of the medically necessary leave of absence involved.

**(3) Certification by physician**

Paragraph (1) shall apply to a group health plan only if the plan, or the issuer of health insurance coverage offered in connection with the plan, has received written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) described in subsection (a) is medically necessary.

**(c) Notice**

A group health plan shall include, with any notice regarding a requirement for certification of student status for coverage under the plan, a description of the terms of this section for continued coverage during medically necessary leaves of absence. Such description shall be in language which is understandable to the typical plan participant.

**(d) No change in benefits**

A dependent child whose benefits are continued under this section shall be entitled to the same benefits as if (during the medically necessary leave of absence) the child continued to be a covered student at the institution of higher education and was not on a medically necessary leave of absence.

**(e) Continued application in case of changed coverage**

If—

(1) a dependent child of a participant or beneficiary is in a period of coverage under a group health plan, pursuant to a medically necessary leave of absence of the child described in subsection (b);

(2) the manner in which the participant or beneficiary is covered under the plan changes, whether through a change in health insurance coverage or health insurance issuer, a change between health insurance coverage and self-insured coverage, or otherwise; and

(3) the coverage as so changed continues to provide coverage of beneficiaries as dependent children,

this section shall apply to coverage of the child under the changed coverage for the remainder of the period of the medically necessary leave of absence of the dependent child under the plan in the same manner as it would have applied if the changed coverage had been the previous coverage.

(Added Pub. L. 110–381, §2(c)(1), Oct. 9, 2008, 122 Stat. 4084.)

**Editorial Notes**

REFERENCES IN TEXT

Section 102 of the Higher Education Act of 1965, referred to in subsec. (a), is classified to section 1002 of Title 20, Education.

**Statutory Notes and Related Subsidiaries**

EFFECTIVE DATE

Pub. L. 110–381, §2(d), Oct. 9, 2008, 122 Stat. 4086, provided that: ''The amendments made by this Act [enacting this section, section 1185c of Title 29, Labor, and sections 300gg–7 and 300gg–54 of Title 42, The Public Health and Welfare] shall apply with respect to plan years beginning on or after the date that is one year after the date of the enactment of this Act [Oct. 9, 2008] and to medically necessary leaves of absence beginning during such plan years.''

## §9815.[1] Additional market reforms

**(a) General rule**

Except as provided in subsection (b)—

(1) the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subchapter; and

(2) to the extent that any provision of this subchapter conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.

**(b) Exception**

Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this subchapter shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.

(Added Pub. L. 111–148, title I, §1563(f), formerly §1562(f), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 270, 911.)

**Editorial Notes**

REFERENCES IN TEXT

The Public Health Service Act, referred to in text, is act July 1, 1944, ch. 373, 58 Stat. 682. Part A of title XXVII of the Act is classified generally to part A (§300gg et seq.) of subchapter XXV of chapter 6A of Title 42, The Public Health and Welfare. Sections 2716 and 2718 of title XXVII of the Act are classified to sections 300gg–16 and 300gg–18, respectively, of Title 42. For complete classification of this Act to the Code, see Short Title note set out under section 201 of Title 42 and Tables.

The Patient Protection and Affordable Care Act, referred to in text, is Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 119. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of Title 42, The Public Health and Welfare, and Tables.

## §9816. Preventing surprise medical bills

**(a) Coverage of emergency services**

**(1) In general**

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

[1] So in original. No section 9814 has been enacted.

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

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

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

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

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

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

(iv) the group health plan—

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

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

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

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

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

**(A) Audit process**

**(i) In general**

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

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

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

**(ii) Audit samples**

Under the process established pursuant to clause (i), the Secretary—

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

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

**(iii) Reports**

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

**(B) Rulemaking**

Not later than July 1, 2021, the Secretary, in consultation with the Secretary of Labor and the Secretary of Health and Human Services, shall establish through rulemaking—

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

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

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

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

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

**(3) Definitions**

In this subchapter:

**(A) Emergency department of a hospital**

The term ''emergency department of a hospital'' includes a hospital outpatient department that provides emergency services (as defined in subparagraph (C)(i)).

**(B) Emergency medical condition**

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

**(C) Emergency services**

**(i) In general**

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

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

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

**(ii) Inclusion of additional services**

**(I) In general**

For purposes of this subsection and section 2799B–1 of the Public Health Service Act, in the case of a participant or beneficiary who is enrolled in a group health plan and who is furnished services described in clause (i) with respect to an emergency medical condition, the term ''emergency services'' shall include, unless each of the conditions described in subclause (II) are met, in addition to the items and services described in clause (i), items and services—

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

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

**(II) Conditions**

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

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

(bb) Such provider furnishing such additional items and services satisfies the notice and consent criteria of section 2799B–2(d)[1] with respect to such items and services.

(cc) Such individual is in a condition to receive (as determined in accordance with guidelines issued by the Secretary pursuant to rulemaking) the information described in section 2799B–2[1] and to provide informed consent under such section, in accordance with applicable State law.

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

**(D) Independent freestanding emergency department**

The term ''independent freestanding emergency department'' means a health care facility that—

[1] See References in Text note below.

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

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

**(E) Qualifying payment amount**

**(i) In general**

The term ''qualifying payment amount'' means, subject to clauses (ii) and (iii), with respect to a sponsor of a group health plan—

(I) for an item or service furnished during 2022, the median of the contracted rates recognized by the plan (determined with respect to all such plans of such sponsor that are offered within the same insurance market (specified in subclause (I), (II), or (III) of clause (iv)) as the plan) as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by the plan) under such plans on January 31, 2019 for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established by the Secretary under paragraph (2)(B), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, such percentage increase over 2020, and such percentage increase over 2021; and

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

**(ii) New plans and coverage**

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

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

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

**(iii) Insufficient information; newly covered items and services**

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

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

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

(III) for an item or service furnished in the first sufficient information year for such item or service with respect to such plan, has the meaning given the term qualifying payment amount in clause (i)(I), except that in applying such clause to such item or service, the reference to ''furnished during 2022'' shall be treated as a reference to furnished during such first sufficient information year, the reference to ''on January 31, 2019'' shall be treated as a reference to in such sufficient information year, and the increase described in such clause shall not be applied; and

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

erence to furnished during the year after such first sufficient information year or a subsequent year.

**(iv) Insurance market**

For purposes of clause (i)(I), a health insurance market specified in this clause is one of the following:

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

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

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

**(v) Definitions**

For purposes of this subparagraph:

**(I) First coverage year**

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

**(II) First sufficient information year**

The term ''first sufficient information year'' means, with respect to a group health plan—

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

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

**(III) Newly covered item or service**

The term ''newly covered item or service'' means, with respect to a group health plan, an item or service for which coverage was not offered in 2019 under such plan or coverage, but is offered under such plan or coverage in a year after 2019.

**(F) Nonparticipating emergency facility; participating emergency facility**

**(i) Nonparticipating emergency facility**

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

**(ii) Participating emergency facility**

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

**(G) Nonparticipating providers; participating providers**

**(i) Nonparticipating provider**

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

**(ii) Participating provider**

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

**(H) Recognized amount**

The term ''recognized amount'' means, with respect to an item or service furnished by a nonparticipating provider or nonparticipating emergency facility during a year and a group health plan—

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

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

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

[2] Closing parentheses so in original.

**(I) Specified State law**

The term ''specified State law'' means, with respect to a State, an item or service furnished by a nonparticipating provider or nonparticipating emergency facility during a year and a group health plan, a State law that provides for a method for determining the total amount payable under such a plan (to the extent such State law applies to such plan, subject to section 514[1]) in the case of a participant or beneficiary covered under such plan and receiving such item or service from such a nonparticipating provider or nonparticipating emergency facility.

**(J) Stabilize**

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

**(K) Out-of-network rate**

The term ''out-of-network rate'' means, with respect to an item or service furnished in a State during a year to a participant or beneficiary of a group health plan receiving such item or service from a nonparticipating provider or nonparticipating emergency facility—

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

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

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

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

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

[3] So in original. Probably should be ''given''.

**(L) Cost-sharing**

The term ''cost-sharing'' includes copayments, coinsurance, and deductibles.

**(b) Coverage of non-emergency services performed by nonparticipating providers at certain participating facilities**

**(1) In general**

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

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

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

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

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

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

**(2) Definitions**

In this section:

**(A) Participating health care facility**

**(i) In general**

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

**(ii) Health care facility described**

A health care facility described in this clause, with respect to a group health plan or health insurance coverage offered in the group or individual market, is each of the following:

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

(II) A hospital outpatient department.

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

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

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

**(B) Visit**

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

**(c) Determination of out-of-network rates to be paid by health plans; independent dispute resolution process**

**(1) Determination through open negotiation**

**(A) In general**

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

**(B) Accessing independent dispute resolution process in case of failed negotiations**

In the case of open negotiations pursuant to subparagraph (A), with respect to an item or service, that do not result in a determination of an amount of payment for such item or service by the last day of the open negotiation period described in such subparagraph with respect to such item or service, the provider or facility (as applicable) or group health plan that was party to such negotiations may, during the 4-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process under paragraph (2) with respect to such item or service. The independent dispute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the other party and to the Secretary of a notification (containing such information as specified by the Secretary) and for purposes of this subsection, the date of initiation of such process shall be the date of such submission or such other date specified by the Secretary pursuant to regulations that is not later than the date of receipt of such notification by both the other party and the Secretary.

**(2) Independent dispute resolution process available in case of failed open negotiations**

**(A) Establishment**

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

**(B) Authority to continue negotiations**

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

mine how to allocate between the parties to such determination the payment of the compensation of the entity selected with respect to such determination.

**(C) Clarification**

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

**(3) Treatment of batching of items and services**

**(A) In general**

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

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

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

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

(iv) such items and services were furnished during the 30 day[4] period following the date on which the first item or service included with respect to such determination was furnished or an alternative period as determined by the Secretary, for use in limited situations, such as by the consent of the parties or in the case of low-volume items and services, to encourage procedural efficiency and minimize health plan and provider administrative costs.

**(B) Treatment of bundled payments**

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

**(4) Certification and selection of IDR entities**

**(A) In general**

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

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

(ii) is not—

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

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

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

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

(iv) meets appropriate indicators of fiscal integrity;

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

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

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

**(B) Period of certification**

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

**(C) Revocation**

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

**(D) Petition for denial or withdrawal**

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

**(E) Sufficient number of entities**

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

**(F) Selection of certified IDR entity**

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

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

[4] So in original. Probably should be ''30-day''.

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

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

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

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

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

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

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

**(5) Payment determination**

**(A) In general**

Not later than 30 days after the date of selection of the certified IDR entity with respect to a determination for a qualified IDR item or service, the certified IDR entity shall—

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

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

**(B) Submission of offers**

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

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

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

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

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

**(C) Considerations in determination**

**(i) In general**

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

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

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

**(ii) Additional circumstances**

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

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

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

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

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

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

**(D) Prohibition on consideration of certain factors**

In determining which offer is the payment to be applied with respect to qualified IDR items and services furnished by a provider or facility, the certified IDR entity with respect to a determination shall not consider usual and customary charges, the amount that would have been billed by such provider or facility with respect to such items and services had the provisions of section 2799B–1 of the Public Health Service Act or 2799B–2 of such Act (as applicable) not applied, or the payment or reimbursement rate for such items and services furnished by such provider or facility payable by a public payor,

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

**(E) Effects of determination**

**(i) In general**

A determination of a certified IDR entity under subparagraph (A)—

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

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

**(ii) Suspension of certain subsequent IDR requests**

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

**(iii) Subsequent submission of requests permitted**

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

**(iv) Reports**

The Secretary, jointly with the Secretary of Labor and the Secretary of the Health and Human Services, shall examine the impact of the application of clause (ii) and whether the application of such clause delays payment determinations or impacts early, alternative resolution of claims (such as through open negotiations), and shall submit to Congress, not later than 2 years after the date of implementation of such clause an interim report (and not later than 4 years after such date of implementation, a final report) on whether any group health plans or health insurance issuers offering group or individual health insurance coverage or types of such plans or coverage have a pattern or practice of routine denial, low payment, or down-coding of claims, or otherwise abuse the 90-day period described in such clause, including recommendations on ways to discourage such a pattern or practice.

**(F) Costs of independent dispute resolution process**

In the case of a notification under paragraph (1)(B) submitted by a nonparticipating provider, nonparticipating emergency facility, or group health plan and submitted to a certified IDR entity—

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

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

**(6) Timing of payment**

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

**(7) Publication of information relating to the IDR process**

**(A) Publication of information**

For each calendar quarter in 2022 and each calendar quarter in a subsequent year, the Secretary shall make available on the public website of the Department of the Treasury—

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

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

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

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

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

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

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

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

**(B) Information**

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

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

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

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

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

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

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

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

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

(ix) any other information specified by the Secretary.

**(C) IDR entity requirements**

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

**(D) Clarification**

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

**(8) Administrative fee**

**(A) In general**

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

**(B) Amount of fee**

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

**(9) Waiver authority**

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

**(d) Certain access fees to certain databases**

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

**(e) Transparency regarding in-network and out-of-network deductibles and out-of-pocket limitations**

A group health plan providing or covering any benefit with respect to items or services shall include, in clear writing, on any physical or electronic plan or insurance identification card issued to the participants or beneficiaries in the plan the following:

(1) Any deductible applicable to such plan.

(2) Any out-of-pocket maximum limitation applicable to such plan.

(3) A telephone number and Internet website address through which such individual may seek consumer assistance information, such as information related to hospitals and urgent care facilities that have in effect a contractual relationship with such plan for furnishing items and services under such plan.

**(f) Advanced explanation of benefits**

**(1) In general**

For plan years beginning on or after January 1, 2022, each group health plan shall, with respect to a notification submitted under section 2799B–6 of the Public Health Service Act by a health care provider or health care facility to the plan for a participant or beneficiary under plan scheduled to receive an item or service from the provider or facility (or authorized representative of such participant or beneficiary), not later than 1 business day (or, in the case such item or service was so sched-

[5] So in original. Probably should be ''paragraph (4)''.

uled at least 10 business days before such item or service is to be furnished (or in the case of a request made to such plan or coverage by such participant or beneficiary), 3 business days) after the date on which the plan receives such notification (or such request), provide to the participant or beneficiary (through mail or electronic means, as requested by the participant or beneficiary) a notification (in clear and understandable language) including the following:

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

(i) in the case the provider or facility is a participating provider or facility with respect to the plan or coverage with respect to the furnishing of such item or service, the contracted rate under such plan for such item or service (based on the billing and diagnostic codes provided by such provider or facility); and

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

(B) The good faith estimate included in the notification received from the provider or facility (if applicable) based on such codes.

(C) A good faith estimate of the amount the plan is responsible for paying for items and services included in the estimate described in subparagraph (B).

(D) A good faith estimate of the amount of any cost-sharing for which the participant or beneficiary would be responsible for such item or service (as of the date of such notification).

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

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

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

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

**(2) Authority to modify timing requirements in the case of specified items and services**

**(A) In general**

In the case of a participant or beneficiary scheduled to receive an item or service that is a specified item or service (as defined in subparagraph (B)), the Secretary may modify any timing requirements relating to the provision of the notification described in paragraph (1) to such participant or beneficiary with respect to such item or service. Any modification made by the Secretary pursuant to the previous sentence may not result in the provision of such notification after such participant or beneficiary has been furnished such item or service.

**(B) Specified item or service defined**

For purposes of subparagraph (A), the term ''specified item or service'' means an item or service that has low utilization or significant variation in costs (such as when furnished as part of a complex treatment), as specified by the Secretary.

(Added and amended Pub. L. 116–260, div. BB, title I, §§102(c)(1), 103(c), 107(c), 111(b), Dec. 27, 2020, 134 Stat. 2784, 2815, 2859, 2863.)

**Editorial Notes**

REFERENCES IN TEXT

Section 2704 of the Public Health Service Act, referred to in subsec. (a)(1)(D), is classified to section 300gg–3 of Title 42, The Public Health and Welfare.

Section 715 of the Employee Retirement Income Security Act of 1974, referred to in subsec. (a)(1)(D), is classified to section 1185d of Title 29, Labor.

Section 9815 of this Act, referred to in subsec. (a)(1)(D), is section 9815 of the Internal Revenue Code of 1986, which is classified to section 9815 of this title.

Section 332 of the Public Health Service Act, referred to in subsec. (a)(2)(B)(iii), is classified to section 254e of Title 42, The Public Health and Welfare.

Section 109(a) of the No Surprises Act, referred to in subsec. (a)(2)(B), is section 109(a) of Pub. L. 116–260, div. BB, title I, Dec. 27, 2020, 134 Stat. 2859, which is not classified to the Code.

The Social Security Act, referred to in subsecs. (a)(3)(B), (C)(i), (H)(iii), (K)(iii), (b)(2)(A)(ii), and (c)(5)(C)(ii)(I), (D), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles XVIII, XIX, and XXI of the Act are classified generally to subchapters XVIII (§1395 et seq.), XIX (§1396 et seq.), and XXI (§1397aa et seq.), respectively, of chapter 7 of Title 42, The Public Health and Welfare. Sections 1115A, 1833, 1861, 1867, and 1890 are classified to sections 1315a, 1395*l*, 1395x, 1395dd, and 1395aaa, respectively, of Title 42. For complete classification of this Act to the Code, see section 1305 of Title 42 and Tables.

Section 2799B–1 of the Public Health Service Act, referred to in subsecs. (a)(3)(C)(ii)(I) and (c)(5)(D), is classified to section 300gg–131 of Title 42, The Public Health and Welfare.

Section 2799B–2 of the Public Health Service Act, cited also as ''section 2799B–2'', referred to in subsecs. (a)(3)(C)(ii)(II)(bb), (cc), (b)(1), and (c)(2)(C), (5)(D), is classified to section 300gg–132 of Title 42, The Public Health and Welfare.

Section 514, referred to in subsec. (a)(3)(I), probably means section 514 of the Employee Retirement Income Security Act of 1974, which relates to application of State laws and is classified to section 1144 of Title 29, Labor.

The date of the enactment of this subsection, referred to in subsec. (c)(2)(A), is the date of enactment of Pub. L. 116–260, which was approved Dec. 27, 2020.

Section 2799B–6 of the Public Health Service Act, referred to in subsec. (f)(1), is classified to section 300gg–136 of Title 42, The Public Health and Welfare.

AMENDMENTS

2020—Subsecs. (c), (d). Pub. L. 116–260, § 103(c), added subsec. (c) and redesignated former subsec. (c) as (d).
Subsec. (e). Pub. L. 116–260, § 107(c), added subsec. (e).
Subsec. (f). Pub. L. 116–260, § 111(b), added subsec. (f).

**Statutory Notes and Related Subsidiaries**

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116–260, div. BB, title I, § 107(d), Dec. 27, 2020, 134 Stat. 2859, provided that: ''The amendments made by this subsection [probably means ''this section'', amending this section, section 1185e of Title 29, Labor, and section 300gg–111 of Title 42, The Public Health and Welfare] shall apply with respect to plan years beginning on or after January 1, 2022.''

EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after Jan. 1, 2022, see section 102(e) of div. BB of Pub. L. 116–260, set out as an Effective Date of 2020 Amendment note under section 8902 of Title 5, Government Organization and Employees.

## § 9817. Ending surprise air ambulance bills

### (a) In general

In the case of a participant or beneficiary in a group health plan who receives air ambulance services from a nonparticipating provider (as defined in section 9816(a)(3)(G)) with respect to such plan, if such services would be covered if provided by a participating provider (as defined in such section) with respect to such plan—

(1) the cost-sharing requirement with respect to such services shall be the same requirement that would apply if such services were provided by such a participating provider, and any coinsurance or deductible shall be based on rates that would apply for such services if they were furnished by such a participating provider;

(2) such cost-sharing amounts shall be counted towards the in-network deductible and in-network out-of-pocket maximum amount under the plan for the plan year (and such in-network deductible shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider; and

(3) the group health plan shall—

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

(B) pay a total plan payment, in accordance with, if applicable, subsection (b)(6), directly to such provider furnishing such services to such participant, beneficiary, or enrollee that is, with application of any initial payment under subparagraph (A), equal to the amount by which the out-of-network rate (as defined in section 9816(a)(3)(K)) for such services and year involved exceeds the cost-sharing amount imposed under the plan for such services (as determined in accordance with paragraphs (1) and (2)).

### (b) Determination of out-of-network rates to be paid by health plans; independent dispute resolution process

#### (1) Determination through open negotiation

##### (A) In general

With respect to air ambulance services furnished in a year by a nonparticipating provider, with respect to a group health plan, and for which a payment is required to be made by the plan pursuant to subsection (a)(3), the provider or plan may, during the 30-day period beginning on the day the provider receives a payment or a statement of denial of payment from the plan regarding a claim for payment for such service, initiate open negotiations under this paragraph between such provider and plan for purposes of determining, during the open negotiation period, an amount agreed on by such provider, and such plan for payment (including any cost-sharing) for such service. For purposes of this subsection, the open negotiation period, with respect to air ambulance services, is the 30-day period beginning on the date of initiation of the negotiations with respect to such services.

##### (B) Accessing independent dispute resolution process in case of failed negotiations

In the case of open negotiations pursuant to subparagraph (A), with respect to air ambulance services, that do not result in a determination of an amount of payment for such services by the last day of the open negotiation period described in such subparagraph with respect to such services, the provider or group health plan that was party to such negotiations may, during the 4-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process under paragraph (2) with respect to such services. The independent dispute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the other party and to the Secretary of a notification (containing such information as specified by the Secretary) and for purposes of this subsection, the date of initiation of such process shall be the date of such submission or such other date specified by the Secretary pursuant to regulations that is not later than the date of receipt of such notification by both the other party and the Secretary.

#### (2) Independent dispute resolution process available in case of failed open negotiations

##### (A) Establishment

Not later than 1 year after the date of the enactment of this subsection, the Secretary, jointly with the Secretary of Health and Human Services and the Secretary of Labor, shall establish by regulation one independent dispute resolution process (referred to in this subsection as the ''IDR process'') under which, in the case of air ambulance services with respect to which a provider or group health plan submits a notification under paragraph (1)(B) (in this subsection re-