

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

A BILL

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

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Healthy Competition
5 for Better Care Act”.

1 **SEC. 2. BANNING ANTICOMPETITIVE TERMS IN FACILITY**
2 **AND INSURANCE CONTRACTS THAT LIMIT AC-**
3 **CESS TO HIGHER QUALITY, LOWER COST**
4 **CARE.**

5 (a) IN GENERAL.—

6 (1) PHSA.—

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

11 “(b) PROTECTING HEALTH PLANS NETWORK DE-
12 SIGN FLEXIBILITY.—

13 “(1) IN GENERAL.—A group health plan or a
14 health insurance issuer offering group or individual
15 health insurance coverage may not enter into an
16 agreement with a covered entity (as defined in para-
17 graph (3)) if such agreement, directly or indirectly—

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

23 “(i) directing or steering participants
24 or beneficiaries to other health care pro-
25 viders who are not subject to such agree-
26 ment; or

1 “(ii) offering incentives to encourage
2 participants or beneficiaries to utilize spe-
3 cific health care providers;

4 “(B) requires the group health plan or
5 health insurance issuer to enter into any addi-
6 tional agreement with an affiliate of the covered
7 entity;

8 “(C) requires the group health plan or
9 health insurance issuer to agree to payment
10 rates or other terms for any affiliate of the cov-
11 ered entity not party to the agreement; or

12 “(D) restricts other group health plans or
13 health insurance issuers not party to the agree-
14 ment from paying a lower rate for items or
15 services than the plan or issuer involved in the
16 agreement pays for such items or services.

17 “(2) EXCEPTIONS FOR CERTAIN PROVIDER
18 GROUP AND VALUE-BASED NETWORK DESIGNS.—
19 Paragraph (1)(A) shall not apply to a group health
20 plan or health insurance issuer offering group or in-
21 dividual health insurance coverage with respect to—

22 “(A) a health maintenance organization
23 (as defined in section 2791(b)(3)), if such
24 health maintenance organization operates pri-
25 marily through exclusive contracts with multi-

1 specialty physician groups, nor to any arrange-
2 ment between such a health maintenance orga-
3 nization and its affiliates; or

4 “(B) a value-based network arrangement,
5 such as an exclusive provider network, account-
6 able care organization, center of excellence, a
7 provider sponsored health insurance issuer that
8 operates primarily through aligned multi-spe-
9 cialty physician group practices or integrated
10 health systems, or such other similar network
11 arrangements as determined by the Secretary
12 through guidance or rulemaking.

13 “(3) COVERED ENTITY DEFINED.—For pur-
14 poses of this subsection, the term ‘covered entity’
15 means a health care provider, network or association
16 of providers, third-party administrator, or other
17 service provider offering access to a network of pro-
18 viders.

19 “(4) RULE OF CONSTRUCTION.—Except as pro-
20 vided in paragraph (1), nothing in this subsection
21 shall be construed to limit network design or cost or
22 quality initiatives by a group health plan or health
23 insurance issuer, including accountable care organi-
24 zations, exclusive provider organizations, networks
25 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:

1 “(b) PROTECTING HEALTH PLANS NETWORK DE-
2 SIGN FLEXIBILITY.—

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

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

13 “(i) directing or steering participants
14 or beneficiaries to other health care pro-
15 viders who are not subject to such agree-
16 ment; or

17 “(ii) offering incentives to encourage
18 participants or beneficiaries to utilize spe-
19 cific health care providers;

20 “(B) requires the group health plan or
21 health insurance issuer to enter into any addi-
22 tional agreement with an affiliate of the covered
23 entity;

24 “(C) requires the group health plan or
25 health insurance issuer to agree to payment

1 rates or other terms for any affiliate of the cov-
2 ered entity not party to the agreement; or

3 “(D) restricts other group health plans or
4 health insurance issuers not party to the agree-
5 ment from paying a lower rate for items or
6 services than the plan or issuer involved in the
7 agreement pays for such items or services.

8 “(2) EXCEPTIONS FOR CERTAIN PROVIDER
9 GROUP AND VALUE-BASED NETWORK DESIGNS.—

10 Paragraph (1)(A) shall not apply to a group health
11 plan or health insurance issuer offering group health
12 insurance coverage with respect to—

13 “(A) a health maintenance organization
14 (as defined in section 733(b)(3)), if such health
15 maintenance organization operates primarily
16 through exclusive contracts with multi-specialty
17 physician groups, nor to any arrangement be-
18 tween such a health maintenance organization
19 and its affiliates; or

20 “(B) a value-based network arrangement,
21 such as an exclusive provider network, account-
22 able care organization, center of excellence, a
23 provider sponsored health insurance issuer that
24 operates primarily through aligned multi-spe-
25 cialty physician group practices or integrated

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

4 “(3) COVERED ENTITY DEFINED.—For pur-
 5 poses of this subsection, the term ‘covered entity’
 6 means a health care provider, network or association
 7 of providers, third-party administrator, or other
 8 service provider offering access to a network of pro-
 9 viders.

10 “(4) RULE OF CONSTRUCTION.—Except as pro-
 11 vided in paragraph (1), nothing in this subsection
 12 shall be construed to limit network design or cost or
 13 quality initiatives by a group health plan or health
 14 insurance issuer, including accountable care organi-
 15 zations, exclusive provider organizations, networks
 16 that tier providers by cost or quality or steer enroll-
 17 ees to centers of excellence, or other pay-for-per-
 18 formance programs.”.

19 (B) CLERICAL AMENDMENT.—The table of
 20 contents in section 1 of such Act is amended,
 21 in the entry relating to section 724, by amend-
 22 ing such entry to read as follows:

“Sec. 724. Increasing transparency; prohibition on anticompetitive agree-
 ments.”.

23 (C) REGULATIONS.—Not later than 1 year
 24 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—

1 “(A) restricts (including by operation of
2 any agreement in effect between such covered
3 entity and another covered entity) the group
4 health plan (whether self-insured or fully in-
5 sured) from—

6 “(i) directing or steering participants
7 or beneficiaries to other health care pro-
8 viders who are not subject to such agree-
9 ment; or

10 “(ii) offering incentives to encourage
11 participants or beneficiaries to utilize spe-
12 cific health care providers;

13 “(B) requires the group health plan to
14 enter into any additional agreement with an af-
15 filiate of the covered entity;

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

20 “(D) restricts other group health plans not
21 party to the agreement from paying a lower
22 rate for items or services than the plan involved
23 in the agreement pays for such items or serv-
24 ices.

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

5 “(A) a health maintenance organization
6 (as defined in section 9832(b)(3)), if such
7 health maintenance organization operates pri-
8 marily through exclusive contracts with multi-
9 specialty physician groups, nor to any arrange-
10 ment between such a health maintenance orga-
11 nization and its affiliates; or

12 “(B) a value-based network arrangement,
13 such as an exclusive provider network, account-
14 able care organization, center of excellence, a
15 provider sponsored health insurance issuer that
16 operates primarily through aligned multi-spe-
17 cialty physician group practices or integrated
18 health systems, or such other similar network
19 arrangements as determined by the Secretary
20 through guidance or rulemaking.

21 “(3) COVERED ENTITY DEFINED.—For pur-
22 poses of this subsection, the term ‘covered entity’
23 means a health care provider, network or association
24 of providers, third-party administrator, or other

1 service provider offering access to a network of pro-
2 viders.

3 “(4) RULE OF CONSTRUCTION.—Except as pro-
4 vided in paragraph (1), nothing in this subsection
5 shall be construed to limit network design or cost or
6 quality initiatives by a group health plan, including
7 accountable care organizations, exclusive provider or-
8 ganizations, networks that tier providers by cost or
9 quality or steer enrollees to centers of excellence, or
10 other pay-for-performance programs.”.

11 (B) CLERICAL AMENDMENT.—The table of
12 contents in section 1 of such Act is amended,
13 in the entry relating to section 9824, by amend-
14 ing such entry to read as follows:

“Sec. 9824. Increasing transparency; prohibition on anticompetitive agree-
ments.”.

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

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

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

