116TH CONGRESS
1ST SESSION

S. _____

IN THE SENATE OF THE UNITED STATES

_____ introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Lower Health Care Costs Act''.

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

SEC. 2. DEFINITIONS.

TITLE I—ENDING SURPRISE MEDICAL BILLS

SEC. 101. PROTECTING PATIENTS AGAINST OUT-OF-NETWORK DEDUCTIBLES IN EMERGENCIES.

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

(1) in paragraph (1)—

(A) in the matter preceding subparagraph (A), by inserting ''or a freestanding emergency room'' after ''hospital''; and

(B) in subparagraph (C)—

(i) in clause (ii)(I), by inserting ''or emergency room'' after ''emergency department''; and

(ii) in subparagraph (C)(ii)(II), by adding, ''a deductible,'' after ''(expressed as''; and

(2) in paragraph (2)(B)—

(A) in clause (i)—

(i) by inserting ''or freestanding emergency room'' after ''hospital''; and

(ii) by inserting ''or emergency room'' after ''emergency department''; and

(B) in clause (ii), by inserting ''or emergency room'' after ''hospital''.

SEC. 102. PROTECTION AGAINST SURPRISE BILLS.

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

''(e) COVERAGE OF CERTAIN OUT-OF-NETWORK SERVICES.—

''(1) IN GENERAL [*Option 1, with 'subtitle A' option*].—Subject to subsection (h), in the case of an enrollee in a group health plan or group or individual health insurance coverage who receives out-of-network non-emergency services at an in-network facility—

''(A) the cost-sharing requirement (expressed as a copayment amount, coinsurance rate, or deductible) with respect to such services shall be the same requirement that would apply if such services were provided by an in-network practitioner; and

"(B) such cost-sharing amounts shall be counted towards the in-network deductible and in-network out-of-pocket maximum amount under the plan or coverage for the plan year.

"(2) IN GENERAL [*Option 2/Option 3, with 'subtitle B' or 'subtitle C' option*].—Subject to subsection (h), in the case of an enrollee in a group health plan or group or individual health insurance coverage who receives out-of-network, ancillary, non-emergency services at an in-network facility, including any referrals for diagnostic services—

"(A) the cost-sharing requirement (expressed as a copayment amount, coinsurance rate, or deductible) with respect to such services shall be the same requirement that would apply if such services were provided by an in-network practitioner; and

"(B) such cost-sharing amounts shall be counted towards the in-network deductible and in-network out-of-pocket maximum amount under the plan or coverage for the plan year.

"(3) DEFINITION.—For purposes of this subsection, the term 'facility' has the meaning given the term 'health care facility' in section 2729A(c).

''(f) COVERAGE OF OUT-OF-NETWORK SERVICES FOR ENROLLEES ADMITTED AFTER EMERGENCY SERVICES.—

''(1) NOTICE AND CONSENT.—Subject to subsection (h), in the case of an enrollee in a group health plan or group or individual health insurance coverage who is admitted to a hospital after receiving emergency services, or maternal care for a woman in labor, in the emergency department of such hospital and being stabilized (within the meaning of subsection (b)(2)(C)), the cost-sharing requirement (expressed as a copayment amount, coinsurance rate, or deductible) with respect to any out-of-network services is the same requirement that would apply if such services were provided by a participating provider, unless the enrollee, once stable and in a condition, including having sufficient mental capacity, to receive the information described in this subsection —

''(A) has been provided by the hospital, prior to the provision of any post-stabilization, out-of-network service at such hospital, with—

''(i) paper and electronic notification that the practitioner or hospital is an out-of-network health care provider and the out-of-network rate of the provider, as ap-

plicable, and the option to affirmatively consent to receiving services from such practitioner or hospital;

"(ii) a list of in-network practitioners or hospitals that could provide the same services, and an option for a referral to such providers; and

"(iii) the estimated amount that such provider will charge the participant, beneficiary, or enrollee for such items and services involved; and

"(B) has acknowledged that the out-of-network treatment may not be covered or may be covered at an out-of-network cost-sharing amount, requiring higher cost-sharing obligations of the enrollee than if the service were provided at an in-network facility, and has assumed, in writing, full responsibility of out-of-pocket costs associated with services furnished after the enrollee has been stabilized, from the out-of-network practitioner or hospital, as applicable.

"(2) REQUIREMENTS OF NOTICE.—The notice under paragraph (1) shall be in a format determined by the Secretary to give a reasonable layperson clear

comprehension of the terms of the agreement, including all possible financial responsibilities, including the requirements that the notice—

"(A) does not exceed one page in length;

"(B) is readily identifiable for its purpose and as a contract of consent;

"(C) clearly states that consent is optional;

"(D) includes an estimate of the amount that such provider will charge the participant, beneficiary, or enrollee for such items and services involved; and

"(E) is printed in the enrollee's primary language.

"(g) PROHIBITION ON BILLING MORE THAN AN IN-NETWORK RATE UNDER CERTAIN CIRCUMSTANCES.—

"(1) IN GENERAL.—A health care facility or practitioner furnishing—

"(A) emergency services, as defined in subsection (b)(2), regardless of the state in which the patient resides;

"(B) services at an in-network facility described in subsection (e); or

"(C) out-of-network services furnished after the enrollee has been stabilized (within the meaning of subsection (b)(2)(C)), where the no-

tice and option for referral required under subsection (f)(1) have not been provided to the enrollee and the assumption of responsibility for out-of-pockets costs under subsection (f)(2) has not been obtained,

may not bill an enrollee in a group health plan or group or individual health insurance coverage for amounts beyond the cost-sharing amount that would apply under subsection (b)(1)(C)(ii)(II), (e), or (f), as applicable.

''(2) ENFORCEMENT.—

''(A) IN GENERAL.—Subject to subparagraph (B), a health care facility or practitioner that violates a requirement under paragraph (1) shall be subject to a civil monetary penalty of not more than $10,000 for each act constituting such violation.

''(B) PROCEDURE.—The provisions of section 1128A of the Social Security Act, other than subsections (a) and (b) and the first sentence of subsection (c)(1) of such section, shall apply to civil money penalties under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A of the Social Security Act.

"(C) SAFE HARBOR.—The Secretary may waive the penalties described under subparagraph (A) with respect to a facility or practitioner who unknowingly violates paragraph (1) with respect to an enrollee, if such facility or practitioner, within 30 days of the violation, withdraws the bill that was in violation of paragraph (1), and, as applicable, reimburses the group health plan, health insurance issuer, or enrollee, as applicable, in an amount equal to the amount billed in violation of paragraph (1), plus interest, at an interest rate determined by the Secretary.

"(h) MAINTAINING STATE SURPRISE BILLING PROTECTIONS.—

"(1) IN GENERAL.—Notwithstanding section 514 of the Employee Retirement Income Security Act of 1974, except with respect to self-insured group health plans, nothing in this section shall prevent a State from establishing or continuing in effect an alternate method under State law for determining the appropriate compensation for services described in subsection (b), (e), or (f).

"(2) ADDITIONAL APPLICATION.—In the case of group health plans or health insurance coverage in

the individual or group market offered in a State that has not enacted an alternate method described in paragraph (1), such as arbitration or a benchmark, or for services described in subsection (b), (e), or (f) that are not covered by such State's alternate method described in paragraph (1), the provisions of this section shall apply.

''(3) SELF-INSURED PLANS.—Subsections (b), (e), and (f) shall apply to a self-insured group health plan that is not subject to State insurance regulation.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect beginning in the second plan year that begins after the date of enactment of this Act.

Subtitle A—Option 1

SEC. 103. IN-NETWORK GUARANTEE.

(a) IN GENERAL.—Subpart II of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–11 et seq.) is amended by adding at the end the following:

''SEC. 2729A. IN-NETWORK GUARANTEE.

''(a) IN GENERAL.—

''(1) CONTRACTS.—A group health plan and a health insurance issuer offering group or individual

health insurance coverage may not contract (or enter into a similar arrangement) with a health care facility with respect to such plan or coverage unless the health care facility guarantees in the contract (or arrangement) that—

"(A) each health care practitioner who provides services in the facility will be under contract as a participating health care practitioner with respect to the plan or coverage with respect to all services provided at such facility; and

"(B) all laboratory or diagnostic services—

"(i) provided in such facility, are included in the network contract between such facility and the group health plan or health insurance issuer with respect to such coverage; and

"(ii) referred by health care practitioners at such facility, are referred only to providers included in the network contract between such facility and the group health plan or health insurance issuer with respect to such coverage.

"(2) SEPARATE CONTRACTS.—Contracts between the group health plan or health insurance

issuer and applicable health care practitioners may be separate contracts from the contracts between the group health plan or health insurance issuer and the health care facility.

''(b) PROVIDER CHOICE.—A practitioner may elect to be considered in-network for purposes of subsection (a) if the practitioner agrees to have his or her reimbursement from a group health plan or health insurance issuer included as part of the group health plan or health insurance issuer's payment to the facility in which the practitioner provides the services, and the practitioner agrees to not separately bill the group health plan or health insurance issuer or an enrollee in the group health plan or health insurance coverage offered by such health insurance issuer.

''(c) FACILITY.—For purposes of this section, the term 'health care facility' includes hospitals, hospital outpatient departments, critical access hospitals, ambulatory surgery centers, laboratories, radiology clinics, and any other facility that provides services that are covered under a group health plan or health insurance coverage.

''(d) FAILURE TO COMPLY.—In the case of a health care practitioner who does not establish a network contract with a group health plan or health insurance issuer that has a network contract with a facility in which the

practitioner provides services, as described in subsection (a), the group health plan or health insurance issuer shall not reimburse the health care practitioner for any services provided to enrollees in the plan or coverage.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect beginning in the second plan year that begins after the date of enactment of this Act.

SEC. 104. COVERAGE OF OUT-OF-NETWORK EMERGENCY SERVICES.

(a) IN GENERAL.—Subpart II of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–11 et seq.) is amended by adding at the end the following:

''SEC. 2729B. COVERAGE OF OUT-OF-NETWORK, EMERGENCY SERVICES.

''(a) IN GENERAL.—In the case of an enrollee in a group health plan or group or individual health insurance coverage offered by a health insurance issuer who receives emergency services (as defined in section 2719A(b)(2)) that are covered by such plan or coverage at an out-of-network hospital, the group health plan or health insurance coverage and facility and practitioner shall determine, within 30 business days of the service, the appropriate reimbursement for such services.

''(b) DEFAULT RATE.—If, after the 30-business-day period described in subsection (a), the group health plan or health insurance issuer offering group or individual health insurance coverage and the facility and practitioner do not reach an agreement under subsection (a), the group health plan or health insurance issuer shall reimburse the hospital and any out-of-network practitioners providing such services in an amount that is equal to the median contracted rate, using a methodology determined under subsection (c), for the same or similar services offered by the group health plan or group or individual health insurance coverage in that geographic region.

''(c) MEDIAN CONTRACTED RATE.—

''(1) IN GENERAL.—For purposes of this section, the term 'median contracted rate' means, with respect to health care services covered by a group health plan or health insurance coverage, the median negotiated rate under the applicable plan or coverage recognized under the plan or coverage as the total maximum payment for the service, minus the in-network cost-sharing for such service under the plan or coverage, for the same or a similar service that is provided by a provider in the same or similar specialty, and in the geographic region in which the service is furnished.

''(2) RULEMAKING.—Not later than 1 year after the date of enactment, the Secretary shall, through rulemaking, determine the methodology a group health plan or health insurance issuer is required to use to determine the median contracted rate described in paragraph (1), the information the plan or issuer shall share with the non-participating provider involved when making such a determination , and the geographic regions applied for purposes of this subparagraph.

''(3) CERTAIN INSURERS.—If a group health plan or health insurance issuer offering group or individual health insurance coverage does not have sufficient information to calculate a median in-network rate for this service or provider type, or amount of, claims for services (as determined by the applicable State authority, in the case of health insurance coverage, or by the Secretary of Labor, in the case of a self-insured group health plan) covered under the list of out-of-network services set by the State authority or Secretary of Labor, as applicable, in a particular geographic area, such plan or issuer shall demonstrate that it will use a database free of conflicts of interest that has sufficient information reflecting rates paid to noncontracting individual

health care providers for relevant services provided in the applicable geographic region, and that such plan or issuer will use that database to determine a median contracted rate. The group health plan or health insurance issuer shall cover the cost of accessing the database.

''(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall prevent a group health plan or health insurance issuer from establishing separate calculations of a median contracted rate under paragraph (1) for services delivered in non-hospital facilities, including freestanding emergency rooms.

''(d) MAINTAINING STATE SURPRISE BILLING PROTECTIONS.—Notwithstanding section 514 of the Employee Retirement Income Security Act of 1974, except with respect to self-insured group health plans, nothing in this section shall prevent a State from establishing or continuing in effect a requirement with respect to payments described in subsection (a).''.

(b) EFFECTIVE DATE.—Section 2729B of the Public Health Service Act, as added by subsection (a), shall take effect beginning in the second plan year that begins after the date of enactment of this Act.

SEC. 105. REPORT.

Not later than 1 year after the effective date described in section 2(b), and annually for the following 4 years, the Secretary, in consultation with the Federal Trade Commission and the Attorney General, shall—

(1) conduct a study on—

(A) the effects of the amendments made by sections 102, 103, and 104, including any patterns of vertical or horizontal integration of health care facilities, providers, or insurers;

(B) the effects of the amendments made by section 102, 103, and 104 on overall health care costs; and

(C) recommendations for enforcement action of sections 2729A and 2729B of the Public Health Service Act, as added by sections 103 and 104, respectively, including potential challenges to addressing anti-competitive consolidation by health care facilities, providers, or insurers; and

(2) submit a report on such study to the Committee on Health, Education, Labor, and Pensions, the Committee on Commerce, Science, and Transportation, the Committee on Finance, and the Committee on the Judiciary of the Senate and the Committee on Education and Labor, the Committee on

Energy and Commerce, the Committee on Ways and Means, and the Committee on the Judiciary of the House of Representatives.

Subtitle B—Option 2

SEC. 103. INDEPENDENT DISPUTE RESOLUTION.

Subpart II of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–11 et seq.) is amended by adding at the end the following:

"SEC. 2729A. INDEPENDENT DISPUTE RESOLUTION.

''(a) ESTABLISHMENT.—The Secretary, in consultation with the Secretary of Labor, shall establish an independent dispute resolution process (referred to in this section as the 'IDR process') for resolving payment disputes between group health plans or health insurance issuers offering group or individual health insurance coverage, and facilities or practitioners furnishing services subject to section 2719A(g).

''(b) CERTIFICATION OF ENTITIES.—An entity may conduct the IDR process under this section only after receiving certification as an independent dispute resolution entity from the Secretary. An entity wishing to receive such certification shall submit an application to the Secretary. The Secretary, in consultation with the Secretary of Labor, shall determine eligibility of applicant entities, taking into consideration whether each applicant entity is

unbiased and unaffiliated with health plans and health insurance issuers and providers and free of conflicts of interest, in accordance with the Secretary's rulemaking on determining criteria for conflicts of interest. For purposes of this section, an entity certified under this subsection is a 'certified IDR entity'.

''(c) CLAIMS.—

''(1) APPLICABLE CLAIMS.—

''(A) IN GENERAL.—The IDR process under this section may be used by a group health plan or health insurance issuer offering group or individual health insurance coverage, or by a facility or practitioner, for the resolution of claims for services described in subsection (a) that exceed $750.

''(B) ADJUSTMENT.—The Secretary, in consultation with the Secretary of Labor, shall annually adjust the dollar amount in this subsection in accordance with the rate of inflation.

''(2) NONAPPLICABLE CLAIMS.—In the case of a claim for services described in subsection (a) that are equal to or less than the dollar amount described in paragraph (1)(A), as adjusted under paragraph (1)(B), as applicable, a group health plan or health insurance issuer shall pay the facility or practitioner

the median contracted rate, using a methodology determined under subsection (e) for the same or similar services offered by the group health plan or health insurance issuer in that geographic region

''(d) IDR PROCESS.—

''(1) TIMING.—A certified IDR entity that receives a request from a group health plan, health insurance issuer, facility, or practitioner under this section shall, not later than 30 days after receiving such request, determine the amount the group health plan or health insurance issuer is required to pay the facility or practitioner for services described in subsection (a). Such amount shall be—

''(A) the amount determined by the parties through a settlement under paragraph (2); or

''(B) the amount a certified IDR entity determines reasonable in accordance with paragraph (3).

''(2) SETTLEMENT.—

''(A) IN GENERAL.—If a certified IDR entity determines, based on the amounts indicated in the request under this section, that a settlement between the group health plan or health insurance issuer, and the facility or practitioner is likely, the entity may direct the parties to at-

tempt, for a period not to exceed 10 days, a good faith negotiation for a settlement.

''(B) TIMING.—The period for a settlement described in subparagraph (A) shall accrue towards the 30-day period required under paragraph (1).

''(3) DETERMINATION OF AMOUNT.—

''(A) FINAL OFFERS.—In the absence of a settlement under paragraph (2), the group health plan or health insurance issuer, and facility or practitioner shall each submit to the certified IDR entity their final offer. Such entity shall determine which of the 2 amounts is more reasonable based on the factors described in subparagraph (C).

''(B) FINAL DECISIONS.—The amount that is determined to be the more reasonable amount under subparagraph (A) shall be the final decision of the certified IDR entity as to the amount the group health plan or health insurance issuer is required to pay the facility or practitioner.

''(C) FACTORS.—In determining which final offer to select as the more reasonable amount under subparagraph (A), the certified

IDR entity shall consider relevant factors including the median contracted rate, using a methodology determined under subsection (e) for the same or similar services offered by the group health plan or health insurance issuer in that geographic region.

''(D) EFFECT OF DECISION.—A final decision of a certified IDR entity under subparagraph (B)—

''(i) shall be binding; and

''(ii) shall not be subject to judicial review, except in cases comparable to those described in section 10(a) of title 9, United States Code, as determined by the Secretary in consultation with the Secretary of Labor, and cases in which information submitted by 1 party was determined to be fraudulent.

''(4) PRIVACY LAWS.—A certified IDR entity shall, in conducting an IDR process under this section, comply with all applicable Federal and State privacy laws.

''(5) COSTS OF INDEPENDENT DISPUTE RESOLUTION PROCESS.—The party whose final offer is not chosen under paragraph (3) shall be responsible

for paying all fees charged by the certified IDR entity. If the parties reach a settlement prior to completion of the IDR process, the costs of such process shall be divided equally between the parties.

''(6) PAYMENT.—Plans shall pay directly to the health care facility or practitioner amounts determined by the certified IDR entity within 30 days of the amount being determined.

''(e) MEDIAN CONTRACTED RATE.—

''(1) IN GENERAL.—For purposes of this section, the term 'median contracted rate' means, with respect to health care services covered by a group health plan or group or individual health insurance coverage, the median negotiated rate under the applicable plan or coverage recognized under the plan or coverage as the total maximum payment for the service, minus the in-network cost-sharing for such service under the plan or coverage, for the same or a similar service that is provided by a provider in the same or similar specialty and in the geographic region in which the service is furnished.

''(2) RULEMAKING.—Not later than 1 year after the date of enactment, the Secretary shall, through rulemaking, determine the methodology a group health plan or health insurance issuer is re-

quired to use to determine the median contracted rate described in paragraph (1), the information the plan or issuer shall share with the nonparticipating provider involved when making such a determination, and the geographic regions applied for purposes of this subparagraph.

''(3) CERTAIN INSURERS.—If a group health plan or health insurance issuer offering group or individual health insurance coverage does not have sufficient information to calculate a median in-network rate for this service or provider type, or amount of, claims for services (as determined by the applicable State authority, in the case of health insurance coverage, or by the Secretary of Labor, in the case of a self-insured group health plan) covered under the list of out-of-network services set by the State authority or Secretary of Labor, as applicable, in a particular geographic area, such plan or issuer shall demonstrate that it will use a database free of conflicts of interest that has sufficient information reflecting rates paid to noncontracting individual health care providers for relevant services provided in the applicable geographic region, and that such plan or issuer will use that database to determine a median contracted rate. The group health plan or

health insurance issuer shall cover the cost of accessing the database.

''(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall prevent a group health plan or health insurance issuer from establishing separate calculations of a median contracted rate under paragraph (1) for services delivered in nonhospital facilities, including freestanding emergency rooms.

''(f) FACILITY.—For purposes of this section, the term 'health care facility' includes hospitals, hospital outpatient departments, critical access hospitals, ambulatory surgery centers, laboratories, radiology clinics, and any other facility that provides services that are covered under a group health plan or health insurance coverage, including settings of care subject to section 2719A(b).''.

Subtitle C—Option 3

SEC. 103. BENCHMARK FOR PAYMENT.

Subpart II of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–11 et seq.) is amended by adding at the end the following:

''SEC. 2729A. BENCHMARK FOR PAYMENT.

''(a) ESTABLISHMENT OF BENCHMARK.—A group health plan or health insurance issuer offering group or individual health insurance coverage shall pay facilities or practitioners furnishing services for which such facilities

and practitioners are prohibited from billing enrollees under section 2719A(g), the median contracted rate, using a methodology determined under subsection (b) for the same or similar services offered by the group health plan or health insurance issuer in that geographic region.

''(b) MEDIAN CONTRACTED RATE.—

''(1) IN GENERAL.—For purposes of this section, the term 'median contracted rate' means, with respect to health care services covered by a group health plan or group or individual health insurance coverage, the median negotiated rate under the applicable plan or coverage recognized under the plan or coverage as the total maximum payment for the service, minus the in-network cost-sharing for such service under the plan or coverage, for the same or a similar service that is provided by a provider in the same or similar specialty and in the geographic region in which the service is furnished.

''(2) RULEMAKING.—Not later than 1 year after the date of enactment of the Lower Health Care Costs Act, the Secretary shall, through rulemaking, determine the methodology a group health plan or health insurance issuer is required to use to determine the median contracted rate described in paragraph (1), the information the plan or issuer

shall share with the nonparticipating provider involved when making such a determination, and the geographic regions applied for purposes of this subparagraph.

''(3) CERTAIN INSURERS.—If a group health plan or health insurance issuer offering group or individual health insurance coverage does not have sufficient information to calculate a median in-network rate for this service or provider type, or amount of, claims for services (as determined by the applicable State authority, in the case of health insurance coverage, or by the Secretary of Labor, in the case of a self-insured group health plan) covered under the list of out-of-network services set by the State authority or Secretary of Labor, as applicable, in a particular geographic area, such plan or issuer shall demonstrate that it will use a database free of conflicts of interest that has sufficient information reflecting rates paid to noncontracting individual health care providers for relevant services provided in the applicable geographic region, and that such plan or issuer will use that database to determine a median contracted rate. The group health plan or health insurance issuer shall cover the cost of accessing the database.

"(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall prevent a group health plan or health insurance issuer from establishing separate calculations of a median contracted rate under paragraph (1) for services delivered in nonhospital facilities, including freestanding emergency rooms.

"(c) FACILITY.—For purposes of this section, the term 'health care facility' includes hospitals, hospital outpatient departments, critical access hospitals, ambulatory surgery centers, laboratories, radiology clinics, and any other facility that provides services that are covered under a group health plan or health insurance coverage, including settings of care subject to section 2719A(b).".

Subtitle D—Air Ambulance

SEC. 106. SIMPLIFYING EMERGENCY AIR AMBULANCE BILLING.

(a) IN GENERAL.—Providers of emergency air medical services shall submit to a group health plan or health insurance issuer offering group or individual health insurance coverage, together with an electronic claims transaction with respect to an enrollee in such plan or coverage, a description of charges for such services that are separated by—

(1) the cost of air travel; and

(2) the cost of emergency medical services and supplies.

(b) RULEMAKING.—Not later than 1 year after the date of enactment of this Act, the Secretary shall determine the form and manner for submitting the description of charges in subsection (a) through notice and comment rulemaking.

(c) CIVIL MONETARY PENALTIES.—

(1) IN GENERAL.—A provider of emergency air medical services who violates the requirements of subsection (a) shall be subject to a civil monetary penalty of not more than $10,000 for each act constituting such violation.

(2) PROCEDURE.—The provisions of section 1128A of the Social Security Act (42 U.S.C. 1320a–7a), other than subsections (a) and (b) and the first sentence of subsection (c)(1) of such section, shall apply to civil money penalties under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A of the Social Security Act.

(d) DEFINITIONS.—In this section—

(1) the terms ''group health plan'', ''health insurance coverage'', and ''health insurance issuer'' have the meanings given such terms in section 2791

of the Public Health Service Act (42 U.S.C. 300gg–91); and

(2) the term ''Secretary'' means the Secretary of Health and Human Services.

(e) EFFECTIVE DATE.—The requirement under subsection (a) shall take effect 6 months after the rules described in subsection (b) are finalized.

TITLE II—REDUCING THE PRICES OF PRESCRIPTION DRUGS

SEC. 201. BIOLOGICAL PRODUCT PATENT TRANSPARENCY.

(a) IN GENERAL.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended by adding at the end the following:

''(o) ADDITIONAL REQUIREMENTS WITH RESPECT TO PATENTS.—

''(1) APPROVED APPLICATION HOLDER LISTING REQUIREMENTS.—

''(A) IN GENERAL.—Beginning on the date of enactment of the Biologic Patent Transparency Act, within 60 days of approval of an application under subsection (a) or (k), the holder of such approved application shall submit to the Secretary a list of each patent re-

quired to be disclosed (as described in paragraph (3)).

"(B) PREVIOUSLY APPROVED OR LICENSED BIOLOGICAL PRODUCTS.—

"(i) PRODUCTS LICENSED UNDER SECTION 351 OF THE PHSA.—Not later than 30 days after the date of enactment of the Biologic Patent Transparency Act, the holder of a biological product license that was approved under subsection (a) or (k) before the date of enactment of such Act shall submit to the Secretary a list of each patent required to be disclosed (as described in paragraph (3)).

"(ii) PRODUCTS APPROVED UNDER SECTION 505 OF THE FFDCA.—Not later than 30 days after March 23, 2020, the holder of an approved application for a biological product under section 505 of the Federal Food, Drug, and Cosmetic Act that is deemed to be a license for the biological product under this section on March 23, 2020, shall submit to the Secretary a list of each patent required to be disclosed (as described in paragraph (3)).

"(C) UPDATES.—The holder of a biological product license that is the subject of an application under subsection (a) or (k) shall submit to the Secretary a list that includes—

"(i) any patent not previously required to be disclosed (as described in paragraph (3)) under subparagraph (A) or (B), as applicable, within 30 days of the earlier of—

"(I) the date of issuance of such patent by the United States Patent and Trademark Office; or

"(II) the date of approval of a supplemental application for the biological product; and

"(ii) any patent, or any claim with respect to a patent, included on the list pursuant to this paragraph, that the Patent Trial and Appeal Board of the United States Patent and Trademark Office determines in a decision to be invalid or unenforceable, within 30 days of such decision.

"(2) PUBLICATION OF INFORMATION.—

"(A) IN GENERAL.—Within 1 year of the date of enactment of the Biologic Patent Trans-

parency Act, the Secretary shall publish and make available to the public a single, easily searchable, list that includes—

"(i) the official and proprietary name of each biological product licensed under subsection (a) or (k), and of each biological product application approved under section 505 of the Federal Food, Drug, and Cosmetic Act and deemed to be a license for the biological product under this section on March 23, 2020;

"(ii) with respect to each biological product described in clause (i), each patent submitted in accordance with paragraph (1);

"(iii) the date of licensure and application number for each such biological product;

"(iv) the marketing status, dosage form, route of administration, strength, and, if applicable, reference product, for each such biological product;

"(v) the licensure status for each such biological product, including whether the li-

cense at the time of listing is approved, withdrawn, or revoked;

''(vi) with respect to each such biological product, any period of any exclusivity under paragraph (6), (7)(A), or (7)(B) of subsection (k) of this section or section 527 of the Federal Food, Drug, and Cosmetic Act, and any extension of such period in accordance with subsection (m) of this section, for which the Secretary has determined such biological product to be eligible, and the date on which such exclusivity expires;

''(vii) information regarding any determination of biosimilarity or interchangeability for each such biological product; and

''(viii) information regarding approved indications for each such biological product, in such manner as the Secretary determines appropriate.

''(B) UPDATES.—Every 30 days after the publication of the first list under subparagraph (A), the Secretary shall revise the list to include—

"(i)(I) each biological product licensed under subsection (a) or (k) during the 30-day period; and

"(II) with respect to each biological product described in subclause (I), the information described in clauses (i) through (viii) of subparagraph (A); and

"(ii) any updates to information previously published in accordance with subparagraph (A).

"(C) NONCOMPLIANCE.—Beginning 18 months after the date of enactment of the Biologic Patent Transparency Act, the Secretary, in consultation with the Director of the United States Patent and Trademark Office, shall publish and make available to the public a list of any holders of biological product licenses, and the corresponding biological product or products, that failed to submit information as required under paragraph (1), including any updates required under paragraph (1)(C), in such manner and format as the Secretary determines appropriate. If information required under paragraph (1) is submitted following publication of such list, the Secretary shall remove

such holders of such biological product licenses from the public list in a reasonable period of time.

''(3) PATENTS REQUIRED TO BE DISCLOSED.—In this section, a 'patent required to be disclosed' is any patent for which the holder of a biological product license approved under subsection (a) or (k), or a biological product application approved under section 505 of the Federal Food, Drug, and Cosmetic Act and deemed to be a license for a biological product under this section on March 23, 2020, believes a claim of patent infringement could reasonably be asserted by the holder, or by a patent owner that has granted an exclusive license to the holder with respect to the biological product that is the subject of such license, if a person not licensed by the holder engaged in the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of such license.''.

(b) DISCLOSURE OF PATENTS.—Section 351(l)(3)(A)(i) of the Public Health Service Act (42 U.S.C. 262(l)(3)(A)(i)) is amended by inserting ''included in the list provided by the reference product sponsor under subsection (o)(1)'' after ''a list of patents''.

(c) REVIEW AND REPORT ON NONCOMPLIANCE.—Not later than 30 months after the date of enactment of this Act, the Secretary shall—

(1) solicit public comments regarding appropriate remedies, in addition to the publication of the list under subsection (o)(2)(C) of section 351 of the Public Health Service Act (42 U.S.C. 262), as added by subsection (a), with respect to holders of biological product licenses who fail to timely submit information as required under subsection (o)(1) of such section 351, including any updates required under subparagraph (C) of such subsection (o)(1); and

(2) submit to Congress an evaluation of comments received under paragraph (1) and the recommendations of the Secretary concerning appropriate remedies.

(d) REGULATIONS.—The Secretary of Health and Human Services may promulgate regulations to carry out subsection (o) of section 351 of the Public Health Service Act (42 U.S.C. 262), as added by subsection (a).

(e) RULE OF CONSTRUCTION.—Nothing in this Act, including an amendment made by this Act, shall be construed to require or allow the Secretary of Health and Human Services to delay the licensing of a biological prod-

uct under section 351 of the Public Health Service Act (42 U.S.C. 262).

SEC. 202. ORANGE BOOK MODERNIZATION.

(a) SUBMISSION OF PATENT INFORMATION FOR BRAND NAME DRUGS.—Paragraph (1) of section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)) is amended to read as follows:

''(b)(1)(A) Any person may file with the Secretary an application with respect to any drug subject to the provisions of subsection (a). Such persons shall submit to the Secretary as part of the application—

''(i) full reports of investigations which have been made to show whether or not such drug is safe for use and whether such drug is effective in use;

''(ii) a full list of the articles used as components of such drug;

''(iii) a full statement of the composition of such drug;

''(iv) a full description of the methods used in, and the facilities and controls used for, the manufacture, processing, and packing of such drug;

''(v) such samples of such drug and of the articles used as components thereof as the Secretary may require;

"(vi) specimens of the labeling proposed to be used for such drug;

"(vii) any assessments required under section 505B; and

"(viii) the patent number and expiration date, of each patent for which a claim of patent infringement could reasonably be asserted if a person not licensed by the owner engaged in the manufacture, use, or sale of the drug, and that—

"(I) claims the drug for which the applicant submitted the application and is a drug substance patent or a drug product patent; or

"(II) claims the method of using the drug for which approval is sought or has been granted in the application.

"(B) If an application is filed under this subsection for a drug, and a patent of the type described in subparagraph (A)(viii) that claims such drug or a method of using such drug is issued after the filing date but before approval of the application, the applicant shall amend the application to include such patent information.

"(C) Upon approval of the application, the Secretary shall publish the information submitted under subparagraph (A)(viii).

''(D) The Secretary shall, in consultation with the Director of the National Institutes of Health and with representatives of the drug manufacturing industry, review and develop guidance, as appropriate, on the inclusion of women and minorities in clinical trials required by subparagraph (A)(i).''.

(b) CONFORMING CHANGES TO REQUIREMENTS FOR SUBSEQUENT SUBMISSION OF PATENT INFORMATION.—Section 505(c)(2) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(7)) is amended—

(1) by inserting before the first sentence the following: ''Not later than 30 days after the date of approval of an application under subsection (b), the holder of the approved application shall file with the Secretary the patent number and the expiration date of any patent described in subclause (I) or (II) of subsection (b)(1)(A)(viii), except that a patent that claims a method of using such drug shall be filed only if approval for such use has been granted in the application. The holder of the approved application shall file with the Secretary the patent number and the expiration date of any patent described in subclause (I) or (II) of subsection (b)(1)(A)(viii) that is issued after the date of approval of the application, not later than 30 days of the date of issuance of the

patent, except that a patent that claims a method of using such drug shall be filed only if approval for such use has been granted in the application.'';

(2) by inserting after ''the patent number and the expiration date of any patent which'' the following: ''fulfills the criteria in subsection (b) and'';

(3) by inserting after the third sentence (as amended by paragraph (1)) the following: ''Patent information that is not the type of patent information required by subsection (b)(1)(A)(viii) shall not be submitted under this paragraph.''; and

(4) by inserting after ''could not file patent information under subsection (b) because no patent'' the following: ''of the type required to be submitted in subsection (b)''.

(c) LISTING OF EXCLUSIVITIES.—Subparagraph (A) of section 505(j)(7) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(7)) is amended by adding at the end the following:

''(iv) For each drug included on the list, the Secretary shall specify any exclusivity period that is applicable, for which the Secretary has determined the expiration date, and for which such period has not yet expired under—

"(I) clause (ii), (iii), or (iv) of subsection (c)(3)(E) of this section;

"(II) clause (iv) or (v) of paragraph (5)(B) of this subsection;

"(III) clause (ii), (iii), or (iv) of paragraph (5)(F) of this subsection;

"(IV) section 505A;

"(V) section 505E;

"(VI) section 527(a); or

"(VII) section 505(u)".

(d) ORANGE BOOK UPDATES WITH RESPECT TO INVALIDATED PATENTS.—

(1) IN GENERAL.—

(A) AMENDMENTS.—Section 505(j)(7)(A) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(7)(A)), as amended by subsection (c), is further amended by adding at the end the following:

"(v) In the case of a listed drug for which the list under clause (i) includes a patent or patent claim for the drug, or a patent or a patent claim for the use of such drug, and where the Under Secretary of Commerce for Intellectual Property and Director of the United States Patent and Trademark Office has cancelled any claim of the patent

relating to such drug or such use pursuant to a decision by the Patent Trial and Appeal Board in an inter partes review conducted under chapter 31 of title 35, United States Code, or a post-grant review conducted under chapter 32 of that title, and from which no appeal has been taken, or can be taken, the holder of the applicable approved application shall notify the Secretary, in writing, within 14 days of such cancellation, and, if the patent has been deemed wholly inoperative or invalid, or if a patent claim has been cancelled, the revisions required under clause (iii) shall include striking the patent or information regarding such patent claim from the list with respect to such drug.''.

(B) APPLICATION.—The amendment made by subparagraph (A) shall not apply with respect to any determination with respect to a patent or patent claim that is made prior to the date of enactment of this Act.

(2) NO EFFECT ON FIRST APPLICANT EXCLUSIVITY PERIOD.—Section 505(j)(5)(B)(iv)(I) is amended by adding at the end the following: ''This subclause shall apply even if a patent is stricken from the list under paragraph (7)(A), pursuant to paragraph (7)(A)(v), provided that, at the time that

the first applicant submitted an application under this subsection containing a certification described in paragraph (2)(A)(vii)(IV), the patent that was the subject of such certification was included in such list with respect to the listed drug.''.

SEC. 203. ENSURING TIMELY ACCESS TO GENERICS.

Section 505(q) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(q)(1)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A)(i), by inserting '', 10.31,'' after ''10.30'';

(B) in subparagraph (E)—

(i) by striking ''application and'' and inserting ''application or'';

(ii) by striking ''If the Secretary'' and inserting the following:

''(i) IN GENERAL.—If the Secretary'';

(iii) by striking the second sentence and inserting the following:

''(ii) PRIMARY PURPOSE OF DELAYING.—

''(I) IN GENERAL.—For purposes of this subparagraph, a petition or supplement to a petition may be considered to be submitted with the pri-

mary purpose of delaying an application under subsection (b)(2) or (j) of this section or section 351(k) of the Public Health Service Act, if the petitioner has the purpose of setting aside, delaying, rescinding, withdrawing, or preventing submission, review, or the approval of such an application.

''(II) FACTORS.—In determining whether a petition was submitted with the primary purpose of delaying an application, the Secretary may consider the following factors:

''(aa) Whether the petition was submitted in accordance with paragraph (2)(B), based on when the petitioner knew or reasonably should have known the relevant information relied upon to form the basis of such petition.

''(bb) Whether the petitioner has submitted multiple or serial petitions raising issues that reasonably could have been known

to the petitioner at the time of submission of the earlier petition or petitions.

"(cc) Whether the petition was submitted close in time to a known, first date upon which an application under subsection (b)(2) or (j) of this section or section 351(k) of the Public Health Service Act could be approved.

"(dd) Whether the petition was submitted without any relevant data or information in support of the scientific positions forming the basis of such petition.

"(ee) Whether the petition raises the same or substantially similar issues as a prior petition to which the Secretary has responded substantively already, including if the subsequent submission follows such response from the Secretary closely in time.

"(ff) Whether the petition requests changing the applicable standards that other applicants are required to meet, including requesting testing, data, or labeling standards that are more onerous or rigorous than the standards applicable to the listed drug, reference product, or petitioner's version of the same drug.

"(gg) The petitioner's record of submitting petitions to the Food and Drug Administration that have been determined by the Secretary to have been submitted with the primary purpose of delay.

"(hh) Other relevant and appropriate factors, which the Secretary shall describe in guidance.

"(III) GUIDANCE.—The Secretary may issue or update guidance, as appropriate, to describe factors the

Secretary considers in accordance with subclause (II).'';

(C) by adding at the end the following:

''(iii) REFERRAL TO THE FEDERAL TRADE COMMISSION.—The Secretary shall establish procedures for referring to the Federal Trade Commission any petition or supplement to a petition that the Secretary determines was submitted with the primary purpose of delaying approval of an application. Such procedures shall include notification to the petitioner and an opportunity for judicial review after the issuance of an order by the Federal Trade Commission.'';

(D) by striking subparagraph (F);

(E) by redesignating subparagraphs (G) through (I) as subparagraphs (F) through (H), respectively;

(F) in subparagraph (H), as so redesignated, by striking ''submission of this petition'' and inserting ''submission of this document'';

(2) in paragraph (2)—

(A) by redesignating subparagraphs (A) through (C) as subparagraphs (C) through (E), respectively;

(B) by inserting before subparagraph (C), as so redesignated, the following:

''(A) IN GENERAL.—A person shall submit a petition to the Secretary under paragraph (1) before filing a civil action in which the person seeks to set aside, delay, rescind, withdraw, or prevent submission, review, or approval of an application submitted under subsection (b)(2) or (j) of this section or section 351(k) of the Public Health Service Act. Such petition and any supplement to such a petition shall describe all information and arguments that form the basis of the relief requested in any civil action described in the previous sentence.

''(B) TIMELY SUBMISSION OF CITIZEN PETITION.—A petition and any supplement to a petition shall be submitted within 60 days after the person knew, or reasonably should have known, the information that forms the basis of the request of the petition or supplement.'';

(C) in subparagraph (C), as so redesignated, by—

(i) in the heading, by striking ''WITHIN 150 DAYS'';

(ii) in clause (i), by striking ''during the 150-day period referred to in paragraph (1)(F),''; and

(iii) by amending clause (ii) to read as follows:

''(ii) on or after the date that is 151 days after the date of submission of the petition, the Secretary approves or has approved the application that is the subject of the petition without having made such a final decision.'';

(D) by amending subparagraph (D), as so redesignated, to read as follows:

''(D) DISMISSAL OF CERTAIN CIVIL ACTIONS.—

''(i) PETITION.—If a person files a civil action against the Secretary in which a person seeks to set aside, delay, rescind, withdraw, or prevent submission, review, or approval of an application submitted under subsection (b)(2) or (j) of this section or section 351(k) of the Public Health Service Act without complying with the requirements of subparagraph (A), the court shall

dismiss without prejudice the action for failure to exhaust administrative remedies.

''(ii) TIMELINESS.—If a person files a civil action against the Secretary in which a person seeks to set aside, delay, rescind, withdraw, or prevent submission, review, or approval of an application submitted under subsection (b)(2) or (j) of this section or section 351(k) of the Public Health Service Act without complying with the requirements of subparagraph (B), the court shall dismiss with prejudice the action for failure to timely file a petition.

''(iii) FINAL RESPONSE.—If a civil action is filed against the Secretary with respect to any issue raised in a petition timely filed under paragraph (1) in which the petitioner requests that the Secretary take any form of action that could, if taken, set aside, delay, rescind, withdraw, or prevent submission, review, or approval of an application submitted under subsection (b)(2) or (j) of this section or section 351(k) of the Public Health Service Act before the Secretary has issued a final response to

any such petition submitted, the court shall dismiss without prejudice the action for failure to exhaust administrative remedies.''; and

(E) in subparagraph (E), as so redesignated—

(i) in clause (ii), by striking '', if issued''; and

(ii) in clause (iii), by striking ''final agency action as defined under subparagraph (2)(A)'' and inserting ''the final response to the petitioner''; and

(3) in paragraph (4)—

(A) by striking ''EXCEPTIONS'' and all that follows through ''This subsection does'' and inserting ''EXCEPTIONS—This subsection does'';

(B) by striking subparagraph (B); and

(C) by redesignating clauses (i) and (ii) as subparagraphs (A) and (B), respectively, and adjusting the margins accordingly.

SEC. 204. PROTECTING ACCESS TO BIOLOGICAL PRODUCTS.

Section 351(k)(7) of the Public Health Service Act (42 U.S.C. 262(k)(7)) is amended by adding at the end the following:

''(D) DEEMED LICENSES.—

"(i) NO ADDITIONAL EXCLUSIVITY THROUGH DEEMING.—An approved application that is deemed to be a license for a biological product under this section pursuant to section 7002(e)(4) of the Biologics Price Competition and Innovation Act of 2009 shall not be treated as having been first licensed under subsection (a) for purposes of subparagraphs (A) and (B).

"(ii) LIMITATION ON EXCLUSIVITY.—Subparagraph (C) shall apply to any reference product, without regard to whether—

"(I) such product was first licensed under subsection (a); or

"(II) the approved application for such product was deemed to be a license for a biological product as described in clause (i).

"(iii) APPLICABILITY.—Any unexpired period of exclusivity under section 527 or section 505A(c)(1)(A)(ii) of the Federal Food, Drug, and Cosmetic Act with respect to a biological product shall continue to apply to such biological product after an

approved application for the biological product is deemed to be a license for the biological product as described in clause (i).''.

SEC. 205. PREVENTING BLOCKING OF GENERIC DRUGS.

Section 505(j)(5)(B)(iv)(I) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(5)(B)(iv)(I)) is amended—

(1) by striking ''180 days after the date'' and inserting ''180 days after the earlier of the following:

''(aa) The date''; and

(2) by adding at the end the following:

''(bb) The date on which all of the following conditions are first met:

''(AA) An application for the drug submitted by an applicant other than a first applicant could receive approval, if no first applicant were eligible for 180-day exclusivity under this clause.

''(BB) Thirty months have passed since the date of submission of an application for the drug by at least one first applicant.

''(CC) Approval of an application for the drug submitted by at least one first applicant would not be precluded under clause (iii).

''(DD) No application for the drug submitted by any first applicant is approved at the time the conditions under subitems (AA), (BB), and (CC) are all met, regardless of whether such an application is subsequently approved.''.

SEC. 206. EDUCATION ON BIOLOGICAL PRODUCTS.

Subpart 1 of part F of title III of the Public Health Service Act (42 U.S.C. 262 et seq.) is amended by adding at the end the following:

''SEC. 352A. EDUCATION ON BIOLOGICAL PRODUCTS.

''(a) INTERNET WEBSITE.—

''(1) IN GENERAL.—The Secretary may establish, maintain, and operate an internet website to provide educational materials for health care providers, patients, and caregivers, regarding the meaning of the terms, and the standards for review and licensing of, biosimilar biological products and interchangeable biological products.

"(2) CONTENT.—Educational materials provided under paragraph (1) may include explanations of—

"(A) key statutory and regulatory terms, including 'biosimilar' and 'interchangeable', and clarification regarding the appropriate use of interchangeable biosimilar biological products;

"(B) information related to the development program for biosimilar biological products and relevant clinical considerations for prescribers;

"(C) the process for reporting adverse events for biological products, including biosimilar and interchangeable biological products; and

"(D) the relationship between biosimilar biological products licensed under section 351(k) and the applicable reference products (as defined in section 351(i));

"(3) FORMAT.—The educational materials provided under paragraph (1) may be—

"(A) in formats such as webinars, continuing medical education modules, videos, fact sheets, infographics, stakeholder toolkits, or

other formats as appropriate and applicable; and

''(B) tailored for the unique needs of health care providers, patients, caregivers, and other audiences, as the Secretary determines appropriate.

''(4) OTHER INFORMATION.—In addition to the information described in paragraph (2), the internet website established under paragraph (1) shall include the following information, as a single, searchable database:

''(A) The action package of each biological product licensed under subsection (a) or (k), within 30 days of licensure, or, in the case of a biological product licensed before the date of enactment of the Lower Health Care Costs Act, not later than 1 year after such date of enactment.

''(B) The summary review of each biological product licensed under subsection (a) or (k), within 7 days of licensure, except where such materials require redaction by the Secretary, or, in the case of a biological product licensed before the date of enactment of the Lower Health

Care Costs Act, not later than 1 year after such date of enactment.

''(5) CONFIDENTIAL AND TRADE SECRET INFORMATION.—This subsection does not authorize the disclosure of any trade secret, confidential commercial or financial information, or other matter described in section 552(b) of title 5.

''(b) CONTINUING MEDICAL EDUCATION.—The Secretary shall advance education and awareness among health care providers regarding biosimilar biological products, as appropriate, including by developing or improving continuing medical education programs that advance the education of such providers on the prescribing of, and relevant clinical considerations with respect to, biosimilar biological products.''.

SEC. 207. BIOLOGICAL PRODUCT INNOVATION.

Section 351(j) of the Public Health Service Act (42 U.S.C. 262(j)) is amended—

(1) by striking ''except that a product'' and inserting ''except that—

''(1) a product'';

(2) by striking ''Act.'' and inserting ''Act; and''; and

(3) by adding at the end the following:

''(2) no requirement under such Act regarding an official compendium (as defined in section 201(j) of such Act), or other reference in such Act to an official compendium (as so defined), shall apply with respect to a biological product subject to regulation under this section.''.

SEC. 208. CLARIFYING THE MEANING OF NEW CHEMICAL ENTITY.

Chapter V of the Federal Food, Drug, and Cosmetic Act is amended—

(1) in section 505 (21 U.S.C. 355)—

(A) in subsection (c)(3)(E)—

(i) in clause (ii), by striking ''active ingredient (including any ester or salt of the active ingredient)'' and inserting ''active moiety (as defined by the Secretary in section 314.3 of title 21, Code of Federal Regulations (or any successor regulations))''; and

(ii) in clause (iii), by striking ''active ingredient (including any ester or salt of the active ingredient)'' and inserting ''active moiety (as defined by the Secretary in section 314.3 of title 21, Code of Federal

Regulations (or any successor regulations))''; and

(B) in subsection (j)(5)(F)—

(i) in clause (ii), by striking ''active ingredient (including any ester or salt of the active ingredient)'' and inserting ''active moiety (as defined by the Secretary in section 314.3 of title 21, Code of Federal Regulations (or any successor regulations))''; and

(ii) in clause (iii), by striking ''active ingredient (including any ester or salt of the active ingredient)'' and inserting ''active moiety (as defined by the Secretary in section 314.3 of title 21, Code of Federal Regulations (or any successor regulations))'';

(C) in subsection (l)(2)(A)(i), by striking ''active ingredient (including any ester or salt of the active ingredient)'' and inserting ''active moiety (as defined by the Secretary in section 314.3 of title 21, Code of Federal Regulations (or any successor regulations))'';

(D) in subsection (s), in the matter preceding paragraph (1), by striking ''active ingre-

dient (including any ester or salt of the active ingredient)'' and inserting ''active moiety (as defined by the Secretary in section 314.3 of title 21, Code of Federal Regulations (or any successor regulations))'';

(E) in subsection (u)(1), in the matter preceding subparagraph (A)—

(i) by striking ''active ingredient (including any ester or salt of the active ingredient)'' and inserting ''active moiety (as defined by the Secretary in section 314.3 of title 21, Code of Federal Regulations (or any successor regulations))''; and

(ii) by striking ''same active ingredient'' and inserting ''same active moiety'';

(2) in section 512(c)(2)(F) (21 U.S.C. 360b(c)(2)(F))—

(A) in clause (i), by striking ''active ingredient (including any ester or salt of the active ingredient)'' and inserting ''active moiety (as defined by the Secretary in section 314.3 of title 21, Code of Federal Regulations (or any successor regulations))'';

(B) in clause (ii), by striking ''active ingredient (including any ester or salt of the active

ingredient)'' and inserting ''active moiety (as defined by the Secretary in section 314.3 of title 21, Code of Federal Regulations (or any successor regulations))''; and

(C) in clause (v), by striking ''active ingredient (including any ester or salt of the active ingredient)'' and inserting ''active moiety (as defined by the Secretary in section 314.3 of title 21, Code of Federal Regulations (or any successor regulations))'';

(3) in section 524(a)(4)(C) (21 U.S.C. 360n(a)(4)(C)), by striking ''active ingredient (including any ester or salt of the active ingredient)'' and inserting ''active moiety (as defined by the Secretary in section 314.3 of title 21, Code of Federal Regulations (or any successor regulations))'';

(4) in section 529(a)(4)(A)(ii) (21 U.S.C. 21 U.S.C. 360ff(a)(4)(A)(ii)), by striking ''active ingredient (including any ester or salt of the active ingredient)'' and inserting ''active moiety (as defined by the Secretary in section 314.3 of title 21, Code of Federal Regulations (or any successor regulations))''; and

(5) in section 565A(a)(4)(D) (21 U.S.C. 360bbb–4a(a)(4)(D)), by striking ''active ingredient

(including any ester or salt of the active ingredient)'' and inserting ''active moiety (as defined by the Secretary in section 314.3 of title 21, Code of Federal Regulations (or any successor regulations))''.

SEC. 209. STREAMLINING THE TRANSITION OF BIOLOGICAL PRODUCTS.

Section 7002(e)(4) of the Biologics Price Competition and Innovation Act of 2009 (Public Law 111–148) is amended by adding at the end the following: ''With respect to an application for a biological product under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) with a filing date that is not later than September 23, 2019, the Secretary shall continue to review and approve such application under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), even if such review and approval process continues after March 23, 2020. Effective on the later of March 23, 2020, or the date of approval of such application under such section 505, such approved application shall be deemed to be a license for the biological product under section 351 of the Public Health Service Act.''.

TITLE III—IMPROVING TRANSPARENCY IN HEALTH CARE

SEC. 301. INCREASING TRANSPARENCY BY REMOVING GAG CLAUSES ON PRICE AND QUALITY INFORMATION.

Subpart II of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–11 et seq.), as amended by section 103, is amended by adding at the end the following:

"SEC. 2729B. INCREASING TRANSPARENCY BY REMOVING GAG CLAUSES ON PRICE AND QUALITY INFORMATION.

"(a) INCREASING PRICE AND QUALITY TRANSPARENCY FOR PLAN SPONSORS AND CONSUMERS.—

"(1) GROUP HEALTH PLANS.—A group health plan or a health insurance issuer offering group health insurance coverage may not enter into an agreement with a health care provider, network or association of providers, or other service provider offering access to a network of providers that would directly or indirectly restrict a group health plan or health insurance issuer from—

"(A) providing provider-specific cost or quality of care information, through a consumer engagement tool or any other means, to refer-

ring providers, the plan sponsor, enrollees, or eligible enrollees of the plan or coverage;

"(B) electronically accessing de-identified claims and encounter data for each enrollee in the plan or coverage, upon request and consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act, the amendments to this Act made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990, with respect to the applicable health plan or health insurance coverage, including, on a per claim basis—

"(i) financial information, such as the allowed amount;

"(ii) provider information, including name and clinical designation; or

"(iii) service codes; or

"(C) sharing data described in subparagraph (A) or (B) with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health

Insurance Portability and Accountability Act, the amendments to this Act made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.

"(2) INDIVIDUAL HEALTH INSURANCE COVERAGE.—A health insurance issuer offering individual health insurance coverage may not enter into an agreement with a health care provider, network or association of providers, or other service provider offering access to a network of providers that would, directly or indirectly restrict the health insurance issuer from—

"(A) providing provider-specific price or quality of care information, through a consumer engagement tool or any other means, to referring providers or the plan sponsor, enrollees, or eligible enrollees of the plan or coverage; or

"(B) sharing data described in subparagraph (A) with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act,

the amendments to this Act made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990, for plan design, plan administration, and plan, financial, legal, and quality improvement activities.

''(3) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in paragraph (1)(A) or (2)(A) prevents a health care provider, network or association of providers, or other service provider from placing reasonable restrictions on the public disclosure of the information described in such paragraphs (1) and (2).''.

SEC. 302. BANNING ANTICOMPETITIVE TERMS IN FACILITY AND INSURANCE CONTRACTS THAT LIMIT ACCESS TO HIGHER QUALITY, LOWER COST CARE.

(a) IN GENERAL.—Section 2729B of the Public Health Service Act, as added by section 301, is amended by adding at the end the following:

''(b) PROTECTING HEALTH PLANS NETWORK DESIGN FLEXIBILITY.—

''(1) IN GENERAL.—A group health plan or a health insurance issuer offering group or individual health insurance coverage shall not enter into an

agreement with a provider, network or association of providers, third-party administrator, or other service provider if such agreement, directly or indirectly—

"(A) restricts the group health plan or health insurance issuer from—

"(i) directing or steering enrollees to other health care providers; or

"(ii) offering incentives to encourage enrollees to utilize specific health care providers; or

"(B) requires the group health plan or health insurance issuer to enter into any additional contract with an affiliate of the provider as a condition of entering into a contract with such provider;

"(C) requires the group health plan or health insurance issuer to agree to payment rates or other terms for any affiliate not party to the contract of the provider involved;

"(D) restricts other group health plans or health insurance issuers not party to the contract, from paying a lower rate for items or services than the contracting plan or issuer pays for such items or services; and

''(2) ADDITIONAL REQUIREMENT FOR SELF-INSURED PLANS.—A self-insured group health plan shall not enter into an agreement with a provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers if such agreement, directly or indirectly requires the group health plan to certify, attest, or otherwise confirm in writing that the group health plan is bound by the terms of the contract between the service provider and a third-party administrator that the group health plan is not party to and is not allowed to review.

''(c) MAINTENANCE OF EXISTING HIPAA, GINA, AND ADA PROTECTIONS.—Nothing in this section shall modify, reduce, or eliminate the existing privacy protections and standards provided by reason of State and Federal law, including the requirements of parts 160 and 164 of title 45, Code of Federal Regulations (or any successor regulations).

''(d) REGULATIONS.—The Secretary, in coordination with the Secretary of Labor and the Secretary of the Treasury, not later than 1 year after the date of enactment of the Lower Health Care Costs Act, shall promulgate regulations to carry out this section.''.

(b) EFFECTIVE DATE.—Section 2729B of the Public Health Service Act (as added by section 301 and amended by subsection (a)) shall apply with respect to any contract entered into after the date of enactment of this Act. With respect to an applicable contract that is in effect on the date of enactment of this Act, such section 2729B shall apply on the earlier of the date of renewal of such contract or 3 years after such date of enactment.

SEC. 303. DESIGNATION OF A NONGOVERNMENTAL, NONPROFIT TRANSPARENCY ORGANIZATION TO LOWER AMERICANS' HEALTH CARE COSTS.

(a) IN GENERAL.—Subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191 et seq.) is amended by adding at the end the following:

"SEC. 735. DESIGNATION OF A NONGOVERNMENTAL, NONPROFIT TRANSPARENCY ORGANIZATION TO LOWER AMERICANS' HEALTH CARE COSTS.

''(a) IN GENERAL.—The Secretary, in consultation with the Secretary of Health and Human Services, not later than 6 months after the date of enactment of the Lower Health Care Costs Act, shall have in effect a contract with a nonprofit entity to support the establishment and maintenance of a database that receives and utilizes health care claims information and related information

and issues reports that are available to the public and authorized users, and are submitted to the Department of Labor.

''(b) REQUIREMENTS.—

''(1) IN GENERAL.—The database established under subsection (a) shall—

''(A) improve transparency by using de-identified health care data to—

''(i) inform patients about the cost and quality of their care;

''(ii) assist providers and hospitals, as they work with patients, to make informed choices about care;

''(iii) enable providers, hospitals, and communities to improve services and outcomes for patients by benchmarking their performance against that of other providers, hospitals, and communities;

''(iv) enable purchasers, including employers, employee organizations, and health plans, to develop value-based purchasing models, improve quality, and reduce the cost of health care and insurance coverage for enrollees;

"(v) enable employers and employee organizations to evaluate network design and construction, and the cost of care for enrollees;

"(vi) facilitate State-led initiatives to lower health care costs and improve quality; and

"(vii) promote competition based on quality and cost;

"(B) collect medical claims, prescription drug claims, and remittance data consistent with the protections and requirements of subsection (d);

"(C) be established in such a manner that allows the data collected pursuant to subparagraph (B) to be shared with State all-payer claims databases at cost, using a standardized format, if such State databases also submit claims data to the database established under this section; and

"(D) be available to—

"(i) the Director of the Congressional Budget Office, the Comptroller General of the United States, the Executive Director of the Medicare Payment Advisory Com-

mission, and the Executive Director of the Medicaid and CHIP Payment Advisory Commission, upon request, subject to the privacy and security requirements of authorized users under subsection (e)(2); and

"(ii) authorized users, including employers, employee organizations, researchers and policymakers, subject to subsection (e).

"(2) PRIVACY AND SECURITY.—The entity receiving a contract under subsection (a) shall, in accordance with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996—

"(A) ensure that the database under subsection (a) is capable of—

"(i) receiving data under subsection (d);

"(ii) providing data access to authorized users; and

"(iii) storing data on secure servers in a manner that is consistent with the privacy, security, and data breach regulations promulgated under section 264(c) of the Health Insurance Portability and Account-

ability Act of 1996 (or successor regulations);

"(B) not disclose to the public any protected health information or proprietary financial information;

"(C) strictly limit staff access to the data to staff with appropriate training, clearance, and background checks;

"(D) maintain effective security standards for transferring data or making data available to authorized users;

"(E) develop a process for providing access to data to authorized users, in a secure manner that maintains privacy and confidentiality of data;

"(F) adhere to current best security practices with respect to the management and use of such data for health services research, in accordance with applicable Federal privacy law; and

"(G) report on the security methods of the entity to the Secretary, the Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Education and Labor of the House of Representatives

''(3) CONSULTATION.—

''(A) ADVISORY COMMITTEE.—Not later than 180 days after the date of enactment of the Lower Health Care Costs Act, the Secretary shall convene an Advisory Committee (referred to in this section as the 'Committee'), consisting of 11 members, to advise the Secretary, the contracting entity, and Congress on the establishment, operations, and use of the database established under this section.

''(B) MEMBERSHIP.—

''(i) APPOINTMENT.—The Secretary, in consultation with the Secretary of Health and Human Services, shall, not later than 1 year after the date of enactment of the Lower Health Care Costs Act, appoint members to the Committee who have distinguished themselves in the fields of health services research, health economics, health informatics, or the governance of State all-payer claims databases, or who represent organizations likely to submit data to or use the database, including patients, employers, or employee organizations that sponsor group health plans,

health care providers, health insurance issuers, and third-party administrators of group health plans. Such members shall serve 3-year terms on a staggered basis. Vacancies on the Committee shall be filled by appointment consistent with this subsection not later than 3 months after the vacancy arises.

''(ii) COMPOSITION.—The members appointed to the Committee under clause (i) shall include—

''(I) 1 member selected by the Secretary, in coordination with the Secretary of Health and Human Services, to serve as the chair of the Committee;

''(II) the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services;

''(III) 1 representative of the Centers for Medicare & Medicaid Services;

''(IV) 1 representative of the Agency for Health Research and Quality;

''(V) 1 representative of the Office for Civil Rights of the Department of Health and Human Services with expertise in data privacy and security;

''(VI) 1 representative of the National Center for Health Statistics;

''(VII) 1 representative of an employer that sponsors a group health plan;

''(VIII) 1 representative of an employee organization that sponsors a group health plan;

''(IX) 1 academic researcher with expertise in health economics or health services research; and

''(X) 2 additional members.

''(C) DUTIES.—The Committee shall—

''(i) assist and advise the Secretary on the management of the contract under subsection (a);

"(ii) assist and advise the entity receiving the contract under subsection (a) in establishing—

"(I) the scope and format of the data to be submitted under subsection (d);

"(II) the appropriate uses of data by authorized users, including developing standards for the approval of requests by organizations to access and use the data; and

"(III) the appropriate formats and methods for making reports and analyses based on the database to the public;

"(iii) make reports, as appropriate, to the Secretary and Congress on the operation of the database and opportunities to better achieve the objectives of this section; and

"(iv) establish objectives for research and public reporting.

"(4) STATE REQUIREMENTS.—A State may require health insurance issuers and other payers to submit claims data to the database established

under this section, provided that such data is submitted in a form and manner established by the Secretary, and pursuant to subsection (d)(4)(B).

''(c) CONTRACT REQUIREMENTS.—

''(1) COMPETITIVE PROCEDURES.—The Secretary shall enter into the contract under subsection (a) using full and open competition procedures pursuant to chapter 33 of title 41, United States Code.

''(2) ELIGIBLE ENTITIES.—To be eligible to enter into a contract described in subsection (a), an entity shall—

''(A) be a private nonprofit entity governed by a board that includes representatives of the academic research community and individuals with expertise in employer-sponsored insurance, research using health care claims data and actuarial analysis;

''(B) conduct its business in an open and transparent manner that provides the opportunity for public comment on its activities; and

''(C) hold an active certification as a qualified entity under section 1874(e) of the Social Security Act (or any successor program).

"(3) CONSIDERATIONS.—In awarding the contract under subsection (a), the Secretary shall consider an entity's experience in—

"(A) health care claims data collection, aggregation, quality assurance, analysis, and security;

"(B) supporting academic research on health costs, spending, and utilization for and by privately insured patients;

"(C) working with large health insurance issuers and third-party administrators to assemble a national claims database;

"(D) effectively collaborating with and engaging stakeholders to develop reports;

"(E) meeting budgets and timelines, including in connection with report generation; and

"(F) facilitating the creation of, or supporting, State all-payer claims databases.

"(4) CONTRACT TERM.—A contract awarded under this section shall be for a period of 5 years, and may be renewed after a subsequent competitive bidding process under this section.

"(5) TRANSITION OF CONTRACT.—If the Secretary, following a competitive process at the end of

the contract period, selects a new entity to maintain the database, all data shall be transferred to the new entity according to a schedule and process to be determined by the Secretary. Upon termination of a contract, no entity may keep data held by the database or disclose such data to any entity other than the entity so designated by the Secretary. The Secretary shall include enforcement terms in any contract with an organization chosen under this section, to ensure the timely transfer of all data to a new entity in the event of contract termination.

''(d) RECEIVING HEALTH INFORMATION.—

''(1) REQUIREMENTS.—

''(A) IN GENERAL.—An applicable self-insured group health plan shall, through its health insurance issuer, third-party administrator, pharmacy benefit manager, or other entity designated by the group health plan, electronically submit all claims data required pursuant to subparagraph (B) with respect to the plan.

''(B) SCOPE OF INFORMATION AND FORMAT OF SUBMISSION.—The entity awarded the contract under subsection (a), in consultation with the Committee described in subsection

(b)(3), and pursuant to the privacy and security requirements of subsection (b)(2), shall specify—

"(i) the data elements required to be submitted under subparagraph (A), which shall include all data related to transactions described in subparagraphs (A) and (E) of section 1173(a)(2) of the Social Security Act, including all data elements normally present in such transactions when adjudicated, and enrollment information; and

"(ii) the form and manner for such submissions, including the frequency of such submissions.

"(C) DE-IDENTIFICATION OF DATA.—The entity awarded the contract under subsection (a) shall—

"(i) establish a process under which data is de-identified in accordance with section 164.514(a) of title 45, Code of Federal Regulations (or any successor regulations), while retaining the ability to link data longitudinally for the purposes of research on cost and quality, and the ability

to complete risk adjustment and geographic analysis;

''(ii) ensure that any third-party subcontractors who perform the de-identification process described in clause (i) retain the minimum necessary information to perform such a process, and adhere to effective security and encryption practices in data storage and transmission;

''(iii) store claims and other data collected under this subsection only in de-identified form, in accordance with section 164.514(a) of title 45, Code of Federal Regulations (or any successor regulations); and

''(iv) ensure that data is encrypted, in accordance with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

''(2) APPLICABLE SELF-INSURED GROUP HEALTH PLAN.—For purposes of paragraph (1), a self-insured group health plan is an applicable self-insured group health plan if such plan is self-administered, or is administered by a health insurance

issuer or third-party administrator that meets 1 or both of the following criteria:

"(A) Administers health benefits for more than 50,000 enrollees.

"(B) Is one of the 5 largest administrators or issuers of self-insured group health plans in a State in which such administrator operates, as measured by the number of enrollees.

"(3) ISSUERS AND THIRD-PARTY ADMINISTRATORS.—In the case of a health insurance issuer or third-party administrator that is required under this subsection to submit claims data with respect to an applicable self-insured group health plan, such issuer or administrator shall submit claims data with respect to all self-insured group health plans that the issuer or administrator administers, including such plans that are not applicable self-insured group health plans, as described in paragraph (2).

"(4) RECEIVING OTHER INFORMATION.—

"(A) MEDICARE DATA.—The entity awarded the contract under subsection (a) shall maintain active certification as a qualified entity pursuant to section 1874(e) of the Social Security Act for the term of the contract awarded under subsection (a).

''(B) STATE DATA.—The entity awarded the contract under subsection (a) shall collect data from State all payer claims databases that seek access to the database established under this section.

''(5) AVAILABILITY OF DATA.—An entity required to submit data under this subsection may not place any restrictions on the use of such data by authorized users.

''(e) USES OF INFORMATION.—

''(1) IN GENERAL.—The entity awarded the contract under subsection (a) shall make the database available to users who are authorized under this subsection, at cost, and reports and analyses based on the data available to the public with no charge.

''(2) AUTHORIZATION OF USERS.—

''(A) IN GENERAL.—An entity may request authorization by the entity awarded the contract under subsection (a) for access to the database in accordance with this paragraph.

''(B) APPLICATION.—An entity desiring authorization under this paragraph shall submit to the entity awarded the contract an application for such access, which shall include—

"(i) in the case of an entity requesting access for research purposes—

"(I) a description of the uses and methodologies for evaluating health system performance using such data; and

"(II) documentation of approval of the research by an institutional review board, if applicable for a particular plan of research; or

"(ii) 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.

"(C) REQUIREMENTS.—

"(i) RESEARCH.—Upon approval of an application for research purposes under subparagraph (B)(i), the authorized user shall enter into a data use and confidentiality agreement with the entity awarded the contract under subsection (a), which shall include a prohibition on the disclo-

sure of protected health information and proprietary financial information.

"(ii) QUALITY IMPROVEMENT AND COST-CONTAINMENT.—In consultation with the Committee described in subsection (b)(3), the Secretary shall, through rule-making, establish the form and manner in which authorized users described in sub-paragraph (B)(ii) may access data. Data provided to such authorized users shall be provided in a form and manner such that users may not obtain individually identifi-able price information with respect to di-rect competitors. Upon approval, such au-thorized user shall enter into a data use and confidentiality agreement with the en-tity.

"(iii) CUSTOMIZED REPORTS.—Em-ployers and employer organizations may request customized reports from the entity awarded the contract under subsection (a), at cost, subject to the requirements of this section with respect to privacy, security, and proprietary financial information.

"(f) FUNDING.—

''(1) INITIAL FUNDING.—There are authorized to be appropriated, and there are appropriated, out of monies in the Treasury not otherwise appropriated, $20,000,000 for fiscal year 2020, for the implementation of the initial contract and establishment of the database under this section.

''(2) ONGOING FUNDING.—There are authorized to be appropriated $15,000,000 for each of fiscal years 2021 through 2025, for purposes of carrying out this section (other than the grant program under subsection (h)).

''(g) ANNUAL REPORT.—

''(1) SUBMISSION.—Not later than March 1, 2021, and March 1 of each year thereafter, the entity receiving the contract under subsection (a) shall submit to Congress, the Secretary of Labor, and the Secretary of Health and Human Services, and publish online for access by the general public, a report containing a description of—

''(A) trends in the price, utilization, and total spending on health care services, including a geographic analysis of differences in such trends;

''(B) progress towards the objectives of this section; and

''(C) the performance by the entity of the duties required under such contract.

''(2) PUBLIC REPORTS AND RESEARCH.—The entity receiving a contract under subsection (a) shall, in coordination with authorized users, make analyses and research available to the public on an ongoing basis to promote the objectives of this section.

''(h) GRANTS TO STATES.—

''(1) IN GENERAL.—The Secretary, in consultation with the Secretary of Health and Human Services, may award grants to States for the purpose of establishing and maintaining State all-payer claims databases that improve transparency of data in order to meet the goals of subsection (a)(1).

''(2) REQUIREMENT.—To be eligible to receive the funding under paragraph (1), a State shall submit data to the database as described in subsection (b)(1)(C), using the format described in subsection (d)(1).

''(3) FUNDING.—There is authorized to be appropriated $100,000,000 for the period of fiscal years 2020 through 2029 for purposes of carrying out the grant program under this subsection.

''(i) EXEMPTION FROM PUBLIC DISCLOSURE.—

''(1) IN GENERAL.—Claims data provided to the database, and the database itself shall not be considered public records and shall be exempt from public disclosure requirements.

''(2) RESTRICTIONS ON USES FOR CERTAIN PROCEEDINGS.—Data disclosed to authorized users shall not be subject to discovery or admission as public information, or evidence in judicial or administrative proceedings without consent of the affected parties.

''(j) DEFINITIONS.—

''(1) PROTECTED HEALTH INFORMATION.—The term 'protected health information' has the meaning given such term in section 160.103 of title 45, Code of Federal Regulations (or any successor regulations).

''(2) PROPRIETARY FINANCIAL INFORMATION.—The term 'proprietary financial information' means data that would disclose the terms of a specific contract between an individual health care provider or facility and a specific group health plan, Medicaid managed care organization or other managed care entity, or health insurance issuer offering group or individual coverage.

"(k) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to affect or modify enforcement of the privacy, security, or breach notification rules promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (or successor regulations).".

(b) GAO REPORT.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study on—

(A) the performance of the entity awarded a contract under section 735(a) of the Employee Retirement Income Security Act of 1974, as added by subsection (a), under such contract;

(B) the privacy and security of the information reported to the entity; and

(C) the costs incurred by such entity in performing such duties.

(2) REPORTS.—Not later than 2 years after the effective date of the first contract entered into under section 735(a) of the Employee Retirement Income Security Act of 1974, as added by subsection (a), and again not later than 4 years after such effective date, the Comptroller General of the United States shall submit to Congress a report containing the re-

sults of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(c) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 734 the following new item:

"Sec. 735. Designation of a nongovernmental, nonprofit transparency organization to lower Americans' health care costs.".

SEC. 304. PROTECTING PATIENTS AND IMPROVING THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

Subpart II of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-11 et seq.), as amended by sections 301 and 302, is further amended by adding at the end the following:

"SEC. 2729C. PROTECTING PATIENTS AND IMPROVING THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

"(a) PATIENT PROTECTIONS.—Beginning on the date that is one year after the date of enactment of this section, a group health plan or a health insurance issuer offering coverage in the individual or group market shall—

''(1) establish business processes to ensure that all enrollees in such plan or coverage receive proof of a health care provider's network status—

''(A) through a written electronic communication from the plan or issuer to the enrollee, not later than 24 hours after a telephone inquiry is made by such enrollee for such information; and

''(B) in real-time through an online health care provider directory search tool maintained by the plan or issuer; and

''(2) not apply cost-sharing to an enrollee for treatment or services provided by a health care provider in excess of the normal cost-sharing applied for in-network care (including any balance bill issued by the health care provider involved), if such enrollee, or health care provider referring such enrollee, can demonstrate (based on the electronic information described in paragraph (1)(A) or a copy of the online provider directory described in paragraph (1)(B) on the date the enrollee attempted to obtain the provider's network status) that the enrollee relied on the information described in this subsection, regardless of whether the provider's network status or di-

rectory information is incorrect, at the time the treatment or services involved was provided.

''(b) REFUNDS TO ENROLLEES.—If a health care provider submits a bill to an enrollee in violation of subsection (a)(2), and the enrollee pays such bill, the provider shall reimburse the enrollee for the full amount paid by the enrollee in excess of the in-network cost-sharing amount for the treatment or services involved, plus interest, at an interest rate determined by the Secretary.

''(c) ENFORCEMENT.—

''(1) IN GENERAL.—Subject to paragraph (2), a health care provider that violates a requirement under subsection (a) or (b) shall be subject to a civil monetary penalty of not more than $10,000 for each act constituting such violation.

''(2) SAFE HARBOR.—The Secretary may waive the penalty described under paragraph (1) with respect to a health care provider that unknowingly violates subsection (a) with respect to an enrollee if such provider rescinds the bill involved and, if applicable, reimburses the enrollee within 30 days of the date on which the provider billed the enrollee in violation of such subsection.

''(3) PROCEDURE.—The provisions of section 1128A of the Social Security Act, other than sub-

sections (a) and (b) and the first sentence of subsection (c)(1), shall apply to civil money penalties under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A of the Social Security Act.

''(d) BUSINESS PROCESSES.—Beginning on the date that is one year after the date of enactment of this section, a group health plan or a health insurance issuer offering coverage in the individual or group market shall establish business processes to—

''(1) verify and update, at least once every 90 days, an online, core set of health care provider directory information (as defined in subsection (e)) for all network providers; and

''(2) remove network providers from the online directory described in paragraph (1) if such providers have not verified the directory information within the previous 6 months.

''(e) PROVIDER DIRECTORY INFORMATION DEFINED.—For purposes of this section, the term 'provider directory information' shall include the names, addresses, specialty, and telephone numbers of individual health care providers, and the names, addresses, and telephone numbers of each medical group, clinic, or facility contracted

to participate in any of the networks of the group health plan or health insurance issuer involved.

''(f) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to preempt or limit any provision of State law relating to health care provider directories or network adequacy.''.

SEC. 305. TIMELY BILLS FOR PATIENTS.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

''SEC. 399V–7. TIMELY BILLS FOR PATIENTS.

''(a) IN GENERAL.—The Secretary shall require—

''(1) health care facilities and practitioners to provide to patients a list of services rendered during the visit to such facility or practitioner upon discharge; and

''(2) health care facilities and practitioners to send all bills to the patient within 30 business days.

''(b) PAYMENT AFTER BILLING.—No patient may be required to pay a bill for health care services any earlier than 30 business days after receipt of a bill for such services.

''(c) EFFECT OF VIOLATION.—

''(1) NOTIFICATION AND REFUND REQUIREMENTS.—If a facility or practitioner bills a patient

after the 30-business-day period described in subsection (a)(2), such facility or practitioner shall—

"(A) report such bill to the Secretary; and

"(B) refund the patient for the full amount paid in response to such bill with interest, at a rate determined by the Secretary.

"(2) CIVIL MONETARY PENALTIES.—

"(A) IN GENERAL.—The Secretary may impose civil monetary penalties of up to $10,000 a day on any facility or practitioner that submits more than 10 bills outside of the period described in subsection (a)(2), beginning on the date on which such facility or practitioner sends the tenth such bill.

"(B) PROCEDURE.—The provisions of section 1128A of the Social Security Act, other than subsections (a) and (b) and the first sentence of subsection (c)(1) of such section, shall apply to civil money penalties under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A of the Social Security Act.".

SEC. 306. HEALTH PLAN OVERSIGHT OF PHARMACY BENEFIT MANAGER SERVICES.

Subpart II of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–11 et seq.), as amended by section 304, is further amended by adding at the end the following:

"SEC. 2729D. HEALTH PLAN OVERSIGHT OF PHARMACY BENEFIT MANAGER SERVICES.

''(a) IN GENERAL.—A group health plan or health insurance issuer offering group or individual health insurance coverage or an entity or subsidiary providing pharmacy benefits management services shall not enter into a contract with a drug manufacturer, distributor, wholesaler, subcontractor, rebate aggregator, or any associated third party that limits the disclosure of information to plan sponsors in such a manner that prevents the plan or coverage, or an entity or subsidiary providing pharmacy benefits management services on behalf of a plan or coverage from making the reports described in subsection (b).

''(b) REPORTS TO GROUP PLAN SPONSORS.—

''(1) IN GENERAL.—Beginning with the first plan year that begins after the date of enactment of the Lower Health Care Costs Act, not less frequently than once per plan quarter, a health insurance issuer offering group health insurance coverage or an entity providing pharmacy benefits manage-

ment services on behalf of a group health plan shall submit to the plan sponsor (as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974) of such group health plan or health insurance coverage a report in accordance with this subsection, in a machine-readable format. Each such report shall include, with respect to the applicable group health plan or health insurance coverage—

"(A) a description of all formulary tiers and the utilization mechanisms (such as prior authorization or step therapy) employed for each therapeutic class within such tier; and

"(B) a list of each covered drug dispensed during the reporting period, including, with respect to each such drug during the reporting period—

"(i) the brand name, chemical entity, and National Drug Code;

"(ii) the number of enrollees for whom the drug was filled during the plan year, the total number of prescription fills for the drug (including original prescriptions and refills), and the total number of dosage units of the drug dispensed across

the plan year, including whether the dispensing channel was by retail, mail order, or specialty pharmacy;

"(iii) cost and price information, listed as cost per days supply and cost per pill, or in the case of a drug in another form, per dose, on the date of dispensing, including—

"(I) the list unit price;

"(II) the usual and customary cost; and

"(III) the net unit price (after all discounts, rebates, and fees tied to the list price or sales volume of the drug) paid by the plan or coverage;

"(iv) amount received from drug manufacturers in rebates due to be paid by drug manufacturers for claims incurred during the reporting period, fees, alternative discounts, and all other remuneration received from any third party related to utilization of that drug under such health plan or health insurance coverage;

"(v) the total net spending by the health plan or health insurance coverage on the drug;

"(vi) total gross spending by the health plan or health insurance coverage on the drug, before rebates and fees;

"(vii) the total out-of-pocket spending by enrollees, including copayments, coinsurance, and deductibles that are pending;

"(viii) amount paid to the coverage in rebates and fees;

"(ix) amounts paid directly or indirectly in rebates, fees, or any other type of remuneration to brokers, consultants, advisors, or any other individual or firm who referred the group health plan's or health insurance issuer's business to the pharmacy benefit manager; and

"(x) the total amount of copayment assistance dollars paid, or copayment cards applied, with respect to the drug that were funded by the drug manufacturer or other nongovernmental entities to reduce an enrollee's cost-sharing amount with respect to the drug;

"(C) for any drug on which the plan or issuer, with respect to the applicable health insurance coverage, spent more than $1,000 during the reporting period—

"(i) a list of all other drugs, including brand name drugs and biological products and the generic drugs or biosimilar biological products that are in the same therapeutic category or class of such brand name drugs or biological products;

"(ii) the formulary tier and utilization mechanism for each such potential substitute drug; and

"(iii) the list price on the date of dispensing for each such potential substitute drug, as reported in publically-available databases; and

"(D) the total net spending on prescription drugs by the health plan or health insurance coverage;

"(E) the total gross spending on prescription drugs, before rebates and fees, by the health plan or health insurance coverage; and

"(F) for a therapeutic class with more than one drug, the net spending and gross

spending, before rebates and fees, on drugs in such class.

''(2) PRIVACY REQUIREMENTS.—Health insurance issuers offering group health insurance coverage and entities providing pharmacy benefits management services on behalf of a group health plan shall provide information under paragraph (1) in a manner consistent with the privacy, security, and breach notification regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (or successor regulations), and shall restrict the use and disclosure of such information according to such privacy regulations.

''(3) DISCLOSURE AND REDISCLOSURE.—

''(A) LIMITATION TO BUSINESS ASSOCIATES.—A group health plan receiving a report under paragraph (1) may disclose such information only to business associates of such plan as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations).

''(B) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this section prevents a health insurance issuer offering group health insurance coverage or an

entity providing pharmacy benefits management services on behalf of a group health plan from placing reasonable restrictions on the public disclosure of the information contained in a report described in paragraph (1).

''(c) LIMITATIONS ON SPREAD PRICING.—

''(1) IN GENERAL.—A group health plan, a health insurance issuer offering group or individual health insurance coverage, or an entity providing pharmacy benefits management services under such health plan or health insurance coverage may not charge the group health plan, health insurance issuer, or enrollee a price for a prescription drug dispensed to an enrollee that exceeds the actual price paid by the group health plan or health insurance issuer to the pharmacy for the drug, including amounts paid by such plan, coverage, or entity and cost-sharing amounts paid directly by the enrollee, and excluding penalties paid by pharmacies to such plan, coverage, or entity.

''(2) LIMITATIONS ON SPREAD PRICING.—The price charged to a group health plan or health insurance issuer offering group or individual health insurance coverage for a prescription drug that is dispensed by a pharmacy that is wholly owned by the

group health plan, health insurance issuer, or the prescription benefits manager or other pharmacy benefits administrator of such plan or coverage, to an enrollee in the plan or coverage may not exceed the lesser of—

"(A) the wholesale acquisition cost of the drug paid by the pharmacy, plus clearly documented dispensing costs, including pharmacy profit; or

"(B) the price charged to the group health plan or health insurance issuer when the same drug is dispensed by another similarly-situated pharmacy not wholly owned by the group health plan, health insurance issuer, or the prescription benefits manager or other pharmacy benefits administrator of such plan or coverage.

"(d) FULL REBATE PASS-THROUGH TO PLAN.—

"(1) IN GENERAL.—A pharmacy benefits manager, a third-party administrator of a group health plan, a health insurance issuer offering group health insurance coverage, or an entity providing pharmacy benefits management services under such health plan or health insurance coverage shall remit 100 percent of rebates, fees, alternative discounts, and all other remuneration received from a pharma-

ceutical manufacturer, distributor or any other third party, that are related to utilization of drugs under such health plan or health insurance coverage, to the group health plan.

"(2) FORM AND MANNER OF REMITTANCE.—Such rebates, fees, alternative discounts, and other remuneration shall be—

"(A) remitted to the group health plan in a timely fashion after the period for which such rebates, fees, or other remuneration is calculated, and in no case later than 90 days after the end of such period;

"(B) fully disclosed and enumerated to the group health plan sponsor, as described in (b)(2)(D); and

"(C) available for audit by the plan sponsor, or a third-party designated by a plan sponsor no less than once per plan year.

"(e) ENFORCEMENT.—

"(1) FAILURE TO PROVIDE TIMELY INFORMATION.—A group health plan, a health insurance issuer offering group health insurance coverage, or an entity providing pharmacy benefit management services that violates subsection (a), fails to provide information required under subsection (b), engages

in spread pricing as defined in subsection (c), or fails to comply with the requirements of subsection (d) in a timely manner shall be subject to a civil monetary penalty in the amount of $10,000 for each day during which such violation continues or such information is not disclosed or reported.

''(2) FALSE INFORMATION.—An entity providing pharmacy benefit management services that knowingly provides false information under this section shall be subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information. Such civil money penalty shall be in addition to other penalties as may be prescribed by law.

''(3) PROCEDURE.—The provisions of section 1128A of the Social Security Act, other than subsection (a) and (b) and the first sentence of subsection (c)(1) of such section shall apply to civil monetary penalties under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A of the Social Security Act.

''(f) DEFINITIONS.—In this section—

''(1) the term 'similarly situated pharmacy' means, with respect to a particular pharmacy, an-

other pharmacy that is approximately the same size (as measured by the number of prescription drugs dispensed), and that serves patients in the same geographical area, whether through physical locations or mail order; and

''(2) the term 'wholesale acquisition cost' has the meaning given such term in sectionb1847A(c)(6)(B) of the Social Security Act.''.

SEC. 307. GOVERNMENT ACCOUNTABILITY OFFICE STUDY ON PROFIT- AND REVENUE-SHARING IN HEALTH CARE.

(a) STUDY.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall conduct a study to—

(1) describe what is known about profit- and revenue-sharing relationships in the commercial health care markets, including those relationships that—

(A) involve one or more—

(i) physician groups that practice within a hospital included in the profit- or revenue-sharing relationship, or refer patients to such hospital;

(ii) laboratory, radiology, or pharmacy services that are delivered to privately insured patients of such hospital;

(iii) surgical services; or

(iv) rehabilitation or physical therapy facilities or services; and

(B) include revenue- or profit-sharing whether through a joint venture, management or professional services agreement, or other form of gain-sharing contract;

(2) describe Federal oversight of such relationships, including authorities of the Department of Health and Human Services and the Federal Trade Commission to review such relationships and their potential to increase costs for patients, and identify limitations in such oversight; and

(3) as appropriate, make recommendations to improve Federal oversight of such relationships.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall prepare and submit a report on the study conducted under subsection (a) to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Education and Labor and Com-

mittee on Energy and Commerce of the House of Representatives.

SEC. 308. DISCLOSURE OF DIRECT AND INDIRECT COMPENSATION FOR BROKERS AND CONSULTANTS TO EMPLOYER-SPONSORED HEALTH PLANS AND ENROLLEES IN PLANS ON THE INDIVIDUAL MARKET.

(a) GROUP HEALTH PLANS.—Section 408(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1108(b)(2)) is amended—

(1) by striking ''(2) Contracting or making'' and inserting ''(2)(A) Contracting or making''; and

(2) by adding at the end the following:

''(B)(i) No contract or arrangement for services between a covered plan and a covered service provider, and no extension or renewal of such a contract or arrangement, is reasonable within the meaning of this paragraph unless the requirements of this clause are met.

''(ii)(I) For purposes of this subparagraph:

''(aa) The term 'covered plan' means a group health plan as defined section 733(a).

''(bb) The term 'covered service provider' means a service provider that enters into a contract or arrangement with the covered plan and

reasonably expects $1,000 (or such amount as the Secretary may establish in regulations to account for inflation since the date of enactment of the Lower Health Care Costs Act, as appropriate) or more in compensation, direct or indirect, to be received in connection with providing one or more of the following services, pursuant to the contract or arrangement, regardless of whether such services will be performed, or such compensation received, by the covered service provider, an affiliate, or a subcontractor:

''(AA) Brokerage services, for which the covered service provider, an affiliate, or a subcontractor reasonably expects to receive indirect compensation or direct compensation described in item (dd), provided to a covered plan with respect to selection of insurance products (including vision and dental), recordkeeping services, medical management vendor, benefits administration (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness services, transparency tools and vendors, group purchasing orga-

nization preferred vendor panels, disease management vendors and products, compliance services, employee assistance programs, or third party administration services.

''(BB) Consulting, for which the covered service provider, an affiliate, or a subcontractor reasonably expects to receive indirect compensation or direct compensation described in item (dd), related to the development or implementation of plan design, insurance or insurance product selection (including vision and dental), recordkeeping, medical management, benefits administration selection (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness design and management services, transparency tools, group purchasing organization agreements and services, participation in and services from preferred vendor panels, disease management, compliance services, employee assistance programs, or third party administration services.

"(cc) The term 'affiliate', with respect to a covered service provider, means an entity that directly or indirectly (through one or more intermediaries) controls, is controlled by, or is under common control with, such provider, or is an officer, director, or employee of, or partner in, such provider.

"(dd)(AA) The term 'compensation' means anything of monetary value, but does not include non-monetary compensation valued at $250 (or such amount as the Secretary may establish in regulations to account for inflation since the date of enactment of the Lower Health Care Costs Act, as appropriate) or less, in the aggregate, during the term of the contract or arrangement.

"(BB) The term 'direct compensation' means compensation received directly from a covered plan.

"(CC) The term 'indirect compensation' means compensation received from any source other than the covered plan, the plan sponsor, the covered service provider, or an affiliate. Compensation received from a subcontractor is indirect compensation, unless it is received in

connection with services performed under a contract or arrangement with a subcontractor.

"(ee) The term 'responsible plan fiduciary' means a fiduciary with authority to cause the covered plan to enter into, or extend or renew, the contract or arrangement.

"(ff) The term 'subcontractor' means any person or entity (or an affiliate of such person or entity) that is not an affiliate of the covered service provider and that, pursuant to a contract or arrangement with the covered service provider or an affiliate, reasonably expects to receive $1,000 (or such amount as the Secretary may establish in regulations to account for inflation since the date of enactment of the Lower Health Care Costs Act, as appropriate) or more in compensation for performing one or more services described in item (bb) under a contract or arrangement with the covered plan.

"(II) For purposes of this subparagraph, a description of compensation or cost may be expressed as a monetary amount, formula, or a per capita charge for each participant or beneficiary or, if the compensation or cost cannot reasonably be expressed in such terms, by any other reasonable method. The

description may include a reasonable and good faith estimate if the covered service provider cannot otherwise readily describe compensation or cost and the covered service provider explains the methodology and assumptions used to prepare such estimate. Any description shall contain sufficient information to permit evaluation of the reasonableness of the compensation or cost.

''(III) No person or entity is a 'covered service provider' within the meaning of subclause (I)(bb) solely on the basis of providing services as an affiliate or a subcontractor that is performing one or more of the services described in subitem (AA) or (BB) of such subclause under the contract or arrangement with the covered plan.

''(iii) A covered service provider shall disclose to a responsible plan fiduciary, in writing, the following:

''(I) A description of the services to be provided to the covered plan pursuant to the contract or arrangement.

''(II) If applicable, a statement that the covered service provider, an affiliate, or a subcontractor will provide, or reasonably expects to provide, services pursuant to the contract or ar-

rangement directly to the covered plan as a fiduciary (within the meaning of section 3(21)).

''(III) A description of all direct compensation, either in the aggregate or by service, that the covered service provider, an affiliate, or a subcontractor reasonably expects to receive in connection with the services described in subclause (I).

''(IV)(aa) A description of all indirect compensation that the covered service provider, an affiliate, or a subcontractor reasonably expects to receive in connection with the services described in subclause (I)—

''(AA) including compensation from a vendor to a brokerage firm based on a structure of incentives not solely related to the contract with the covered plan; and

''(BB) not including compensation received by an employee from an employer on account of work performed by the employee.

''(bb) A description of the arrangement between the payer and the covered service provider, an affiliate, or a subcontractor, as appli-

cable, pursuant to which such indirect compensation is paid.

"(cc) Identification of the services for which the indirect compensation will be received, if applicable.

"(dd) Identification of the payer of the indirect compensation.

"(V) A description of any compensation that will be paid among the covered service provider, an affiliate, or a subcontractor, in connection with the services described in subclause (I) if such compensation is set on a transaction basis (such as commissions, finder's fees, or other similar incentive compensation based on business placed or retained), including identification of the services for which such compensation will be paid and identification of the payers and recipients of such compensation (including the status of a payer or recipient as an affiliate or a subcontractor), regardless of whether such compensation also is disclosed pursuant to subclause (III) or (IV).

"(VI) A description of any compensation that the covered service provider, an affiliate, or a subcontractor reasonably expects to receive in

connection with termination of the contract or arrangement, and how any prepaid amounts will be calculated and refunded upon such termination.

''(iv) A covered service provider shall disclose to a responsible plan fiduciary, in writing a description of the manner in which the compensation described in clause (iii), as applicable, will be received.

''(v)(I) A covered service provider shall disclose the information required under clauses (iii) and (iv) to the responsible plan fiduciary not later than the date that is reasonably in advance of the date on which the contract or arrangement is entered into, and extended or renewed.

''(II) A covered service provider shall disclose any change to the information required under clause (iii) and (iv) as soon as practicable, but not later than 60 days from the date on which the covered service provider is informed of such change, unless such disclosure is precluded due to extraordinary circumstances beyond the covered service provider's control, in which case the information shall be disclosed as soon as practicable.

''(vi)(I) Upon the written request of the responsible plan fiduciary or covered plan administrator, a

covered service provider shall furnish any other information relating to the compensation received in connection with the contract or arrangement that is required for the covered plan to comply with the reporting and disclosure requirements under this Act.

''(II) The covered service provider shall disclose the information required under clause (iii)(I) reasonably in advance of the date upon which such responsible plan fiduciary or covered plan administrator states that it is required to comply with the applicable reporting or disclosure requirement, unless such disclosure is precluded due to extraordinary circumstances beyond the covered service provider's control, in which case the information shall be disclosed as soon as practicable.

''(vii) No contract or arrangement will fail to be reasonable under this subparagraph solely because the covered service provider, acting in good faith and with reasonable diligence, makes an error or omission in disclosing the information required pursuant to clause (iii) (or a change to such information disclosed pursuant to clause (v)(II)) or clause (vi), provided that the covered service provider discloses the correct information to the responsible plan fiduciary as soon as practicable, but not later than 30 days

from the date on which the covered service provider knows of such error or omission.

"(viii)(I) Pursuant to subsection (a), subparagraphs (C) and (D) of section 406(a)(1) shall not apply to a responsible plan fiduciary, notwithstanding any failure by a covered service provider to disclose information required under clause (iii), if the following conditions are met:

"(aa) The responsible plan fiduciary did not know that the covered service provider failed or would fail to make required disclosures and reasonably believed that the covered service provider disclosed the information required to be disclosed.

"(bb) The responsible plan fiduciary, upon discovering that the covered service provider failed to disclose the required information, requests in writing that the covered service provider furnish such information.

"(cc) If the covered service provider fails to comply with a written request described in subclause (II) within 90 days of the request, the responsible plan fiduciary notifies the Secretary of the covered service provider's failure, in accordance with subclauses (II) and (III).

"(II) A notice described in subclause (I)(cc) shall contain—

"(aa) the name of the covered plan;

"(bb) the plan number used for the annual report on the covered plan;

"(cc) the plan sponsor's name, address, and employer identification number;

"(dd) the name, address, and telephone number of the responsible plan fiduciary;

"(ee) the name, address, phone number, and, if known, employer identification number of the covered service provider;

"(ff) a description of the services provided to the covered plan;

"(gg) a description of the information that the covered service provider failed to disclose;

"(hh) the date on which such information was requested in writing from the covered service provider; and

"(ii) a statement as to whether the covered service provider continues to provide services to the plan.

"(III) A notice described in subclause (I)(cc) shall be filed with the Department not later than 30 days following the earlier of—

''(aa) The covered service provider's refusal to furnish the information requested by the written request described in subclause (I)(bb); or

''(bb) 90 days after the written request referred to in subclause (I)(cc) is made.

''(IV) If the covered service provider fails to comply with the written request under subclause (I)(bb) within 90 days of such request, the responsible plan fiduciary shall determine whether to terminate or continue the contract or arrangement under section 404. If the requested information relates to future services and is not disclosed promptly after the end of the 90-day period, the responsible plan fiduciary shall terminate the contract or arrangement as expeditiously as possible, consistent with such duty of prudence.

''(ix) Nothing in this subparagraph shall be construed to supersede any provision of State law that governs disclosures by parties that provide the services described in this section, except to the extent that such law prevents the application of a requirement of this section.''.

(b) APPLICABILITY OF EXISTING REGULATIONS.—Nothing in the amendments made by subsection (a) shall

be construed to affect the applicability of section 2550.408b–2 of title 29, Code of Federal Regulations (or any successor regulations/as in effect on the date of enactment of this Act), with respect to any applicable entity other than a covered plan or a covered service provider (as defined in section 408(b)(2)(B)(ii) of the Employee Retirement Income Security Act of 1974, as amended by subsection (a)).

(c) INDIVIDUAL MARKET COVERAGE.—Subpart 1 of part B of title XVII of the Public Health Service Act (42 U.S.C. 300gg–41 et seq.) is amended by adding at the end the following:

"SEC. 2746. DISCLOSURE TO ENROLLEES OF INDIVIDUAL MARKET COVERAGE.

"(a) IN GENERAL.—A health insurance issuer offering individual health insurance coverage shall make disclosures to enrollees in such coverage, as described in subsection (b), and reports to the Secretary, as described in subsection (c), regarding direct or indirect compensation provided to an agent or broker associated with enrolling individuals in such coverage.

"(b) DISCLOSURE.—A health insurance issuer described in subsection (a) shall disclose to an enrollee the amount of direct or indirect compensation provided to an agent or broker for services provided by such agent or

broker associated with plan selection and enrollment. Such disclosure shall be—

''(1) made prior to the individual finalizing plan selection; and

''(2) included on any documentation confirming the individual's enrollment.

''(c) REPORTING.—A health insurance issuer described in subsection (a) shall report to the Secretary any direct or indirect compensation provided to an agent or broker associated with enrolling individuals in such coverage.

''(d) RULEMAKING.—Not later than 1 year after the date of enactment of the Lower Health Care Costs Act, the Secretary shall finalize, through notice-and-comment rulemaking, the form and manner in which issuers described in subsection (a) are required to make the disclosures described in subsection (b) and the reports described in subsection (c).''.

(d) TRANSITION RULE.—No contract executed prior to the effective date described in subsection (e) by a group health plan subject to the requirements of section 408(b)(2)(B) of the Employee Retirement Income Security Act of 1974 (as amended by subsection (a)) or by a health insurance issuer subject to the requirements of section 2746 of the Public Health Service Act (as added

by subsection (c)) shall be subject to the requirements of such section 408(b)(2)(B) or such section 2746, as applicable.

(e) EFFECTIVE DATE.—The amendments made by subsections (a) and (c) shall take effect 2 years after the date of enactment of this Act.

SEC. 309. ENSURING ENROLLEE ACCESS TO COST-SHARING INFORMATION.

(a) IN GENERAL.—Subpart II of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–11 et seq.), as amended by section 306, is further amended by adding at the end the following:

"SEC. 2729E. PROVISION OF COST-SHARING INFORMATION.

''(a) PROVIDER DISCLOSURES.—A group health plan or a health insurance issuer offering group or individual health insurance coverage shall not contract with a provider with respect to the plan or coverage unless the provider agrees to provide, at the time of scheduling a service or not later than 48 hours of the enrollee requesting such information, an enrollee in the plan or coverage with the expected enrollee cost-sharing for the provision of a particular health care service (including any service that is reasonably expected to be provided in conjunction with such specific service).

''(b) INSURER DISCLOSURES.—A group health plan or a health insurance issuer offering group or individual health insurance coverage shall provide an enrollee in the plan or coverage with a good faith estimate of the enrollee's cost-sharing (including deductibles, copayments, and coinsurance) for which the enrollee would be responsible for paying with respect to a specific health care service (including any service that is reasonably expected to be provided in conjunction with such specific service), not later than 48 hours after receiving a request for such information by an enrollee.''.

(b) EFFECTIVE DATE.—Section 2729E of the Public Health Service Act, as added by subsection (a), shall apply with respect to plan years beginning on or after January 1, 2020.

TITLE IV—IMPROVING PUBLIC HEALTH

SEC. 401. IMPROVING AWARENESS OF DISEASE PREVENTION.

The Public Health Service Act is amended by striking section 313 of such Act (42 U.S.C. 245) and inserting the following:

"SEC. 313. PUBLIC AWARENESS CAMPAIGN ON THE IMPORTANCE OF VACCINATIONS.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in coordination with other offices and agencies, as appropriate, shall award competitive grants to one or more public or private entities to carry out a national, evidence-based campaign to increase awareness of vaccines for the prevention and control of diseases, combat misinformation about vaccines, and disseminate scientific and evidence-based vaccine-related information, with the goal of increasing rates of vaccination across all ages, as applicable, particularly in communities with low rates of vaccination.

''(b) CONSULTATION.—In carrying out the campaign under this section, the Secretary shall consult with appropriate public health and medical experts, including the National Academy of Medicine and medical and public health associations and nonprofit organizations, in the development, implementation, and evaluation of the evidence-based public awareness campaign.

''(c) REQUIREMENTS.—The campaign under this section—

''(1) shall be a national, evidence-based initiative;

''(2) may include the use of television, radio, the internet, and other telecommunications technologies;

''(3) may be focused to address specific needs of communities with low rates of vaccination;

''(4) shall include the development of resources for communities with low rates of vaccination, including culturally- and linguistically-appropriate resources, as applicable;

''(5) shall include the dissemination of vaccine information and communication resources to health care providers and health care facilities, including such providers and facilities that provide prenatal and pediatric care;

''(6) shall be complementary to, and coordinated with, any other Federal efforts and State efforts, as appropriate;

''(7) shall assess the effectiveness of communication strategies to increase rates of vaccination; and

''(8) may include the dissemination of scientific and evidence-based vaccine-related information, such as—

''(A) advancements in evidence-based research related to diseases that may be prevented by vaccines and vaccine development;

''(B) information on vaccinations for individuals and communities, including individuals for whom vaccines are not recommended by the Advisory Committee for Immunization Practices, and the effects of low vaccination rates within a community on such individuals;

''(C) information on diseases that may be prevented by vaccines; and

''(D) information on vaccine safety and the systems in place to monitor vaccine safety.

''(d) EVALUATION.—The Secretary shall—

''(1) establish benchmarks and metrics to quantitatively measure and evaluate the awareness campaign under this section;

''(2) conduct qualitative assessments regarding the awareness campaign under this section; and

''(3) prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and Committee on Energy and Commerce of the House of Representatives an evaluation of the awareness campaign under this section.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section and section 317(k) such sums as may be necessary for fiscal years 2020 through 2024.''.

SEC. 402. GRANTS TO ADDRESS VACCINE-PREVENTABLE DISEASES.

Section 317(k)(1) of the Public Health Service Act (42 U.S.C. 247b(k)(1)) is amended—

(1) in subparagraph (C), by striking ''; and'' and inserting a semicolon;

(2) in subparagraph (D), by striking the period and inserting a semicolon; and

(3) by adding at the end the following:

''(E) planning, implementation, and evaluation of activities to address vaccine-preventable diseases, including activities to—

''(i) identify communities at high risk of outbreaks related to vaccine-preventable diseases;

''(ii) pilot innovative approaches to improve vaccination rates in communities with low rates of vaccination;

''(iii) reduce barriers to accessing vaccines and evidence-based information about the health effects of vaccines;

''(iv) partner with community organizations and health care providers to develop and deliver evidence-based interventions to increase vaccination rates; and

''(v) improve delivery of evidence-based vaccine-related information to parents and others; and

''(F) research related to strategies for improving awareness of scientific and evidence-based vaccine-related information, including for communities with low rates of vaccination, in order to understand barriers to vaccination, improve vaccination rates, and assess the public health outcomes of such strategies.''.

SEC. 403. GUIDE ON EVIDENCE-BASED STRATEGIES FOR STATE HEALTH DEPARTMENT OBESITY PREVENTION PROGRAMS.

(a) DEVELOPMENT AND DISSEMINATION OF AN EVIDENCE-BASED STRATEGIES GUIDE.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the Centers for Disease Control and Prevention, not later than 2 years after the date of enactment of this Act, shall—

(1) develop a guide on evidence-based strategies for State and local health departments, Indian

Tribes, and Tribal organizations to use to build and maintain effective obesity prevention and control programs, which shall—

(A) describe an integrated program structure for implementing interventions proven to be effective in preventing, controlling, and reducing obesity; and

(B) recommend—

(i) optimal resources, including staffing and infrastructure, for promoting nutrition and obesity prevention, control and reduction; and

(ii) strategies for effective obesity prevention programs for State and local health departments, Indian Tribes, and Tribal organizations, including strategies related to—

(I) the application of evidence-based practices to prevent, control, and reduce obesity rates;

(II) demonstrated knowledge of obesity prevention practices that reduce associated preventable diseases, health conditions, death, and health care costs; and

(III) interdisciplinary coordination between relevant public health officials specializing in fields such as nutrition, physical activity, epidemiology, communications, and policy implementation; and

(2) disseminate the guide and current research, evidence-based practices, tools, and educational materials related to obesity prevention, consistent with the guide, to State and local health departments, Indian Tribes, and Tribal organizations.

(b) TECHNICAL ASSISTANCE.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall provide technical assistance to State and local health departments, Indian Tribes, and Tribal organizations to support such health departments in implementing the guide developed under subsection (a)(1).

(c) INDIAN TRIBES; TRIBAL ORGANIZATIONS.—The terms ''Indian Tribe'' and ''Tribal organization'' have the meanings given the terms ''Indian tribe'' and ''tribal organization'', respectively, in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304).

SEC. 404. EXPANDING CAPACITY FOR HEALTH OUTCOMES.

Title III of the Public Health Service Act is amended by inserting after section 330M (42 U.S.C. 254c–19) the following:

"SEC. 330N. EXPANDING CAPACITY FOR HEALTH OUTCOMES.

''(a) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means an entity providing health care services in rural areas, frontier areas, health professional shortage areas, or medically underserved areas, or to medically underserved populations or Native Americans, including Indian tribes or tribal organizations.

''(2) HEALTH PROFESSIONAL SHORTAGE AREA.—The term 'health professional shortage area' means a health professional shortage area designated under section 332.

''(3) INDIAN TRIBE.—The terms 'Indian tribe' and 'tribal organization' have the meanings given such terms in section 4 of the Indian Self-Determination and Education Assistance Act.

''(4) MEDICALLY UNDERSERVED POPULATION.—The term 'medically underserved population' has the meaning given the term in section 330(b)(3).

''(5) NATIVE AMERICANS.—The term 'Native Americans' has the meaning given such term in section 736 and includes Indian tribes and tribal organizations.

''(6) TECHNOLOGY-ENABLED COLLABORATIVE LEARNING AND CAPACITY BUILDING MODEL.—The term 'technology-enabled collaborative learning and capacity building model' means a distance health education model that connects specialists with multiple other health care professionals through simultaneous interactive videoconferencing for the purpose of facilitating case-based learning, disseminating best practices, and evaluating outcomes.

''(b) PROGRAM ESTABLISHED.—The Secretary shall, as appropriate, award grants to evaluate, develop, and, as appropriate, expand the use of technology-enabled collaborative learning and capacity building models, to increase access to health care services, such as those to address chronic diseases and conditions, mental health, substance use disorders, prenatal and maternal health, pediatric care, pain management, palliative care, and other specialty care in medically underserved areas and for medically underserved populations.

''(c) USE OF FUNDS.—Grants awarded under subsection (b) shall, as appropriate, be used for—

''(1) equipment to support the use and expansion of technology-enabled collaborative learning and capacity building models, including for hardware and software that enables distance learning, health care provider support, and the secure exchange of electronic health information;

''(2) support for health care providers and other professionals that provide or assist in the provision of services through such models;

''(3) the development and acquisition of instructional programming, and the training of health care providers and other professionals that provide or assist in the provision of services through such models;

''(4) information collection and evaluation activities to study the impact of such models on patient outcomes and health care providers, and to identify best practices for the expansion and use of such models; and

''(5) other activities consistent with achieving the objectives of the grants awarded under this section, as determined by the Secretary.

''(d) LENGTH OF GRANTS.—Grants awarded under subsection (b) shall be for a period of up to 5 years.

''(e) APPLICATION.—An eligible entity that seeks to receive a grant under subsection (b) shall submit to the

Secretary an application, at such time, in such manner, and containing such information as the Secretary may require. Such application criteria shall include an evaluation of patient outcomes and health care providers resulting from technology-enabled collaborative learning and capacity building models.

''(f) TECHNICAL ASSISTANCE.—The Secretary shall provide (either directly through the Department of Health and Human Services or by contract) technical assistance to eligible entities, including recipients of grants under subsection (b), on the development, use, and evaluation of technology-enabled collaborative learning and capacity building models in order to expand access to health care services provided by such entities, including for medically underserved areas and to medically underserved populations.

''(g) REPORT BY SECRETARY.—Not later than 4 years after the date of enactment of this section, the Secretary shall prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives, and post on the Internet website of the Department of Health and Human Services, a report including, at minimum—

''(1) a description of any new and continuing grants awarded to entities under subsection (b) and the specific purpose and amounts of such grants;

''(2) an overview of—

''(A) the evaluations conducted under subsections (b) or (f); and

''(B) technical assistance provided under subsection (f); and

''(3) a description of any significant findings or developments in patient outcomes and health care providers and best practices for eligible entities expanding, using, or evaluating technology-enabled collaborative learning and capacity building models.

''(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2020 through 2024.''.

SEC. 405. PUBLIC HEALTH DATA SYSTEM MODERNIZATION.

Subtitle C of title XXVIII of the Public Health Service Act (42 U.S.C. 300hh–31 et seq.) is amended by adding at the end the following:

"SEC. 2822. PUBLIC HEALTH DATA SYSTEM MODERNIZATION GRANTS.

"(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall—

"(1) award grants to State, local, Tribal, and territorial public health departments for the expansion and modernization of public health data systems, to assist public health departments in—

"(A) improving secure public health data collection, transmission, exchange, maintenance, and analysis;

"(B) simplifying reporting by health care providers, as applicable, pursuant to State law, including through the use of health information technology, to State, local, Tribal, and territorial public health departments, including public health officials in multiple jurisdictions within such State, as appropriate;

"(C) enhancing interoperability of current public health data systems with health information technology, including certified health information technology;

"(D) supporting earlier disease and health condition detection for public health responses; and

''(E) supporting activities within the applicable jurisdiction related to the expansion and modernization of electronic case reporting;

''(2) conduct activities related to the interoperability and improvement of applicable public health data systems used by the Centers for Disease Control and Prevention, as appropriate; and

''(3) develop and utilize public-private partnerships for technical assistance and related implementation support for State, local, Tribal, and territorial public health departments, and the Centers for Disease Control and Prevention, on the expansion and modernization of electronic case reporting and public health data systems, as applicable.

''(b) REQUIREMENTS.—

''(1) IN GENERAL.—The Secretary may not award a grant under subsection (a)(1) unless the applicant supports standards endorsed by the National Coordinator for Health Information Technology pursuant to section 3001(c)(1) or adopted by the Secretary under section 3004.

''(2) WAIVER.—The Secretary may waive the requirement under paragraph (1) with respect to an applicant if the Secretary determines that the activi-

ties under subsection (a) cannot otherwise be carried out within the applicable jurisdiction.

''(c) USE OF FUNDS.—An entity receiving a grant under this section may use amounts received under such grant for one or both of the following:

''(1) Carrying out activities described in subsection (a)(1) to support public health data systems (including electronic case reporting), which may include support for, and training of, professionals with expertise in contributing to and using such systems.

''(2) Developing and disseminating information related to the use and importance of public health data.

''(d) STRATEGY AND IMPLEMENTATION PLAN.—Not later than 180 days after the date of enactment of the Lower Health Care Costs Act, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives, a coordinated strategy and an accompanying implementation plan that identifies and demonstrates the steps the Secretary will carry out to—

''(1) update and improve applicable public health data systems used by the Centers for Disease Control and Prevention; and

''(2) carry out the activities described in this section to support the improvement of State, local, Tribal, and territorial public health data systems.

''(e) CONSULTATION.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall consult with State, local, Tribal, and territorial health departments, professional medical and public health associations, health information technology experts, and other appropriate entities regarding the plan and grant program to modernize public health data systems pursuant to this section. Such activities may include the provision of technical assistance related to the exchange of information by such public health data systems used by relevant health care and public health entities at the local, State, Federal, Tribal, and territorial levels.

''(f) REPORT TO CONGRESS.—Not later than 1 year after the date of enactment of this section, the Secretary shall submit a report to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives that includes—

''(1) a description of any barriers to—

''(A) public health authorities implementing electronic case reporting and interoperable public health data systems; or

''(B) the exchange of information pursuant to electronic case reporting;

''(2) an assessment of the potential public health impact of implementing electronic case reporting and interoperable public health data systems; and

''(3) a description of the activities carried out pursuant to this section.

''(g) ELECTRONIC CASE REPORTING.—In this section, the term 'electronic case reporting' means the automated identification, generation, and bilateral exchange of reports of health events among electronic health record or health information technology systems and public health authorities.

''(h) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2020 through 2024.''.

SEC. 406. INNOVATION FOR MATERNAL HEALTH.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), in consultation with experts representing a vari-

ety of clinical specialties, State, tribal, or local public health officials, researchers, epidemiologists, statisticians, and community organizations, shall establish a program to award competitive grants to eligible entities for the purpose of—

(1) identifying, developing, or disseminating best practices to improve maternal health care quality and eliminate preventable maternal mortality and severe maternal morbidity, which may include—

(A) information on evidence-based practices to improve the quality and safety of maternity care in hospitals and other health care settings of a State or health care system, including by addressing topics commonly associated with health complications or risks related to prenatal care, labor care, birthing, and postpartum care;

(B) best practices for improving maternity care based on data findings and reviews conducted by a State maternal mortality review committee that address topics of relevance to common complications or health risks related to prenatal care, labor care, birthing, and postpartum care;

(2) collaborating with State maternal mortality review committees to identify issues for the development and implementation of evidence-based practices to improve maternal health outcomes and reduce preventable maternal mortality and severe maternal morbidity; and

(3) providing technical assistance and supporting the implementation of best practices identified in paragraph (1) to entities providing health care services to pregnant and postpartum women.

(b) ELIGIBLE ENTITIES.—To be eligible for a grant under subsection (a), an entity shall—

(1) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require; and

(2) demonstrate in such application that the entity has a demonstrated expertise in data-driven maternal safety and quality improvement initiatives in the areas of obstetrics and gynecology or maternal health.

(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2020 through 2024.

SEC. 407. TRAINING FOR HEALTH CARE PROVIDERS.

Title VII of the Public Health Service Act is amended by striking section 763 (42 U.S.C. 294p) and inserting the following:

"SEC. 763. TRAINING FOR HEALTH CARE PROVIDERS.

''(a) GRANT PROGRAM.—The Secretary shall establish a program to award grants to accredited schools of allopathic medicine, osteopathic medicine, and nursing, and other health professional training programs for the training of health care professionals to reduce and prevent discrimination (including training related to implicit biases) in the provision of health care services related to prenatal care, labor care, birthing, and postpartum care.

''(b) ELIGIBILITY.—To be eligible for a grant under subsection (a), an entity described in such subsection shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2020 through 2024.''.

SEC. 408. STUDY ON TRAINING TO REDUCE AND PREVENT DISCRIMINATION.

Not later than 2 years after date of enactment of this Act, the Secretary of Health and Human Services (re-

ferred to in this section as the ''Secretary'') shall, through a contract with an independent research organization, study and make recommendations for accredited schools of allopathic medicine, osteopathic medicine, and nursing, and other health professional training programs on best practices related to training to reduce and prevent discrimination, including training related to implicit biases, in the provision of health care services related to prenatal care, labor care, birthing, and postpartum care.

SEC. 409. PERINATAL QUALITY COLLABORATIVES.

Section 317K(a)(2) of the Public Health Service Act (42 U.S.C. 247b–12(a)(2)) is amended by adding at the end the following:

''(E)(i) The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in coordination with other offices and agencies, as appropriate, shall establish or continue a competitive grant program for the establishment or support of perinatal quality collaboratives to improve perinatal care and perinatal health outcomes for pregnant and postpartum women and their infants. A State may use funds received through such grant to—

''(I) support the use of evidence-based or evidence-informed practices to improve outcomes for maternal and infant health;

''(II) work with hospital-based or outpatient facility-based clinical teams, experts, and stakeholders, including patients and families, to identify, develop, or disseminate best practices to improve perinatal care and outcomes; and

''(III) employ strategies that provide opportunities for health care professionals and clinical teams to collaborate across health care settings to improve maternal and infant health outcomes, which may include the use of data to provide timely feedback across hospital and clinical teams to inform responses, and to provide support and training to hospital and clinical teams for quality improvement, as appropriate.

''(ii) To be eligible for a grant under clause (i), an entity shall submit to the Secretary an application in such form and manner and containing such information as the Secretary may require.''.

SEC. 410. INTEGRATED SERVICES FOR PREGNANT AND POSTPARTUM WOMEN.

(a) GRANTS.—Title III of the Public Health Service Act is amended by inserting after section 330N of such Act, as added by section 404, the following:

"SEC. 330O. INTEGRATED SERVICES FOR PREGNANT AND POSTPARTUM WOMEN.

''(a) IN GENERAL.—The Secretary may award grants to States for the purpose of establishing or operating evidence-based or innovative, evidence-informed programs to deliver integrated health care services to pregnant and postpartum women, including, as appropriate, by addressing issues researched under subsection (b)(2) of section 317K, and to reduce adverse maternal health outcomes, pregnancy-related deaths, and related health disparities, including such disparities associated with racial and ethnic minority populations.

''(b) INTEGRATED SERVICES FOR PREGNANT AND POSTPARTUM WOMEN.—

''(1) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), a State shall work with relevant stakeholders that coordinate care (including coordinating resources and referrals for health care and social services) to develop and carry out the program, including—

''(A) State, tribal, and local agencies responsible for Medicaid, public health, social services, mental health, and substance use disorder treatment and services;

''(B) health care providers who serve pregnant women; and

''(C) community-based health organizations and health workers, including individuals representing communities with disproportionately high rates of maternal mortality and severe maternal morbidity, and including those representing racial and ethnicity minority populations.

''(2) TERMS.—

''(A) LIMITATION.—The Secretary may award a grant under subsection (a) to up to 10 States.

''(B) PERIOD.—A grant awarded under subsection (a) shall be made for a period of 5 years.

''(C) PRIORITIZATION.—In awarding grants under subsection (a), the Secretary shall prioritize applications from States with the highest rates of maternal mortality and severe maternal morbidity, and shall consider health

disparities related to maternal mortality and severe maternal morbidity, including such disparities associated with racial and ethnic minority populations.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2020 through 2024.''.

(b) REPORT ON GRANT OUTCOMES AND DISSEMINATION OF BEST PRACTICES.—

(1) REPORT.—Not later than April 1, 2025, the Secretary of Health and Human Services shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that describes—

(A) the outcomes of the activities supported by the grants awarded under the amendments made by this section on maternal and child health;

(B) best practices and models of care used by recipients of grants under such amendments; and

(C) obstacles identified by recipients of grants under such amendments, and strategies

used by such recipients to deliver care, improve maternal and child health, and reduce health disparities.

(2) DISSEMINATION OF BEST PRACTICES.—Not later than October 1, 2025, the Secretary of Health and Human Services shall disseminate information on best practices and models of care used by recipients of grants under the amendments made by this section (including best practices and models of care relating to the reduction of health disparities, including such disparities associated with racial and ethnic minority populations, in rates of maternal mortality and severe maternal morbidity) to relevant stakeholders, which may include health providers, medical schools, nursing schools, relevant State, tribal, and local agencies, and the general public.

TITLE V—IMPROVING THE EXCHANGE OF HEALTH INFORMATION

SEC. 501. REQUIREMENT TO PROVIDE HEALTH CLAIMS, NETWORK, AND COST INFORMATION.

(a) IN GENERAL.—Part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended by inserting after section 2715A the following:

"SEC. 2715B. REQUIREMENT TO PROVIDE HEALTH CLAIMS, NETWORK, AND COST INFORMATION.

"(a) IN GENERAL.—A group health plan or a health insurance issuer offering group or individual health insurance coverage shall make available for access, exchange, or use without special effort, through application programming interfaces (or successor technology or standards), the information described in subsection (b), in the manner described in subsection (b) and otherwise consistent with this section.

"(b) INFORMATION.—The following information is required to be made available, in such form and manner as the Secretary may specify, as described in subsection (a):

"(1) Historical claims, provider encounter, and payment data for each enrollee, which shall—

"(A) include adjudicated medical and prescription drug claims and equivalent encounters, including all data elements contained in such transactions—

"(i) that were adjudicated by the group health plan or health insurance issuer during the previous 5 years or the enrollee's entire period of enrollment in the applicable plan or coverage if such period is less than 5 years;

''(ii) that involve benefits managed by any third party, such as a pharmacy benefits manager or radiology benefits manager that manages benefits or adjudicates claims on behalf of the plan or coverage; and

''(iii) from any other health plan or health insurance coverage issued or administered by the same insurance issuer, in which the same enrollee was enrolled during the previous 5 years; and

''(B) be available—

''(i) in a single, longitudinal format that is easy to understand and secure, and that may update automatically, including by using the standards adopted for implementation of section 3001(c)(5)(D)(iv);

''(ii) not later than 3 days after the claim is adjudicated or the data is received by the health plan or health insurance issuer; and

''(iii) to the enrollee, and any providers or third-party applications or services authorized by the enrollee, for 5 years after the end date of the enrollee's enroll-

ment in the plan or in any coverage offered by the health insurance issuer.

''(2) Identifying directory information for all in-network providers, including facilities and practitioners, that participate in the plan or coverage, which shall—

''(A) include—

''(i) the national provider identifier for in-network facilities and practitioners; and

''(ii) the name, address, phone number, and specialty for each such facility and practitioner, based on the most recent interaction between the plan or coverage and that facility or practitioner;

''(B) be capable of returning a list of participating in-network facilities and practitioners, in a given specialty or at a particular facility type, within a specified geographic radius; and

''(C) be capable of returning the network status, when presented with identifiers for a given enrollee and facility or practitioner.

''(3) Estimated patient out-of-pocket costs, including costs expected to be incurred through a de-

ductible, co-payment, coinsurance, or other form of cost-sharing, for—

"(A) a designated set of common services or episodes of care, to be established by the Secretary through rulemaking, including, at a minimum—

"(i) in the case of services provided by a hospital, the 100 most common diagnosis-related groups, as used in the Medicare Inpatient Prospective Patient System (or successor episode-based reimbursement methodology) at that hospital, based on claims data adjudicated by the group health plan or health insurance issuer;

"(ii) in the case of services provided in an out-patient setting, including radiology, lab tests, and out-patient surgical procedures, any service rendered by the facility or practitioner, and reimbursed by the health plan or health insurance issuer; and

"(iii) in the case of post-acute care, including home health providers, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals, the

patient out-of-pocket costs for an episode of care, as the Secretary may determine, which permits users to reasonably compare costs across different facility and service types; and

''(B) all prescription drugs currently included on any tier of the formulary of the plan or coverage.

''(c) AVAILABILITY AND ACCESS.—The application programming interfaces, including all data required to be made available through such interfaces, shall—

''(1) be made available by the applicable group health plan or health insurance issuer, at no charge, to—

''(A) enrollees in the group health plan or health insurance coverage;

''(B) third parties authorized by the enrollee;

''(C) facilities and practitioners who are under contract with the plan or coverage; and

''(D) business associates of such facilities and practitioners, as defined in section 160.103 of title 45, Code of Federal Regulations (or any successor regulations);

''(2) be available to enrollees in the group health plan or health insurance coverage, and to third-party applications or services facilitating such access by enrollees, during the enrollment process and for a minimum of 5 years after the end date of the enrollee's enrollment in the plan or in any coverage offered by the health insurance issuer;

''(3) permit persistent access by authenticated third party applications or services for a reasonable period of time, consistent with current security practices;

''(4) employ the applicable content, vocabulary, and technical standards, including, as appropriate, such standards adopted by the Secretary pursuant to title XXX; and

''(5) employ security and authentication standards, as the Secretary determines appropriate.

''(d) RULE OF CONSTRUCTION REGARDING PRIVACY.—Nothing in this section shall be construed to alter existing obligations under the privacy, security, and breach notification rules promulgated under section 264(c) of the Health Insurance Portability and Accountability Act (or successor regulations), or under State privacy law.''.

(b) EFFECTIVE DATE.—Section 2715B of the Public Health Service Act, as added by subsection (a), shall take effect 1 year after the date of enactment of this Act.

SEC. 502. RECOGNITION OF SECURITY PRACTICES.

Part 1 of subtitle D of the Health Information Technology for Economic and Clinical Health Act (42 U.S.C. 17931 et seq.) is amended by adding at the end the following:

"SEC. 13412. RECOGNITION OF SECURITY PRACTICES.

''(a) IN GENERAL.—Consistent with the authority of the Secretary under sections 1176 and 1177 of the Social Security Act, when making determinations relating to fines under section 13410, decreasing the length and extent of an audit under section 13411, or remedies otherwise agreed to by the Secretary, the Secretary shall consider whether the entity or business associate had, for not less than the previous 12 months, recognized security practices in place that may—

''(1) mitigate fines under section 13410;

''(2) result in the early, favorable termination of an audit under section 13411; and

''(3) limit the remedies that would otherwise be agreed to in any agreement between the entity or business associate and the Department of Health and Human Services.

''(b) ADDITIONAL CONSIDERATION.—At the election of the entity or business associate, the Secretary may provide further consideration to an entity or business associate that can adequately demonstrate that such recognized security practices were in place, as determined by the Secretary.

''(c) DEFINITION AND MISCELLANEOUS PROVISIONS.—

''(1) RECOGNIZED SECURITY PRACTICES.—The term 'recognized security practices' means the standards, guidelines, best practices, methodologies, procedures, and processes developed under section 2(c)(15) of the National Institute of Standards and Technology Act, the approaches promulgated under section 405(d) of the Cybersecurity Information Sharing Act of 2015, and any other program or processes that are equivalent to such requirements as may be developed through regulations. Such practices shall be determined by the entity or business associate, except where additional consideration is requested under subsection (b).

''(2) LIMITATION.—Nothing in this section shall be construed as providing the Secretary authority to—

''(A) increase fines under section 13410, or the length, extent or quantity of audits under section 13411, due to a lack of compliance with the recognized security practices; or

''(B) mandate, direct, or condition the award of any Federal grant, contract, or purchase, on compliance with such recognized security practices.

''(3) NO LIABILITY FOR NONPARTICIPATION.—Nothing in this section shall be construed to subject an entity or business associate to liability for electing not to engage in the recognized security practices defined by this section.

''(4) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to limit the Secretary's authority to enforce the HIPAA Security rule (part 160 of title 45 Code of Federal Regulations and subparts A and C of part 164 of such title), or to supersede or conflict with an entity or business associate's obligations under the HIPAA Security rule.''.

SEC. 503. GAO STUDY ON THE PRIVACY AND SECURITY RISKS OF ELECTRONIC TRANSMISSION OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION TO AND FROM ENTITIES NOT COVERED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall conduct a study to—

(1) describe the roles of Federal agencies and the private sector with respect to protecting the privacy and security of individually identifiable health information transmitted electronically to and from entities not covered by the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note);

(2) identify recent developments regarding the use of application programming interfaces to access individually identifiable health information, and implications for the privacy and security of such information;

(3) identify practices in the private sector, such as terms and conditions for use, relating to the privacy, disclosure, and secondary uses of individually identifiable health information transmitted electroni-

cally to or from entities, selected by an individual, that are not subject to the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996; and

(4) identify steps the public and private sectors can take to improve the private and secure access to and availability of individually identifiable health information.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report concerning the findings of the study conducted under subsection (a).

SEC. 504. TECHNICAL CORRECTIONS.

(a) IN GENERAL.—Section 3022(b) of the Public Health Service Act (42 U.S.C. 300jj–52(b)) is amended by adding at the end the following new paragraph:

''(4) APPLICATION OF AUTHORITIES UNDER INSPECTOR GENERAL ACT OF 1978.—In carrying out this subsection, the Inspector General shall have the same authorities as provided under section 6 of the Inspector General Act of 1978 (5 U.S.C. App.).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enact-

ment of the 21st Century Cures Act (Public Law 114–255).