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119TH CONGRESS
1ST SESSION

H. R. 6248

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

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 21, 2025

Mr. ARRINGTON (for himself, Mr. DAVIS of North Carolina, and Mr. ALLEN) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and Workforce, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

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

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

SECTION 1. SHORT TITLE.

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

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

(a) IN GENERAL.—

(1) PHSA.—

(A) IN GENERAL.—Section 2799A–9 of the Public Health Service Act (42 U.S.C. 300gg–119) is amended by adding at the end the following:

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

''(1) IN GENERAL.—A group health plan or a health insurance issuer offering group or individual health insurance coverage may not enter into an agreement with a covered entity (as defined in paragraph (3)) if such agreement, directly or indirectly—

''(A) restricts (including by operation of any agreement in effect between such covered entity and another covered entity) the group health plan (whether self-insured or fully insured) or health insurance issuer from—

''(i) directing or steering participants or beneficiaries to other health care providers who are not subject to such agreement; or

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

"(B) requires the group health plan or health insurance issuer to enter into any additional agreement with an affiliate of the covered entity;

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

"(D) restricts other group health plans or health insurance issuers not party to the agreement from paying a lower rate for items or services than the plan or issuer involved in the agreement pays for such items or services.

"(2) EXCEPTIONS FOR CERTAIN PROVIDER GROUP AND VALUE-BASED NETWORK DESIGNS.—Paragraph (1)(A) shall not apply to a group health plan or health insurance issuer offering group or individual health insurance coverage with respect to—

"(A) a health maintenance organization (as defined in section 2791(b)(3)), if such health maintenance organization operates primarily through exclusive contracts with multi-

specialty physician groups, nor to any arrangement between such a health maintenance organization and its affiliates; or

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

"(3) COVERED ENTITY DEFINED.—For purposes of this subsection, the term 'covered entity' means a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers.

"(4) RULE OF CONSTRUCTION.—Except as provided in paragraph (1), nothing in this subsection shall be construed to limit network design or cost or quality initiatives by a group health plan or health insurance issuer, including accountable care organizations, exclusive provider organizations, networks that tier providers by cost or quality or steer enroll-

ees to centers of excellence, or other pay-for-performance programs.''.

(B) REGULATIONS.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with the Secretary of Labor and the Secretary of the Treasury, shall promulgate regulations to carry out the amendments made by this paragraph.

(2) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(A) IN GENERAL.—Section 724 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185m) is amended—

(i) in the header, by striking ''**BY REMOVING**'' and all that follows through ''**INFORMATION**'' and inserting ''**; PROHIBITION ON ANTICOMPETITIVE AGREEMENTS**'';

(ii) in subsection (a)(4), in the first sentence, by striking ''section'' and inserting ''subsection''; and

(iii) by adding at the end the following:

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

''(1) IN GENERAL.—A group health plan or a health insurance issuer offering group health insurance coverage may not enter into an agreement with a covered entity (as defined in paragraph (3)) if such agreement, directly or indirectly—

''(A) restricts (including by operation of any agreement in effect between such covered entity and another covered entity) the group health plan (whether self-insured or fully insured) or health insurance issuer from—

''(i) directing or steering participants or beneficiaries to other health care providers who are not subject to such agreement; or

''(ii) offering incentives to encourage participants or beneficiaries to utilize specific health care providers;

''(B) requires the group health plan or health insurance issuer to enter into any additional agreement with an affiliate of the covered entity;

''(C) requires the group health plan or health insurance issuer to agree to payment

rates or other terms for any affiliate of the covered entity not party to the agreement; or

"(D) restricts other group health plans or health insurance issuers not party to the agreement from paying a lower rate for items or services than the plan or issuer involved in the agreement pays for such items or services.

"(2) EXCEPTIONS FOR CERTAIN PROVIDER GROUP AND VALUE-BASED NETWORK DESIGNS.—Paragraph (1)(A) shall not apply to a group health plan or health insurance issuer offering group health insurance coverage with respect to—

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

"(B) a value-based network arrangement, such as an exclusive provider network, accountable care organization, center of excellence, a provider sponsored health insurance issuer that operates primarily through aligned multi-specialty physician group practices or integrated

health systems, or such other similar network arrangements as determined by the Secretary through guidance or rulemaking.

''(3) COVERED ENTITY DEFINED.—For purposes of this subsection, the term 'covered entity' means a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers.

''(4) RULE OF CONSTRUCTION.—Except as provided in paragraph (1), nothing in this subsection shall be construed to limit network design or cost or quality initiatives by a group health plan or health insurance issuer, including accountable care organizations, exclusive provider organizations, networks that tier providers by cost or quality or steer enrollees to centers of excellence, or other pay-for-performance programs.''.

(B) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act is amended, in the entry relating to section 724, by amending such entry to read as follows:

''Sec. 724. Increasing transparency; prohibition on anticompetitive agreements.''.

(C) REGULATIONS.—Not later than 1 year after the date of the enactment of this Act, the

Secretary of Labor, in consultation with the Secretary of Health and Human Services and the Secretary of the Treasury, shall promulgate regulations to carry out the amendments made by this paragraph.

(3) IRC.—

(A) IN GENERAL.—Section 9824 of the Internal Revenue Code of 1986 is amended—

(i) in the header, by striking ''**BY REMOVING**'' and all that follows through ''**INFORMATION**'' and inserting ''**; PROHIBITION ON ANTICOMPETITIVE AGREEMENTS**'';

(ii) in subsection (a)(4), in the first sentence, by striking ''section'' and inserting ''subsection''; and

(iii) by adding at the end the following:

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

''(1) IN GENERAL.—A group health plan may not enter into an agreement with a covered entity (as defined in paragraph (3)) if such agreement, directly or indirectly—

"(A) restricts (including by operation of any agreement in effect between such covered entity and another covered entity) the group health plan (whether self-insured or fully insured) from—

"(i) directing or steering participants or beneficiaries to other health care providers who are not subject to such agreement; or

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

"(B) requires the group health plan to enter into any additional agreement with an affiliate of the covered entity;

"(C) requires the group health plan to agree to payment rates or other terms for any affiliate of the covered entity not party to the agreement; or

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

''(2) EXCEPTIONS FOR CERTAIN PROVIDER GROUP AND VALUE-BASED NETWORK DESIGNS.—Paragraph (1)(A) shall not apply to a group health plan with respect to—

''(A) a health maintenance organization (as defined in section 9832(b)(3)), if such health maintenance organization operates primarily through exclusive contracts with multi-specialty physician groups, nor to any arrangement between such a health maintenance organization and its affiliates; or

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

''(3) COVERED ENTITY DEFINED.—For purposes of this subsection, the term 'covered entity' means a health care provider, network or association of providers, third-party administrator, or other

service provider offering access to a network of providers.

''(4) RULE OF CONSTRUCTION.—Except as provided in paragraph (1), nothing in this subsection shall be construed to limit network design or cost or quality initiatives by a group health plan, including accountable care organizations, exclusive provider organizations, networks that tier providers by cost or quality or steer enrollees to centers of excellence, or other pay-for-performance programs.''.

(B) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act is amended, in the entry relating to section 9824, by amending such entry to read as follows:

''Sec. 9824. Increasing transparency; prohibition on anticompetitive agreements.''.

(C) REGULATIONS.—Not later than 1 year after the date of the enactment of this Act, the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services and the Secretary of Labor, shall promulgate regulations to carry out the amendments made by this paragraph.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to any contract en-

tered into, amended, or renewed on or after the date that is 18 months after the date of enactment of this Act.

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