117TH CONGRESS
1ST SESSION

S. 3139

To ban anticompetitive terms in facility and insurance contracts that limit access to higher quality, lower cost care.

IN THE SENATE OF THE UNITED STATES

NOVEMBER 2, 2021

Mr. BRAUN (for himself and Ms. BALDWIN) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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A BILL

To ban anticompetitive terms in facility and insurance contracts that limit access to higher quality, lower cost care.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Healthy Competition for Better Care Act''.

SEC. 2. BANNING ANTICOMPETITIVE TERMS IN FACILITY AND INSURANCE CONTRACTS THAT LIMIT ACCESS TO HIGHER QUALITY, LOWER COST CARE.

(a) IN GENERAL.—

(1) PHSA.—Section 2799A–9 of the Public Health Service Act (42 U.S.C. 300gg–119) 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, or other service provider offering access to a network of service providers 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;

''(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; or

"(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.

"(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 restrictive contracting terms between the service provider and a third-party administrator that the group health plan is not party to, without a disclosure that such terms exist.

"(3) EXCEPTION FOR CERTAIN GROUP MODEL ISSUERS.—Paragraph (1)(A) shall not apply to a group health plan or health insurance issuer offering

group or individual health insurance coverage with respect to—

"(A) a health maintenance organization (as defined in section 2791(b)(3)), if such health maintenance organization operates primarily through exclusive contracts with multi-specialty physician groups, nor to any arrangement between such a health maintenance organization and its affiliates; or

"(B) a value-based network arrangement, such as an exclusive provider network, accountable care organization or other alternative payment model, center of excellence, a provider sponsored health insurance issuer that operates primarily through aligned multi-specialty physician group practices or integrated health systems, or such other similar network arrangements as determined by the Secretary through rulemaking.

"(4) ATTESTATION.—A group health plan or health insurance issuer offering group or individual health insurance coverage shall annually submit to, as applicable, the applicable authority described in section 2723 or the Secretary of Labor, an attesta-

tion that such plan or issuer is in compliance with the requirements of this subsection.

''(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 consultation with the Secretary of Labor and the Secretary of the Treasury, not later than 1 year after the date of enactment of this section, shall promulgate regulations to carry out this section.

''(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to limit network design or cost or quality initiatives by a group health plan or health insurance issuer, including accountable care organizations, exclusive provider organizations, networks that tier providers by cost or quality or steer enrollees to centers of excellence, or other pay-for-performance programs.

''(f) CLARIFICATION WITH RESPECT TO ANTITRUST LAWS.—Compliance with this section does not constitute compliance with the antitrust laws, as defined in sub-

section (a) of the first section of the Clayton Act (15 U.S.C. 12(a))."'.

(2) ERISA.—Section 724 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185m) 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 health insurance coverage shall not enter into an agreement with a provider, network or association of providers, or other service provider offering access to a network of service providers 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;

"'(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; or

"(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.

"(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 restrictive contracting terms between the service provider and a third-party administrator that the group health plan is not party to, without a disclosure that such terms exist.

"(3) EXCEPTION FOR CERTAIN GROUP MODEL ISSUERS.—Paragraph (1)(A) shall not apply to a

group health plan or health insurance issuer offering group health insurance coverage with respect to—

"(A) a health maintenance organization (as defined in section 733(b)(3)), if such health maintenance organization operates primarily through exclusive contracts with multi-specialty physician groups, nor to any arrangement between such a health maintenance organization and its affiliates; or

"(B) a value-based network arrangement, such as an exclusive provider network, accountable care organization or other alternative payment model, center of excellence, a provider sponsored health insurance issuer that operates primarily through aligned multi-specialty physician group practices or integrated health systems, or such other similar network arrangements as determined by the Secretary through rulemaking.

"(4) ATTESTATION.—A group health plan or health insurance issuer offering group health insurance coverage shall annually submit to the Secretary of Labor an attestation that such plan or issuer is in compliance with the requirements of this subsection.

''(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 consultation with the Secretary of Health and Human Services and the Secretary of the Treasury, not later than 1 year after the date of enactment of this section, shall promulgate regulations to carry out this section.

''(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to limit network design or cost or quality initiatives by a group health plan or health insurance issuer, including accountable care organizations, exclusive provider organizations, networks that tier providers by cost or quality or steer enrollees to centers of excellence, or other pay-for-performance programs.

''(f) CLARIFICATION WITH RESPECT TO ANTITRUST LAWS.—Compliance with this section does not constitute compliance with the antitrust laws, as defined in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)).''.

(3) IRC.—Section 9824 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

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

''(1) IN GENERAL.—A group health plan shall not enter into an agreement with a provider, network or association of providers, or other service provider offering access to a network of service providers if such agreement, directly or indirectly—

''(A) restricts the group health plan from—

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

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

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

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

"(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 restrictive contracting terms between the service provider and a third-party administrator that the group health plan is not party to, without a disclosure that such terms exist.

"(3) EXCEPTION FOR CERTAIN GROUP MODEL ISSUERS.—Paragraph (1)(A) shall not apply to a group health plan with respect to—

"(A) a health maintenance organization (as defined in section 9832(b)(3)), if such health maintenance organization operates primarily through exclusive contracts with multispecialty physician groups, nor to any arrange-

ment between such a health maintenance organization and its affiliates; or

"(B) a value-based network arrangement, such as an exclusive provider network, accountable care organization or other alternative payment model, center of excellence, a provider sponsored health insurance issuer that operates primarily through aligned multi-specialty physician group practices or integrated health systems, or such other similar network arrangements as determined by the Secretary through rulemaking.

"(4) ATTESTATION.—A group health plan shall annually submit to the Secretary of Labor an attestation that such plan is in compliance with the requirements of this subsection.

"(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 consultation with the Secretary of Health and Human Services and the

Secretary of Labor, not later than 1 year after the date of enactment of this section, shall promulgate regulations to carry out this section.

''(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to limit network design or cost or quality initiatives by a group health plan, including accountable care organizations, exclusive provider organizations, networks that tier providers by cost or quality or steer enrollees to centers of excellence, or other pay-for-performance programs.

''(f) CLARIFICATION WITH RESPECT TO ANTITRUST LAWS.—Compliance with this section does not constitute compliance with the antitrust laws, as defined in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to any contract entered into on or after the date that is 18 months 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 amendments shall apply on the earlier of the date of renewal of such contract or 3 years after such date of enactment.

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