McDermott + CONSULTING | HEALTH LOBBYING ANALYTICS POLICY

Surprise Billing Bill Comparison

Provision	Energy & Commerce: "No Surprises Act"	Senate: "STOP Surprise Medical Bills"*
Introduced	May 14, 2019 by Representative Frank Pallone (D-NJ) and Greg Walden (R-OR)	May 16, 2019 by Senators Cassidy (R-LA), Michael Bennet (D-CO), Todd Young (R-IN), Maggie Hassan (D-NH), Lisa Murkowski (R-AK) and Tom Carper (D-DE)
Applies to individual vs. group market	Individual and group market	Individual and group market
Surprise billing in emergency situations	Prohibits surprise billing for all emergency services and patients would only be held responsible for the amount they would have paid in-network.	Prohibits surprise billing for all emergency services and patients would only be held responsible for the amount they would have paid in-network.
Surprise billing in non-emergency situations	Patients should be provided written and oral notice about whether their providers will be in- or out-of-network and what charges they must face. If the patient does not sign a consent form after that notice, they cannot be balance-billed and would only be responsible for the amount they would have paid in-network. (However, if the patient does sign the consent form they could be charged more than the in-network rate.)	Prohibits surprise billing for elective procedures at an in-network facility by an out-of-network provider, and patients would only be held responsible for the amount they would have paid in-network.
Surprise billing in following emergency care	N/A	Prohibits surprise billing for following emergency care at an out-of-network facility when the patient cannot travel without medical transport.
Surprise billing for specialty care	Prohibits surprise billing from providers that a patient could not reasonably be expected to choose themselves, such as anesthesiologists, radiologists, pathologists, neonatologists, assistant surgeons, hospitalists and intensivists.	N/A

Payment methodology	Insurers would be required to make a minimum payment to out-of-network providers for services rendered that is set a benchmark payment rate that is the median contracted (in-network) rate for the geographic area. States would have the ability to determine their own payment standards for plans regulated by the state.	The out-of-network provider will automatically be billed the median in-network rate. If the provider would like to challenge the payment, the provider has 30 days to initiate an independent dispute resolution (IDR) process. The IDR process is between the plan and provider (the patient is not involved). Each party submits one final offer to the IDR entity, which has 30 days to consider commercially reasonable rates (which must be based on in-network rates) for that geographic area when making its award determinations. The non-prevailing party will pay the costs of the IDR process for the prevailing party. Group health plans may include the costs of arbitration as part of medical care costs in their medical loss ratio calculations.
Insurance transparency	N/A	Health plans/issuers have to clearly list on any insurance card issued to enrollees in its plan the amount of the in-network and out-of-network deductibles. Additionally, plans/issuers are required to tell patients or enrollees the expected cost sharing for the provision of a specific health care service, including services reasonably expected to be provided in conjunction with it (e.g., laboratory work) within 48 hours of request. Plans/issuers need to make price information available online for services provided at different sites of care within its network. All group health plans must also annually report to the Secretary of HHS and Secretary of Labor the following information: • The total claims that were submitted by both in-network and out-of-network health care providers with respect to enrollees under the plan or coverage, and the number of such claims that were paid and the number of such claims that were denied;

		• The out-of-pocket costs to enrollees for out-of-network claims and the difference between billed charges and the amount the plan/issuer pays, adjusted by any balance billing limitations; and • The number of out-of-network claims reported for emergency care and the number of out-of-network claims for care performed at in-network facilities.
Provider transparency	N/A	Providers are required to tell patients or enrollees the expected cost sharing for the provision of a specific health care service, including services reasonably expected to be provided in conjunction with it (e.g., laboratory work) within 48 hours of request.
Hospital transparency	N/A	Hospitals have to disclose on their websites and in printed materials any financial relationship or profit-sharing agreement that the hospital has with a physician group. Additionally, hospitals are required to include ancillary services provided by individuals such as phlebotomists, laboratory technicians, and echocardiogram technicians within the hospital bill sent to patients.
Other	Provides $50 million in grants for states looking to develop or maintain an all-payer claims database.	Includes a study by HHS to examine the effects of this bill.