is more than the cost-sharing requirement if they were provided in-network.</p>

applies to FEHB and grandfathered plans.
Effective: plan years beginning on or after January 1, 2022.

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

(a) **In General.** Subject to subsection (b), in the case of a participant with benefits under a group health plan or group or individual health insurance coverage and who is furnished items or services (other than emergency services) 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 for a payment amount for such an item or service furnished by such provider that is more than the in-network cost-sharing requirement for such item or service.**

(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, of a group health plan or group or individual health insurance coverage, **if the provider satisfies the notice and consent criteria of subsection (d).**

(2) Ancillary services described. For purposes of paragraph (1), ancillary services 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 nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

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

(c) **Clarification.** In the case of a nonparticipating provider that satisfies the notice and consent 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 construed as applying with respect to any item or service that is furnished as a result of unforeseen, urgent medical needs that arise at the time such covered item or service is furnished.** For purposes of the previous sentence, a covered item or service shall not include an ancillary service described in subsection (b)(2).

(d) Notice and Consent to Be Treated by a Nonparticipating Provider or Nonparticipating Facility.-

(1) **In general.** A nonparticipating provider or nonparticipating facility satisfies the notice and consent criteria of this subsection, 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 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 (or to an authorized representative of the participant) 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 makes such an appointment within 72 hours of when such items or services are to be furnished, provides to the participant (or to an authorized representative of the participant) on such date the appointment is made), a written notice in paper or electronic form, as selected by the participant (and including electronic notification, as practicable) specified by the Secretary, not later than July 1, 2021, through guidance that-

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

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

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

(B) obtains from the participant (or from such an authorized representative) the consent described in par. (3) to be treated by a nonparticipating provider or nonparticipating facility; and

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

(2) **Information required under written notice.** 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 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 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 is a document specified by the Secretary, in consultation with the Secretary of Labor, through guidance that shall be signed by the participant 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 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; and

(B) documents the date on which the participant 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 shall constitute only consent to the receipt of the information provided pursuant to this subsection and shall not constitute a contractual agreement of the participant 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 of a group health plan or group or individual health insurance coverage (or an authorized representative of such participant) a written notice in accordance with subsection (d)(1)(B), with respect to furnishing an item or service to such participant shall retain such notice for at least a 7-year period after the date on which such item or service is so furnished.

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 of a group health plan or group or individual health insurance coverage a one-page notice (either postal or electronic mail, as specified by the participant) in clear and understandable language containing information on-

- (1) the requirements and 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 charge a participant of a group health plan or group or individual health insurance coverage 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, and any applicable cost-sharing payment from such participant; 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).

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 facilities in the State, the Secretary shall enforce such requirements under subsection (b) insofar as they relate to violations of such requirements occurring in such State.
- (3) **Notification of applicable secretary.** A State may notify the applicable Secretary of instances of violations with respect to participants under a group health plan or health insurance coverage, as applicable 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.
- (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.'

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 above, 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 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, to ensure that appropriate measures have been taken to correct such violations retrospectively and prospectively with respect to participants under a group health plan or group health insurance coverage.

(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 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.

SEC. 105. ENDING SURPRISE AIR AMBULANCE BILLS (2799A-2)

Applicability: ERISA and non-ERISA (non-federal governmental, except FEHB, and church plans) self-funded

The requirements are the same as the first section of the summary regarding **PREVENTING SURPRISE MEDICAL BILLS** at page 2, except that the IDR considers different information:

(C) Considerations in determination.-

(i) The certified IDR entity must consider-

(I) the **qualifying payment amounts** 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

<p>group health plans and fully insured group and individual insurers (insurers); Also applies to grandfathered plans.</p> <p>Effective: plan years beginning on or after January 1, 2022.</p>	<p>(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).</p> <p>(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:</p> <ul style="list-style-type: none"> (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. <p>(iii) Prohibition on consideration of certain factors. In determining which offer is the payment amount to be applied, the certified IDR entity cannot 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</p>
<p>SEC. 106 AIR AMBULANCE REPORT REQUIREMENTS (2799A-8)</p> <p>Applicability: ERISA and non-ERISA (non-federal governmental, and church plans) self-funded group health plans and fully insured group and individual insurers (insurers);</p> <p>Effective: plan years beginning on or after January 1, 2022.</p>	<p>AIR AMBULANCE REPORT REQUIREMENTS.</p> <p>(a) Each group health plan and health insurer must submit to the Secretaries (HHS, Labor and Treasury)-</p> <ul style="list-style-type: none"> (1) not later than 90 days after the last day of the first calendar year beginning on or after the date on which a final rule is promulgated, the information described in subsection (b) with respect to such plan year, and such immediately succeeding plan year. <p>(b) Information Required</p> <ul style="list-style-type: none"> (1) Claims data for air ambulance services furnished by providers of such services, disaggregated by each of the following factors: <ul style="list-style-type: none"> (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.

	<p>(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.</p> <p>(2) Such other information regarding providers of air ambulance services as the Secretary may specify. 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. 300gg0991).</p>
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<p>SEC. 107. ID CARDS and PLAN DOCS (TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET LIMITATIONS)</p> <p>Applicability: ERISA and non-ERISA (non-federal governmental, and church plans) self-funded group health plans and fully insured group and individual insurers (insurers);</p> <p>Effective: plan years beginning on or after January 1, 2022.</p>	<p>A group health plan or a health issuer offering group or individual health insurance coverage must include, in clear writing, on any physical or electronic plan or insurance identification card issued to participants the following:</p> <p>(1) Any deductible applicable to such plan or coverage.</p> <p>(2) Any out-of-pocket maximum limitation applicable to such plan or coverage.</p> <p>(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.</p>
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<p>SEC. 108. IMPLEMENTING PROTECTIONS AGAINST PROVIDER DISCRIMINATION</p>	<p>Not later than January 1, 2022, the Secretaries of HHS, Labor and Treasury will issue a proposed rule implementing the law prohibiting discrimination against providers (42 U.S.C. 300gg-5(a)), and not later than 6 months after the date of the conclusion of the comment period, the Secretaries shall issue a final rule.</p>
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<p>Applicability: Federal agencies will be promulgating regulations</p>	<p>Section 300gg-5(a) states: A group health plan and a group/individual health insurer must not discriminate, regarding participation under the plan or coverage, against any health care provider who is acting within the scope of that provider's license or certification under applicable State law.</p>
<p>SEC. 109. REPORTS (N/A)</p> <p>Applicability: HHS, FTC and AG; N/A to us or our clients</p>	<p>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-</p> <p>(1) conduct a study on the effects of the provisions of, including amendments made by, this Act on-</p> <p>(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;</p> <p>(B) overall health care costs; and</p> <p>(C) access to health care items and services, including specialty services, in rural areas and health professional shortage areas</p>
<p>SEC. 110. CONSUMER PROTECTIONS THROUGH APPLICATION OF HEALTH PLAN EXTERNAL REVIEW IN CASES OF CERTAIN SURPRISE MEDICAL BILLS.</p> <p>Applicability: ERISA and non-ERISA (non-federal governmental, and church plans) self-funded groups health plans and fully insured group and individual insurers (insurers)</p>	<p>Beginning not later than January 1, 2022, the external review process applies to any adverse determination under the surprise medical bills provisions (including air ambulance provisions) of the law, including with respect to whether such respective section applies.</p>

<p>Effective: applies to adverse benefit determinations no later than January 1, 2022 as determined by the federal regulators.</p>	
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<p>Sec 111 Consumer protections through health plan requirement for fair and honest advance cost estimate</p> <p>Applicability: ERISA and non-ERISA (non-federal governmental, and church plans) self-funded groups health plans and fully insured group and individual insurers (insurers)</p> <p>Effective: Plan years beginning on or after January 1, 2022</p>	<p>Advanced EOBs</p> <p>(1) Group health plans and health insurers must, with respect to a notification submitted (under next section 112 summarized below) by a health care provider or facility, to the plan or insurer for a participant scheduled to receive an item or service from the provider or facility not later than:</p> <ul style="list-style-type: none"> - 1 business day or, - 3 business days (in the case such item or service was scheduled at least 10 business days before such item or service is to be furnished (or in the case of a request made by such participant)), <p>of receiving notification, provide to the participant (through mail or electronic means, as requested by the participant) a notification or Advance EOB, (in clear and understandable language) including the following:</p> <p>(A) Whether or not the provider or facility is a participating provider/facility and-</p> <ul style="list-style-type: none"> (i) if the provider or facility is a participating provider or facility, the contracted rate under such plan or coverage (based on the billing and diagnostic codes provided by such provider or facility); and (ii) in the case the provider or facility is nonparticipating, a description of how such individual may obtain information on providers and facilities that are in network, if any. <p>(B) The good faith estimate included in the notification received from the provider or facility (if applicable) based on such codes.</p> <p>(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) above.</p> <p>(D) A good faith estimate of the amount of any cost-sharing the participant would be responsible for (as of the date of such notification).</p> <p>(E) A good faith estimate of the amount that the participant has incurred toward meeting the participants’ cost share limits (including deductibles and out-of-pocket maximums) under the coverage (as of the date of such notification).</p>
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	<p>(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, a disclaimer that coverage for such item or service is subject to such medical management technique.</p> <p>(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.</p> <p>(H) Any other information or disclaimer the plan or coverage determines appropriate that is consistent with information and disclaimers required under this section.</p> <p>(2) Regulatory Authority to modify timing requirements in the case of items and services with low utilization or significant variation in costs.</p> <p>(A) Regulators may modify any timing requirements relating to the provision of the Advanced EOB when the item or service that has low utilization or significant variation in costs such as when furnished as part of a complex treatment as specified in regulations. Any modification made by federal regulators cannot result in the provision of such notification after the participant has received the item or service.</p>
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<p>SEC. 112. PATIENT PROTECTIONS THROUGH TRANSPARENCY AND PATIENT-PROVIDER DISPUTE RESOLUTION (SEC. 2799B-6) (skipped SEC.2799B-7 regarding uninsured individuals)</p> <p>Applicability: Health care providers and facilities</p>	<p>SEC. 2799B-6. PROVISION OF INFORMATION UPON REQUEST AND FOR SCHEDULED APPOINTMENTS</p> <p>Starting January 1, 2022, each health care provider and facility:</p> <ul style="list-style-type: none"> - within 1 business day after the date of scheduling if scheduled at least 3 business days before the item/service is to be furnished; - within 3 business days after the date of scheduling if scheduled at least 10 business days before the item/service is to be furnished (or if requested by the individual). <p>(1) inquire if such individual is enrolled in a group health plan, group or individual health insurance coverage, or a Federal health care program (and if is so enrolled in such plan or coverage, “seeking to have a claim submitted to such plan or coverage”); and</p>
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<p>Effective: January 1, 2022</p>	<p>(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 by another health care provider/facility), with the expected billing and diagnostic codes for any such item or service, to-</p> <p>(A) the plan or insurer, if the individual is enrolled in such a plan or such coverage; and</p> <p>(B) the individual, if the individual is not described in subparagraph (A) and not enrolled in a Federal health care program.</p>
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<p>SEC. 113. ENSURING CONTINUITY OF CARE (2799A-3)</p> <p>Applicability: ERISA and non-ERISA (non-federal governmental, and church plans) self-funded groups health plans and fully insured group and individual insurers (insurers)</p> <p>Effective: Plan years beginning on or after January 1, 2022</p>	<p>(a) Ensuring Continuity of Care With Respect to Terminations of Certain Contractual Relationships Resulting in Changes in Provider Network Status.-</p> <p>(1) If a person is receiving care from a contracted provider/facility while such individual is a continuing care patient (as defined in subsection (b)) with respect to such provider or facility-</p> <p>(A) such contractual relationship is terminated (as defined in subsection (b));</p> <p>(B) benefits provided under the group health plan or 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</p> <p>(C) a contract between such group health plan and a health insurer 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;</p> <p>the plan or insurer must do the following.</p> <p>(2) Plan/Insurer obligations:</p> <p>(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 on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility;</p> <p>(B) provide such individual with an opportunity to notify the plan or insurer of the individual's need for transitional care; and</p> <p>(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-</p>
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	<p>(i) the 90-day period beginning on such date; or</p> <p>(ii) the date on which such individual is no longer a continuing care patient with respect to such provider or facility.</p> <p>(b) Definitions. In this section:</p> <p>(1) The term 'continuing care patient' means an individual who, with respect to a provider or facility-</p> <p>(A) is undergoing a course of treatment for a serious and complex condition from the provider or facility;</p> <p>(B) is undergoing a course of institutional or inpatient care from the provider or facility;</p> <p>(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;</p> <p>(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility;</p> <p>or</p> <p>(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.</p> <p>(2) The term 'serious and complex condition' means -</p> <p>(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</p> <p>(B) in the case of a chronic illness or condition, a condition that is-</p> <p>(i) is life-threatening, degenerative, potentially disabling, or congenital; and</p> <p>(ii) requires specialized medical care over a prolonged period of time.</p> <p>(3) 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.</p>
	<p>SEC. 2799B-8. CONTINUITY OF CARE.</p> <p>A health care provider or health care facility must, in the case of an individual furnished items and services for which coverage is provided under a group health plan or group or individual health insurance coverage (pursuant to section 2799A-3 above) -</p> <p>(1) accept payment from such plan or insurer (as applicable) (and cost-sharing from such individual, if applicable, as if the individual was still in-network with that provider/facility (i.e. in accordance with subsection (a)(2)(C) of section 2799A-3 above) as payment in full for such items and services; and</p>

	(2) continue to adhere to all policies, procedures, and quality standards imposed by such plan or insurer with respect to such individual and such items and services in the same manner as if such termination had not occurred.
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<p>SEC. 114 MAINTENANCE OF PRICE COMPARISON TOOL (2799A-4)</p> <p>Applicability: ERISA and non-ERISA (non-federal governmental, and church plans) self-funded groups health plans and fully insured group and individual insurers (insurers)</p> <p>Effective: Plan years beginning on or after January 1, 2022.</p>	<p>A group health plan or a health insurer must offer price comparison guidance by telephone and make available on the Internet website of the plan or insurer:</p> <p style="padding-left: 40px;">a price comparison tool that (to the extent practicable) allows a participant, with respect to such plan year, geographic region, and participating providers, to compare the amount of cost-sharing that the participant would be responsible for paying under the plan/coverage with respect to the furnishing of a specific item or service by any such provider.</p>
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<p>SEC. 115. STATE ALL PAYER CLAIMS DATABASES</p> <p>Applicability: States, HHS and various parties wanting access to a State All Payer Claims Database</p>	<p>HHS will provide one-time grants to eligible States to establish, or improve an existing, State All Payer Claims Database i.e. a database that may include medical claims, pharmacy claims, dental claims, and eligibility and provider files, which are collected from private and public payers.</p> <p>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.</p> <p>Authorized Users.-</p> <p>(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-</p>
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	<p>(A) in the case of an entity requesting access for research purposes-</p> <ul style="list-style-type: none"> (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 <p>(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.</p> <p>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 requirements regarding privacy, security, and proprietary financial information.</p> <p>Non-customized reports. A State All Payer Claims Database that has received a grant under this section shall make available to all authorized users, free of charge, aggregate data sets available through the State All Payer Claims Database.</p>
<p>SEC. 115. STATE ALL PAYER CLAIMS DATABASES</p> <p>STANDARDIZED REPORTING FORMAT (for VOLUNTARY REPORTING BY ERISA GROUPS)</p> <p>Applicability: ERISA group health plans</p> <p>Effective: Not later than December 27, 2022</p>	<p>Not later than December 27, 2022, the DOL must 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 must provide guidance to States on the process by which States may collect such data from such plans in the standardized reporting format.</p>
<p>SEC. 116. PROTECTING PATIENTS AND IMPROVING THE ACCURACY OF PROVIDER</p>	<p>(a) Provider Directory Information Requirements</p> <ul style="list-style-type: none"> (1) Each group health plan and health insurance insurer must - <ul style="list-style-type: none"> (A) establish the verification process described in paragraph (2); (B) establish the response protocol described in paragraph (3);

**DIRECTORY INFORMATION
(2799A-5)**

Applicability: ERISA and non-ERISA (non-federal governmental, and church plans) self-funded groups health plans and fully insured group and individual insurers (insurers)

Effective: Plan years beginning on or after January 1, 2022.

(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 is a process-

- (A) under which, at least once every 90 days, such plan or insurer (as applicable) verifies and updates the provider directory information included on the database described in paragraph (4) of such plan or insurer of each health care provider and health care facility included in such database;
- (B) that establishes a procedure for the removal of providers or facilities when plan or insurer has been unable to verify such information during a period specified by the plan or insurer; and
- (C) that provides for the update of such database within 2 business days of such plan or insurer receiving from such a provider or facility information pursuant to section 2799B-9 below.

(3) **Response protocol.** The response protocol is, in the case of an individual enrolled under a group health plan or health insurer who requests information through a **telephone call or electronic, web-based, or Internet-based means** on whether a health care provider or facility has a contractual relationship to furnish items and services under such plan or such coverage, **a protocol under which such plan or such insurer** (as applicable), in the case such request is made through a telephone call-

- (A) **responds to such individual** as soon as practicable and **no 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 is **on the public website of such plan or insurer and contains-**

- (A) a list of each health care provider and health care facility with which such plan or insurer 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, with respect to a print provider directory is a notification that such information contained in the 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 insurer to obtain the most current provider directory information with respect to such plan or such coverage.

(6) **Definition.** **'Provider directory information'** includes the name, address, specialty, telephone number, and digital contact information of each health care provider or health care facility with which such plan or insurer has a contractual relationship for furnishing items and services under such plan or such coverage.

(7) **Applicable State law is not pre-empted.** Nothing in this section preempts any State law relating to health care provider directories.

(b) Cost-sharing for Services Provided Based on Reliance on Incorrect Provider Network Information.-

(1) For items or services furnished to a participant of a group health plan or an insurer by a nonparticipating provider or 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 and item or service, the plan or coverage-

- (A) must not impose on such participant a cost-sharing amount that is greater than the cost-sharing amount that would apply had such item or service been furnished by a participating provider; and
- (B) must apply the deductible or out-of-pocket maximum, if any, that would apply if such services were furnished by a participating provider facility.

(2) Criteria described.

(A) The participant 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**, 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 and the participant 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 and was informed through such protocol that the provider was such a participating provider or 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 insurer **must make publicly available, post on a public website of such plan or insurer, and include on each explanation of benefits** for an item or service with respect to which the requirements under section Section 102 Surprise Medical Billing; applies-

(1) information in plain language on-

- (A) the requirements and prohibitions applied under sections above regarding Balance Billing Prohibited on Emergency Services (2799B-1) and Emergency Services Performed by a non-participating provider at a participating facility (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 of such plan or coverage with respect to which such a provider or facility does not have a

	<p>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; and</p> <p>(C) the requirements applied under Section 102 Surprise Medical Billing; and</p> <p>(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.</p>
<p>SubSec. PROVIDER REQUIREMENTS TO PROTECT PATIENTS AND IMPROVE THE ACCURACY OF PROVIDER DIRECTORY INFORMATION (2799B-9)</p> <p>Applicability: Health care providers and facilities</p> <p>Effective: January 1, 2022</p>	<p>(a) Each health care provider and facility must have in place business processes to ensure the timely provision of provider directory information (defined below) to a group health plan or a health insurance insurer to support compliance by such plans or issuers with the prior section. Such providers must submit provider directory information to a plan or insurers at a minimum-</p> <p>(1) when the provider or facility begins a network agreement with a plan or insurer with respect to certain coverage;</p> <p>(2) when the provider or facility terminates a network agreement with a plan or with an issuer with respect to certain coverage;</p> <p>(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) above (prior section) and</p> <p>(4) at any other time (including upon the request of such insurer or plan) determined appropriate by the provider, facility, or the federal regulators.</p> <p>(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) above (prior section) 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 federal regulators.</p> <p>(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 insurer-</p> <p>(1) that the plan or insurer remove, at the time of termination of such contract, the provider from a directory of the plan or insurer; or</p>

	<p>(2) that the plan or insurer bear financial responsibility, including under section 2799A-5(b), for providing inaccurate network status information to an enrollee.</p> <p>(d) 'Provider directory information' includes the names, addresses, specialty (as regards providers), telephone numbers, and digital contact information of individual health care providers, and each medical group, clinic, or facility contracted to participate in any of the networks of the group health plan or health insurance coverage involved.</p> <p>(e) Pre-emption. Nothing in this section preempts any applicable State law relating to health care provider directories.</p>
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