118TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPORT
118–258

TRANSPARENCY IN BILLING ACT OF 2023

NOVEMBER 1, 2023.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Ms. FOXX, from the Committee on Education and the Workforce, submitted the following

R E P O R T

[To accompany H.R. 4509]

The Committee on Education and the Workforce, to whom was referred the bill (H.R. 4509) to amend the Employee Retirement Income Security Act of 1974 to require group health plans and health insurance issuers offering group health insurance coverage to only pay claims submitted by hospitals that have in place policies and procedures to ensure accurate billing practices, and for other purposes, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Transparency in Billing Act of 2023".

SEC. 2. HONEST BILLING REQUIREMENTS.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end the following new section:

"SEC. 726. HONEST BILLING REQUIREMENTS.

"A group health plan or health insurance issuer offering group health insurance coverage may not pay a claim for items and services furnished to an individual at an off-campus outpatient department of a provider (as defined in section 901(c)) submitted by a hospital (as defined in section 1861(e) of the Social Security Act) unless such claim submitted by such hospital includes the separate unique health identifier for the department where items and services were furnished, in accordance with section 901.".

(b) CLERICAL AMENDMENT.—The table of contents of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 note) is amended by adding after the item relating to section 725 the following:

"Sec. 726. Honest billing requirements.".

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect with respect to plan years beginning on or after January 1, 2024.

SEC. 3. REGULATION OF HONEST BILLING.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021 et seq.) is amended by adding at the end the following new part:

"PART 9—BILLING REQUIREMENTS WITH RESPECT TO GROUP HEALTH PLANS AND COVERAGE

"SEC. 901. HONEST BILLING REQUIREMENTS.

"(a) IN GENERAL.—A hospital may not, with respect to items and services furnished to an individual at an off-campus outpatient department of a provider, submit a claim for such items and services to a group health plan or health insurance issuer, and may not hold such individual liable for such items and services, unless—

"(1) such hospital obtains a separate unique health identifier established for such department pursuant to section 1173(b) of the Social Security Act; and

"(2) the claim for such items and services includes such separate unique health identifier for such department where such items and services were furnished.

"(b) PROCESS FOR REPORTING SUSPECTED VIOLATIONS.—Not later than one year after the date of enactment of this section, the Secretary shall establish a process under which a suspected violation of this section may be reported to such Secretary.

"(c) OFF-CAMPUS OUTPATIENT DEPARTMENT OF A PROVIDER DEFINED.—For purposes of this paragraph, the term 'off-campus outpatient department of a provider' means a department of a provider (as defined in section 413.65 of title 42, Code of Federal Regulations, or any successor regulation) that is not located—

"(1) on the campus (as defined in such section) of such provider; or

"(2) within the distance (described in such definition of campus) from a remote location of a hospital facility (as defined in such section).".

(b) CLERICAL AMENDMENT.—The table of contents of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 note) is amended by inserting after the item relating to section 804 the following new item:

"PART 9—BILLING REQUIREMENTS WITH RESPECT TO GROUP HEALTH PLANS AND COVERAGE

"Sec. 901. Honest billing requirements.".

SEC. 4. ENFORCEMENT.

Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) is amended—

(1) in subsection (a)(6), by striking "or (9)" and inserting "(9), or (13)"; and

(2) in subsection (c), by adding at the end the following new paragraph:

"(13) The Secretary may assess a civil monetary penalty against a hospital for a violation under section 901 in an amount—

"(A) in the case of a hospital with not more than 30 beds (as determined under section 180.90(c)(2)(ii)(D) of title 45, Code of Federal Regulations, as in effect on the date of the enactment of this paragraph), not to exceed $300 per day that the violation is ongoing, as determined by the Secretary; and

"(B) in the case of a hospital with more than 30 beds (as so determined), not to exceed $5,500 per each such day.".

SEC. 5. IMPLEMENTATION.

The Secretary of Labor shall implement the amendments made by this Act by rulemaking.

PURPOSE

The hospital industry is the largest contributor to national health expenditures, accounting for nearly one of every three dollars spent on health care in the United States.[1] In addition, perverse economic incentives in health care have fueled provider consolidation, creating upward pressure on health care costs.

H.R. 4509, the *Transparency in Billing Act*, amends the *Employee Retirement Income Security Act of 1974* (ERISA)[2] to require group health plans and health insurance issuers offering group

[1] https://www.cms.gov/files/document/highlights.pdf.
[2] 29 U.S.C. § 1001 *et seq*.

health insurance coverage only to pay claims submitted by hospitals that have in place policies and procedures to ensure accurate billing practices. This legislation includes commonsense provisions to ensure that group health plans only pay for services that are appropriately billed for the correct site of service, and it prevents hospitals from obscuring the true site of service in order to charge higher prices via facility fees or other charges.

COMMITTEE ACTION

116TH CONGRESS

Subcommittee Hearing on Examining Surprise Billing: Protecting Patients from Financial Pain

On April 2, 2019, the Subcommittee on Health, Employment, Labor, and Pensions (HELP) held a hearing entitled "Examining Surprise Billing: Protecting Patients from Financial Pain," which discussed provider billing practices, including unexpected costs to consumers due, in part, to a lack of transparency. Witnesses further discussed the impact that increased transparency could have on boosting competition in health care. The witnesses were Ms. Ilyse Schuman, Senior Vice President, Health Policy, American Benefits Council, Washington, D.C.; Dr. Jack Hoadley, Research Professor Emeritus, Health Policy Institute, Georgetown University McCourt School of Public Policy, McLean, VA; Mr. Frederick Isasi, Executive Director, Families USA, Washington, D.C.; and Ms. Christen Linke Young, Fellow, USC-Brookings Schaeffer Initiative on Health Policy, Washington, D.C.

Full Committee Markup of H.R. 5800, the Ban Surprise Billing Act

On February 11, 2020, the Committee met to mark up H.R. 5800, the *Ban Surprise Billing Act*, introduced by then-Chairman Robert C. "Bobby" Scott (D–VA–3) and then-Ranking Member Virginia Foxx (R–NC–5). The legislation protected participants in employer-provided health plans from exorbitant out-of-network costs and included provisions improving transparency with respect to group health plan service providers, including those providing brokerage and consulting services. The Committee favorably reported the bill by a vote of 32 yeas and 13 nays.

118TH CONGRESS

Subcommittee Hearing on Reducing Health Care Costs for Working Americans and Their Families

On April 26, 2023, the HELP Subcommittee held a hearing entitled "Reducing Health Care Costs for Working Americans and Their Families," which examined challenges facing employer-sponsored health coverage, including the need for increased transparency in health care, addressing dishonest hospital billing practices, and lowering costs by expanding oversight of pharmacy benefit managers (PBMs). The witnesses were Mr. Joel White, President, Council for Affordable Health Coverage, Washington, D.C.; Mrs. Tracy Watts, Senior Partner, Mercer, Washington, D.C.; Ms. Marcie Strouse, Partner, Capitol Benefits Group, Des Moines, Iowa; and Ms. Sabrina Corlette, J.D., Research Professor and Co-Direc-

tor, Center on Health Insurance Reforms, Georgetown University McCourt School of Public Policy, Washington, D.C.

Subcommittee Hearing on Competition and Transparency: The Pathway Forward for a Stronger Health Care Market

On June 21, 2023, the HELP Subcommittee held a hearing entitled "Competition and Transparency: The Pathway Forward for a Stronger Health Care Market," which examined the need to improve competition and transparency in health care through honest billing practices, improving transparency rules, and addressing the role of PBMs in the health care market. The witnesses were Dr. Gloria Sachdev, President and CEO, Employers' Forum of Indiana, Carmel, Indiana; Ms. Sophia Tripoli, Senior Director of Health Policy and Director of the Center for Affordable Whole-Person Care, Families USA, Washington, D.C.; Mr. Greg Baker, CEO, AffirmedRx, Louisville, Kentucky; Ms. Christine Monahan, Assistant Research Professor, Center on Health Insurance Reforms, Georgetown University McCourt School of Public Policy, Washington, D.C.; and Mr. Juan Carlos "JC" Scott, President and CEO, Pharmaceutical Care Management Association, Washington, D.C.

Full Committee Markup of H.R. 4509, the Transparency in Billing Act

On July 10, 2023, Chairwoman Foxx and Ranking Member Scott introduced H.R. 4509, the *Transparency in Billing Act*. On July 12, 2023, the Committee met to mark up H.R. 4509 and adopted an Amendment in the Nature of a Substitute offered by Rep. Aaron Bean (R–FL–4), which made technical changes to H.R. 4509. The Committee reported the bill favorably, as amended, to the House of Representatives by a vote of 39 yeas and 0 nays.

COMMITTEE VIEWS

INTRODUCTION

Competition can drive innovation, improve quality, and lower prices. Unfortunately, the health care system has become increasingly consolidated in recent decades. Three PBM companies control nearly 90 percent of the market;[3] health plans are becoming vertically integrated and purchasing primary and specialty care offices;[4] and hospitals are consolidating at a rapid rate. From 1998 to 2015, 1,412 hospitals merged,[5] and 90 percent of metropolitan statistical areas are considered consolidated for hospital services.[6] The percentage of physicians' practices that are owned by or affiliated with hospitals has also increased.[7]

Consolidation in health care has contributed to significantly higher prices in the commercial market compared to Medicare. A recent Congressional Budget Office (CBO) report found that commercial insurers' prices were 240 percent of Medicare fee-for-service prices for outpatient services and 182 percent for inpatient serv-

[3] https://content.naic.org/cipr-topics/pharmacy-benefit-managers.
[4] https://www.reuters.com/business/healthcare-pharmaceuticals/which-cvs-rivals-also-own-primary-care-services-2023-02-08/.
[5] https://www.aei.org/research-products/report/hospital-competition-and-restrictions-on-physician-owned-hospitals/.
[6] https://www.aei.org/research-products/report/policy-solutions-for-hospital-consolidation/.
[7] https://www.cbo.gov/publication/57778.

ices.[8] Additionally, the prices that commercial insurers pay hospitals are much higher than hospitals' costs.[9]

Given that hospital prices are the number one contributor to national health care expenditures, Congress has taken previous action to rein in spending on services provided at off-campus hospital outpatient departments (HOPDs). *The Bipartisan Budget Act of 2015* established "site-neutral" payments under Medicare for services provided in HOPDs.[10] However, the law exempted existing off-campus HOPDs and those under construction from complying with the requirement. As a result, in practice, often Medicare still pays more for services provided at HOPDs than it does when the same services are provided in a doctor's office or outside of the hospital. In 2022, "Medicare [paid] 141 percent more in an HOPD than in a freestanding office for the first hour of chemotherapy infusion."[11]

Similar issues exist in the commercial market. Hospitals bill private health plans at higher rates than Medicare and often tack on hospital facility fees for provider office visits. In fact, prices for services provided by acquired physicians increase by an average of 14.1 percent after acquisition.[12] Hospital consolidation and a lack of pricing information contribute to private plans paying double what Medicare would have paid for the same services.[13] Estimated savings gained from applying site-neutral payments to the commercial market could reach nearly $60 billion annually.[14]

During the HELP Subcommittee's June 21, 2023, hearing, Ms. Sachdev spoke to the need for legislation to protect plans from hospital facility fees applied to outpatient services, citing recent actions in Indiana.[15] Ms. Monahan elaborated on this point, citing the challenges that plans and insurers face in identifying outpatient services, given the lack of transparency requirements on hospitals to identify services provided in the outpatient setting.[16] Ms. Tripoli further provided examples of patients charged high hospital-facility fees, despite never setting foot in the hospital charging them.[17] Members and witnesses called for legislation to protect employers and workers from unnecessary costs by requiring honest billing practices from hospitals for outpatient services.

Support for Transparency in Billing

Plans and consumers recognize the value of appropriate billing for health care services. Better Solutions for Healthcare applauded the Committee's focus on ensuring honest billing practices by hospitals to promote competition and transparency and to prevent markups of prices for services, all of which create market distortions.[18] Similarly, Families USA praised the Committee's work "to

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[8] *Id.*
[9] *Id.*
[10] Pub. L. No. 114–74 (2015).
[11] https://www.medpac.gov/document/june-2022-report-to-the-congress-medicare-and-the-health-care-delivery-system/.
[12] https://pubmed.ncbi.nlm.nih.gov/29727744/.
[13] https://www.rand.org/health-care/projects/price-transparency/hospital-pricing.html.
[14] https://7fe67d73-acdc-4d7a-9f6a-0a2c5dd0a4bc.usrfiles.com/ugd/7fe67d_b20c817a6e314fb0a05e331a22a2d995.pdf.
[15] https://edworkforce.house.gov/uploadedfiles/sachdev_testimony.pdf.
[16] https://edworkforce.house.gov/uploadedfiles/monahan_testimony.pdf.
[17] https://edworkforce.house.gov/uploadedfiles/tripoli_testimony.pdf.
[18] https://bettersolutionsforhealthcare.org/press-release-better-solutions-applauds-congressional-scrutiny-on-dishonest-billing/.

begin to remedy some of the most obvious health system failings by advancing legislation to rein in dishonest billing practices." [19]

H.R. 4509, THE TRANSPARENCY IN BILLING ACT

H.R. 4509, the *Transparency in Billing Act*, amends ERISA to require group health plans and health insurance issuers offering group health insurance coverage only to pay claims submitted by hospitals that have in place policies and procedures to ensure accurate billing practices. H.R. 4509 prevents hospitals from submitting claims without a separate unique health identifier for the off-campus outpatient department. By imposing this requirement, the legislation ensures that group health plans only pay for services that are appropriately billed for the correct site of service, and it prevents hospitals from obscuring the true site of service in order to charge higher prices via facility fees or other charges.

CONCLUSION

H.R. 4509, the *Transparency in Billing Act*, reaffirms common sense: hospitals should only be allowed to bill at the correct price for the site of care where services are rendered. If a service is provided at an outpatient facility, it should be billed at the rate associated with the off-campus outpatient department, not as if it was provided at a hospital. The bill also protects plans from paying for claims for services rendered at an off-campus outpatient department that are incorrectly billed. These are important protections for plans and the participants and beneficiaries that they serve. Codifying these protections in ERISA ensures that the vast majority of insured Americans will benefit from these protections, which will result in cost savings for employers and workers alike.

SUMMARY

H.R. 4509 SECTION-BY-SECTION SUMMARY

The following is a section-by-section analysis of H.R. 4509, the *Transparency in Billing Act*, introduced by Chairwoman Foxx and Ranking Member Scott and reported favorably by the Committee.

Section 1. Short title

Section 1 provides that the short title is "Transparency in Billing Act."

Section 2. Honest billing requirements

Section 2 amends the *Employee Retirement Income Security Act of 1974* (ERISA) to prevent group health plans and health insurance issuers from paying a claim submitted by a hospital unless the hospital is in compliance with Section 3. The effective date of Section 2 is January 1, 2024.

Section 3. Regulation of honest billing

Section 3 amends ERISA to disallow hospitals from submitting a claim for items or services furnished at an off-campus outpatient department to a group health plan or health insurance issuer un-

[19] https://familiesusa.org/press-releases/families-usa-congress-continues-to-make-important-strides-toward-improved-transparency/.

less (1) the hospital obtains a separate unique health identifier for the off-campus outpatient department, and (2) the claim for these items or services furnished at an off-campus outpatient department includes a separate unique health identifier.

Section 4. Enforcement

Section 4 authorizes the U.S. Secretary of Labor to assess civil monetary penalties against hospitals for violations: $300 per day for ongoing violations for hospitals with not more than 30 beds and $5,500 per day for ongoing violations for hospitals with more than 30 beds.

EXPLANATION OF AMENDMENTS

The amendments, including the amendment in the nature of a substitute, are explained in the body of this report.

APPLICATION OF THE LAW TO THE LEGISLATIVE BRANCH

Section 102(b)3 of Public Law 104–1 requires a description of the application of this bill to the legislative branch. H.R. 4509 takes important steps to increase accountability that will benefit health care consumers—including access for any eligible employees of the Legislative Branch—by protecting employer-sponsored health plans from paying for incorrectly billed outpatient health claims.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIONS

The goal of H.R. 4509 is to protect employer-sponsored health plans from overpaying for services that are incorrectly billed by hospital outpatient facilities.

REQUIRED COMMITTEE HEARING AND RELATED HEARINGS

In compliance with clause 3(c)(6) of rule XIII of the Rules of House of Representatives, the following hearings held during the 118th Congress were used to develop or consider H.R. 4509: on April 26, 2023, the HELP Subcommittee held a hearing entitled "Reducing Health Care Costs for Working Americans and Their Families"; on June 13, 2023, the Committee held a hearing entitled "Examining the Policies and Priorities of the U.S. Department of Health and Human Services"; and on June 21, 2023, the HELP Subcommittee held a hearing entitled "Competition and Transparency: The Pathway Forward for a Stronger Health Care Market."

UNFUNDED MANDATE STATEMENT

Pursuant to Section 423 of the Congressional Budget and Impoundment Control Act of 1974, Pub. L. No. 93–344 (as amended by Section 101(a)(2) of the Unfunded Mandates Reform Act of 1995, Pub. L. No. 104–4), the Committee adopts as its own the cost estimate prepared by the Congressional Budget Office (CBO) pursuant to section 402 of the Congressional Budget and Impoundment Control Act of 1974.

EARMARK STATEMENT

H.R. 4509 does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9 of rule XXI of the Rules of the House of Representatives.

ROLL CALL VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee Report to include, for each record vote on a motion to report the measure or matter and on any amendments offered to the measure or matter, the total number of votes for and against and the names of the Members voting for and against.

Date: 7/12/2023

COMMITTEE ON EDUCATION AND THE WORKFORCE RECORD OF COMMITTEE VOTE

Roll Call: 1 Bill: HR 4509 Amendment Number: n/a

Disposition: Adopted by a Full Committee Roll Call Vote (39-0)

Sponsor/Amendment: Bean Motion to Report

Name & State	Aye	No	Not Voting	Name & State	Aye	No	Not Voting
Mrs. FOXX (NC) (Chairwoman)	X			Mr. SCOTT (VA) (Ranking)	X		
Mr. WILSON (SC)			X	Mr. GRIJALVA (AZ)			X
Mr. THOMPSON (PA)	X			Mr. COURNTEY (CT)	X		
Mr. WALBERG (MI)	X			Mr. SABLAN (MP)	X		
Mr. GROTHMAN (WI)	X			Ms. WILSON (FL)	X		
Ms. STEFANIK (NY)	X			Ms. BONAMICI (OR)	X		
Mr. ALLEN (GA)	X			Mr. TAKANO (CA)	X		
Mr. BANKS (IN)	X			Ms. ADAMS (NC)	X		
Mr. COMER (KY)			X	Mr. DESAULNIER (CA)	X		
Mr. SMUCKER (PA)	X			Mr. NORCROSS (NJ)	X		
Mr. OWENS (UT)	X			Ms. JAYAPAL (WA)			X
Mr. GOOD (VA)	X			Ms. WILD (PA)	X		
Mrs. MCCLAIN (MI)	X			Ms. MCBATH (GA)	X		
Mrs. MILLER (IL)	X			Mrs. HAYES (CT)	X		
Mrs. STEEL (CA)	X			Ms. OMAR (MN)			X
Mr. ESTES (KS)	X			Ms. STEVENS (MI)	X		
Ms. LETLOW (LA)	X			Ms. LEGER FERNÁNDEZ (NM)	X		
Mr. KILEY (CA)	X			Ms. MANNING (NC)	X		
Mr. BEAN (FL)	X			Mr. MRVAN (IN)	X		
Mr. BURLISON (MO)	X			Mr. BOWMAN (NY)	X		
Mr. MORAN (TX)	X						
Mr. JAMES (MI)	X						
Ms. CHAVEZ-DEREMER (OR)	X						
Mr. WILLIAMS (NY)			X				
Ms. HOUCHIN (IN)	X						

TOTALS: Ayes: 39 Nos: 0 Not Voting: 6

Total: 45 / Quorum: / Report:

(25 R - 20 D)

DUPLICATION OF FEDERAL PROGRAMS

No provision of H.R. 4509 establishes or reauthorizes a program of the Federal Government known to be duplicative of another Federal program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

STATEMENT OF OVERSIGHT FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE

In compliance with clause 3(c)(1) of rule XIII and clause 2(b)(1) of rule X of the Rules of the House of Representatives, the Committee's oversight findings and recommendations are reflected in the body of this report.

NEW BUDGET AUTHORITY AND CBO COST ESTIMATE

With respect to the requirements of clause 3(c)(2) of rule XIII of the Rules of the House of Representatives and section 308(a) of the Congressional Budget Act of 1974 and with respect to requirements of clause 3(c)(3) of rule XIII of the Rules of the House of Representatives and section 402 of the Congressional Budget Act of 1974, the Committee requested a cost estimate from the Congressional Budget Office. The Committee adopts the following estimate for H.R. 4509 provided by the Congressional Budget Office to Majority staff via email on August 16, 2023: "For H.R. 4509 (Transparency in Billing Act of 2023, with time stamp July 11, 2023 at 9:50am), consistent with the preliminary estimate we shared on 7/6/2023, we estimate over the 2024–2033 period, there would be a decrease in direct spending by $403 million and increase in revenues by $1,919 million, for a total decrease in the deficit of about $2,321 million (components do not sum to total due to rounding). Of that reduction in the deficit, $81 million is a reduction in Medicare outlays."

COMMITTEE COST ESTIMATE

Clause 3(d)(1) of rule XIII of the Rules of the House of Representatives requires an estimate and a comparison of the costs that would be incurred in carrying out H.R. 4509. However, clause 3(d)(2)(B) of that rule provides that this requirement does not apply when, as with the present report, the committee adopts as its own the cost estimate of the bill prepared by the Congressional Budget Office under section 402 of the Congressional Budget Act.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, and existing law in which no change is proposed is shown in roman):

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

SHORT TITLE AND TABLE OF CONTENTS

SECTION 1. This Act may be cited as the "Employee Retirement Income Security Act of 1974".

TABLE OF CONTENTS

TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

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SUBTITLE B—REGULATORY PROVISIONS

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PART 5—ADMINISTRATION AND ENFORCEMENT

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CIVIL ENFORCEMENT

SEC. 502. (a) A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of section 105(c) or 113(a);

(5) except as otherwise provided in subsection (b), by the Secretary (A) to enjoin any act or practice which violates any pro-

vision of this title, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this title;

(6)by the Secretary to collect any civil penalty under paragraph (2), (4), (5), (6), (7), (8), [or (9)] *(9), or (13)* of subsection (c) or under subsection (i) or (l);

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 609(a)(2)(A));

(8) by the Secretary, or by an employer or other person referred to in section 101(f)(1), (A) to enjoin any act or practice which violates subsection (f) of section 101, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection;

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts;

(10) in the case of a multiemployer plan that has been certified by the actuary to be in endangered or critical status under section 305, if the plan sponsor—

(A) has not adopted a funding improvement or rehabilitation plan under that section by the deadline established in such section, or

(B) fails to update or comply with the terms of the funding improvement or rehabilitation plan in accordance with the requirements of such section,

by an employer that has an obligation to contribute with respect to the multiemployer plan or an employee organization that represents active participants in the multiemployer plan, for an order compelling the plan sponsor to adopt a funding improvement or rehabilitation plan or to update or comply with the terms of the funding improvement or rehabilitation plan in accordance with the requirements of such section and the funding improvement or rehabilitation plan; or

(11) in the case of a multiemployer plan, by an employee representative, or any employer that has an obligation to contribute to the plan, (A) to enjoin any act or practice which violates subsection (k) of section 101 (or, in the case of an employer, subsection (l) of such section), or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection.

(b)(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of the Internal Revenue Code of 1986 (or with respect to which an application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under subsection (a)(5) with respect to a violation of,

or the enforcement of, parts 2 and 3 of this subtitle (relating to participation, vesting, and funding), only if—

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 515.

(3) Except as provided in subsections (c)(9) and (a)(6) (with respect to collecting civil penalties under subsection (c)(9)), the Secretary is not authorized to enforce under this part any requirement of part 7 against a health insurance issuer offering health insurance coverage in connection with a group health plan (as defined in section 706(a)(1)). Nothing in this paragraph shall affect the authority of the Secretary to issue regulations to carry out such part.

(c)(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 606, section 101(e)(1), section 101(f),, section 105(a), or section 113(a) with respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this title to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.

(2) The Secretary may assess a civil penalty against any plan administrator of up to $1,000 a day from the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 101(b)(1). For purposes of this paragraph, an annual report that has been rejected under section 104(a)(4) for failure to provide material information shall not be treated as having been filed with the Secretary.

(3) Any employer maintaining a plan who fails to meet the notice requirement of section 101(d) with respect to any participant or beneficiary or who fails to meet the requirements of section 101(e)(2) with respect to any person or who fails to meet the requirements of section 302(d)(12)(E) with respect to any person may in the court's discretion be liable to such participant or beneficiary or to such person in the amount of up to $100 a day from the date of such failure, and the court may in its discretion order such other relief as it deems proper.

(4) The Secretary may assess a civil penalty of not more than $1,000 a day for each violation by any person of subsection (j), (k), or (l) of section 101 or section 514(e)(3).

(5) The Secretary may assess a civil penalty against any person of up to $1,000 a day from the date of the person's failure or refusal to file the information required to be filed by such person with the Secretary under regulations prescribed pursuant to section 101(g).

(6) If, within 30 days of a request by the Secretary to a plan administrator for documents under section 104(a)(6), the plan administrator fails to furnish the material requested to the Secretary, the Secretary may assess a civil penalty against the plan administrator of up to $100 a day from the date of such failure (but in no event in excess of $1,000 per request). No penalty shall be imposed under this paragraph for any failure resulting from matters reasonably beyond the control of the plan administrator.

(7) The Secretary may assess a civil penalty against a plan administrator of up to $100 a day from the date of the plan administrator's failure or refusal to provide notice to participants and beneficiaries in accordance with subsection (i) or (m) of section 101. For purposes of this paragraph, each violation with respect to any single participant or beneficiary shall be treated as a separate violation.

(8) The Secretary may assess against any plan sponsor of a multiemployer plan a civil penalty of not more than $1,100 per day—

(A) for each violation by such sponsor of the requirement under section 305 to adopt by the deadline established in that section a funding improvement plan or rehabilitation plan with respect to a multiemployer plan which is in endangered or critical status, or

(B) in the case of a plan in endangered status which is not in seriously endangered status, for failure by the plan to meet the applicable benchmarks under section 305 by the end of the funding improvement period with respect to the plan.

(9)(A) The Secretary may assess a civil penalty against any employer of up to $100 a day from the date of the employer's failure to meet the notice requirement of section 701(f)(3)(B)(i)(I). For purposes of this subparagraph, each violation with respect to any single employee shall be treated as a separate violation.

(B) The Secretary may assess a civil penalty against any plan administrator of up to $100 a day from the date of the plan administrator's failure to timely provide to any State the information required to be disclosed under section 701(f)(3)(B)(ii). For purposes of this subparagraph, each violation with respect to any single participant or beneficiary shall be treated as a separate violation.

(10) SECRETARIAL ENFORCEMENT AUTHORITY RELATING TO USE OF GENETIC INFORMATION.—

(A) GENERAL RULE.—The Secretary may impose a penalty against any plan sponsor of a group health plan, or any health insurance issuer offering health insurance coverage in connection with the plan, for any failure by such sponsor or issuer to meet the requirements of subsection (a)(1)(F), (b)(3), (c), or (d) of section 702 or section 701 or

702(b)(1) with respect to genetic information, in connection with the plan.

(B) AMOUNT.—

(i) IN GENERAL.—The amount of the penalty imposed by subparagraph (A) shall be $100 for each day in the noncompliance period with respect to each participant or beneficiary to whom such failure relates.

(ii) NONCOMPLIANCE PERIOD.—For purposes of this paragraph, the term "noncompliance period" means, with respect to any failure, the period—

(I) beginning on the date such failure first occurs; and

(II) ending on the date the failure is corrected.

(C) MINIMUM PENALTIES WHERE FAILURE DISCOVERED.—Notwithstanding clauses (i) and (ii) of subparagraph (D):

(i) IN GENERAL.—In the case of 1 or more failures with respect to a participant or beneficiary—

(I) which are not corrected before the date on which the plan receives a notice from the Secretary of such violation; and

(II) which occurred or continued during the period involved;

the amount of penalty imposed by subparagraph (A) by reason of such failures with respect to such participant or beneficiary shall not be less than $2,500.

(ii) HIGHER MINIMUM PENALTY WHERE VIOLATIONS ARE MORE THAN DE MINIMIS.—To the extent violations for which any person is liable under this paragraph for any year are more than de minimis, clause (i) shall be applied by substituting "$15,000" for "$2,500" with respect to such person.

(D) LIMITATIONS.—

(i) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be imposed by subparagraph (A) on any failure during any period for which it is established to the satisfaction of the Secretary that the person otherwise liable for such penalty did not know, and exercising reasonable diligence would not have known, that such failure existed.

(ii) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN CERTAIN PERIODS.—No penalty shall be imposed by subparagraph (A) on any failure if—

(I) such failure was due to reasonable cause and not to willful neglect; and

(II) such failure is corrected during the 30-day period beginning on the first date the person otherwise liable for such penalty knew, or exercising reasonable diligence would have known, that such failure existed.

(iii) OVERALL LIMITATION FOR UNINTENTIONAL FAILURES.—In the case of failures which are due to reasonable cause and not to willful neglect, the penalty imposed by subparagraph (A) for failures shall not exceed the amount equal to the lesser of—

(I) 10 percent of the aggregate amount paid or incurred by the plan sponsor (or predecessor plan sponsor) during the preceding taxable year for group health plans; or

(II) $500,000.

(E) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by subparagraph (A) to the extent that the payment of such penalty would be excessive relative to the failure involved.

(F) DEFINITIONS.—Terms used in this paragraph which are defined in section 733 shall have the meanings provided such terms in such section.

(11) The Secretary and the Secretary of Health and Human Services shall maintain such ongoing consultation as may be necessary and appropriate to coordinate enforcement under this subsection with enforcement under section 1144(c)(8) of the Social Security Act.

(12) The Secretary may assess a civil penalty against any sponsor of a CSEC plan of up to $100 a day from the date of the plan sponsor's failure to comply with the requirements of section 306(j)(3) to establish or update a funding restoration plan.

(13) The Secretary may assess a civil monetary penalty against a hospital for a violation under section 901 in an amount—

(A) in the case of a hospital with not more than 30 beds (as determined under section 180.90(c)(2)(ii)(D) of title 45, Code of Federal Regulations, as in effect on the date of the enactment of this paragraph), not to exceed $300 per day that the violation is ongoing, as determined by the Secretary; and

(B) in the case of a hospital with more than 30 beds (as so determined), not to exceed $5,500 per each such day.

(d)(1) An employee benefit plan may sue or be sued under this title as an entity. Service of summons, subpena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this title against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this title.

(e)(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this title brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in

section 101(f)(1). State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this title is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g)(1) In any action under this title (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this title by a fiduciary for or on behalf of a plan to enforce section 515 in which a judgment in favor of the plan is awarded, the court shall award the plan—

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of—

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of the Internal Revenue Code of 1986.

(h) A copy of the complaint in any action under this title by a participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle. If the Secretary brings an action under subsection (a) on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) In the case of a transaction prohibited by section 406 by a party in interest with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved in each such transaction (as defined in section 4975(f)(4) of the Internal Revenue Code of 1986) for each year or part thereof during which the prohibited transaction continues, ex-

cept that, if the transaction is not corrected (in such manner as the Secretary shall prescribe in regulations which shall be consistent with section 4975(f)(5) of such Code) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 4975(e)(1) of such Code.

(j) In all civil actions under this title, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of title 28, United States Code), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this Act, or to compel him to take action required under this title, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(l)(1) In the case of—

(A) any breach of fiduciary responsibility under (or other violation of) part 4 by a fiduciary, or

(B) any knowing participation in such a breach or violation by any other person,

the Secretary shall assess a civil penalty against such fiduciary or other person in an amount equal to 20 percent of the applicable recovery amount.

(2) For purposes of paragraph (1), the term "applicable recovery amount" means any amount which is recovered from a fiduciary or other person with respect to a breach or violation described in paragraph (1)—

(A) pursuant to any settlement agreement with the Secretary, or

(B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and beneficiaries in a judicial proceeding instituted by the Secretary under subsection (a)(2) or (a)(5).

(3) The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty under paragraph (1) if the Secretary determines in writing that—

(A) the fiduciary or other person acted reasonably and in good faith, or

(B) it is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan (or to provide the relief ordered pursuant to subsection (a)(9)) without severe financial hardship unless such waiver or reduction is granted.

(4) The penalty imposed on a fiduciary or other person under this subsection with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such fiduciary or other person with respect to such transaction under subsection (i) of this section and section 4975 of the Internal Revenue Code of 1986.

(m) In the case of a distribution to a pension plan participant or beneficiary in violation of section 206(e) by a plan fiduciary, the Secretary shall assess a penalty against such fiduciary in an amount equal to the value of the distribution. Such penalty shall not exceed $10,000 for each such distribution.

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PART 7—GROUP HEALTH PLAN REQUIREMENTS

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SUBPART B—OTHER REQUIREMENTS

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SEC. 726. HONEST BILLING REQUIREMENTS.

A group health plan or health insurance issuer offering group health insurance coverage may not pay a claim for items and services furnished to an individual at an off-campus outpatient department of a provider (as defined in section 901(c)) submitted by a hospital (as defined in section 1861(e) of the Social Security Act) unless such claim submitted by such hospital includes the separate unique health identifier for the department where items and services were furnished, in accordance with section 901.

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PART 9—BILLING REQUIREMENTS WITH RESPECT TO GROUP HEALTH PLANS AND COVERAGE

SEC. 901. HONEST BILLING REQUIREMENTS.

(a) IN GENERAL.—A hospital may not, with respect to items and services furnished to an individual at an off-campus outpatient department of a provider, submit a claim for such items and services to a group health plan or health insurance issuer, and may not hold such individual liable for such items and services, unless—

(1) such hospital obtains a separate unique health identifier established for such department pursuant to section 1173(b) of the Social Security Act; and

(2) the claim for such items and services includes such separate unique health identifier for such department where such items and services were furnished.

(b) PROCESS FOR REPORTING SUSPECTED VIOLATIONS.—Not later than one year after the date of enactment of this section, the Secretary shall establish a process under which a suspected violation of this section may be reported to such Secretary.

(c) OFF-CAMPUS OUTPATIENT DEPARTMENT OF A PROVIDER DEFINED.—For purposes of this paragraph, the term "off-campus outpatient department of a provider" means a department of a provider (as defined in section 413.65 of title 42, Code of Federal Regulations, or any successor regulation) that is not located—

(1) on the campus (as defined in such section) of such provider; or

(2) within the distance (described in such definition of campus) from a remote location of a hospital facility (as defined in such section).

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