AMENDMENT NO. 1 Calendar No._____

Purpose: To require group health plans and health insurance issuers to provide health claims, network, and cost information through application programming interfaces.

IN THE SENATE OF THE UNITED STATES—118th Cong., 1st Sess.

S. 1339

To provide for increased oversight of entities that provide pharmacy benefit management services on behalf of group health plans and health insurance coverage.

Referred to the Committee on _____ and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mr. MULLIN (for himself and Mrs. MURRAY)

Viz:

At the end, add the following:

SEC. 3. 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 insur-

ance coverage shall make available for access, exchange, and use without special effort, through application programming interfaces (or successor technology or standards), consistent with standards and implementation specifications adopted under section 3004, the information described in subsection (b), in the manner described in subsection (b), as applicable, and otherwise consistent with this section.

"(b) INFORMATION.—The following information is required to be made available, as the Secretary may specify:

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

"(A) may 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 the previous 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 offered by the same insurance issuer, in which the same enrollee was enrolled during the previous 5 years; and

"(B) shall be available to an enrollee or former enrollee, the enrollee's providers, and any third-party applications or services authorized by the enrollee—

"(i) through the application programming interfaces (or successor technology or standards) consistent with standards and specifications adopted under section 3004, in a single, longitudinal format that is easy to understand, secure, and that may update automatically;

"(ii) as soon as practicable, and in no case later than the period of time determined by the Secretary, after the claim is adjudicated or the data is received by the health plan or health insurance issuer; and

"(iii) to the enrollee, former 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 enrollment 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, within a timeframe determined by the Secretary, from when the plan or coverage receives provider directory information or updates from that facility or practitioner;

"(B) be capable of returning the information necessary to establish 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 enrollee out-of-pocket costs, including costs expected to be incurred through a deductible, 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 fa-

cility 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.—Subject to all applicable Federal and State privacy, security, and breach notification laws, and within a timeframe determined by the Secretary, 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 and prospective 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 third party applications or services authorized by the enrollee, for a reasonable period of time;

"(4) employ the applicable content, vocabulary, and technical standards, as determined by the Secretary pursuant to title XXX; and

"(5) employ security and authentication standards, as the Secretary determines appropriate.

"(d) DENIAL OR DISCONTINUANCE OF ACCESS.—A group health plan or health insurance issuer offering group or individual health insurance coverage may deny access or discontinue access of the application programming interfaces to third party applications or services on the basis of reasonable privacy or security concerns, as determined by the Secretary, including at the request of the enrollee.

"(e) NOTIFICATION.—When obtaining enrollee authorization to share information with a third party under this section, a group health plan or a health insurance issuer offering group or individual health insurance coverage shall include a notification for the enrollee that information shared with a third party that is not a covered entity or business associate is not subject to the privacy, security, or breach notification rules under parts 160 and 164 of title 45, Code of Federal Regulations (or successor regulations).

"(f) RULE OF CONSTRUCTION REGARDING PRIVACY.—Nothing in this section shall be construed to alter existing obligations of a covered entity or business associate under the privacy, security, and breach notification rules promulgated under section 264(c) of the Health In-

surance Portability and Accountability Act or section 13402 of the HITECH Act, or to alter the Secretary's existing authority to modify such rules, under part 2 of title 42, Code of Federal Regulations (or successor regulations), under section 444 of the General Education Provisions Act (20 U.S.C. 1232g) (commonly referred to as the 'Family Educational Rights and Privacy Act of 1974'), under the amendments made by the Genetic Information Nondiscrimination Act, or under State privacy law.".

(b) EFFECTIVE DATE.—Section 2715B of the Public Health Service Act, as added by subsection (a), shall take effect 18 months after the date of enactment of this Act.