Surprise Billing Comparison: What You Need to Know (Updated July 17, 2019)

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The question is not if, but how – how will lawmakers tackle surprise billing? What started out as an issue for a small Senate working group last year has turned into a major health priority for both parties. Over the past year, discussion drafts were released, bills were introduced, and lawmakers sought feedback from stakeholders in an effort to produce comprehensive bipartisan legislation. Three major bills have emerged:

- The No Surprises Act (HR 3630), introduced by the leaders of the House Energy and Commerce Committee
- The Stopping the Outrageous Practice (STOP) of Surprise Medical Bills Act of 2019 (S 1531), introduced by Senators Bill Cassidy (R-LA), Michael Bennet (D-CO), Todd Young (R-IN), Maggie Hassan (D-NH), Lisa Murkowski (R-AK) and Tom Carper (D-DE)
- The Lower Health Care Costs Act (S 1895), introduced by the leaders of the Senate Health, Education, Labor and Pensions (HELP) Committee

S 1895 has passed out of committee and awaits floor action in the Senate. HR 3630 has passed out of the Health Subcommittee and awaits consideration by the full committee.

As laid out in the following chart, there is considerable alignment among the three approaches, but also a few notable distinctions that are important for stakeholders to consider:

- What constitutes surprise billing
- The process for the provider to challenge the payment rate, if at all
- Transparency requirements

What Constitutes Surprise Billing. The scenarios in which patients are protected are mostly aligned across the three proposals except when a patient is seeking non-emergency care by an out-of-network provider at an in-network facility. The Cassidy Senate bill simply prohibits surprise billing in this circumstance. The House bill, however, allows for an exception if the patient is provided with written and oral notice and consent. Similarly, the Senate HELP bill requires that:

- Patients receiving out-of-network ancillary services would only be required to pay the in-network cost-sharing amount.
- For patients that receive services following emergency services and are not yet stabilized, the patient would be responsible only for the amount they would have paid in-network.

- For patients that receive services following emergency services and are stabilized, or for patients that receive care from an out-of-network provider at an in-network facility, the provider must give advance notice of any out-of-network care, an estimate of the patient's costs for out-of-network care and referrals for alternative options for in-network care. If a patient is not given adequate notice, the patient would be protected from surprise bills or out-of-network cost-sharing.

Process for Providers to Challenge the Payment Rate. The Cassidy Senate bill includes an independent dispute resolution process that allows providers to seek a different payment rate than the default median in-network rate where there is a ban on surprise billing. The House sets the minimum benchmark rate for insurers to pay providers and does not include any mechanism for appeal. Similar to the House bill, the Senate HELP bill sets rates for practitioner or facility based on the median in-network contracted rate for services in that geographic area.

Transparency Requirements. Both Senate bills include transparency requirements for providers, hospitals and health plans/issuers. The House bill includes provider and hospital/facility transparency requirements, but does not include any transparency provisions for health plans/issuers.

In the House, Representatives Frank Pallone and Greg Walden sought feedback on the No Surprises Act discussion draft (stakeholder comments were due May 28, 2019) and held a hearing on the topic on June 12, 2019, entitled "No More Surprises: Protecting Patients from Surprise Medical Bills." On July 9, 2019 Representatives Frank Pallone and Greg Walden formally introduced a new version of the bill. Following that, on July 11, 2019 the Energy and Commerce Health Subcommittee held a mark-up on a number of bills, including the No Surprises Act. During the mark-up there was unanimous support to address surprise billing and protect patients. However, some Members raised concerns about the benchmarking approach. Even with these concerns no amendments to the bill were offered. The No Surprise Act advanced from the subcommittee to the full committee.

As noted, the Senate HELP bill was marked up on June 26, 2019. Additional amendments were added to the bill, one of which was related to surprise billing. That amendment requires plans to include a list of categories of providers of ancillary services for which the plan or coverage has no in-network providers. HELP Committee Chairman Lamar Alexander noted that he would like to see the Senate vote on the bill at the end of July. Discussions are likely to continue about further changes to the bill before it comes to the floor, and likely will involve working with senators who expressed concern with setting a benchmark in-network rate.

Also of note, it has been reported that the Congressional Budget Office (CBO) has developed a preliminary score for the varying payment dispute resolution processes. CBO found that the proposal setting a benchmark payment rate would save the most money at $25 billion over 10 years, the arbitration model would save $20 billion over 10 years, and the network matching proposal would save the least at $9 billion over 10 years. These scores could affect policy decisions and negotiating tactics on issues such as payment methodology, appeals processes, and whether this surprise billing legislation will be packaged with other bills to take advantage of the savings.

Surprise Billing Bill Comparison

Provision	House: HR 3630 No Surprises Act (Updated Version)	Senate: S. 1531 STOP Surprise Medical Bills	Senate: S 1895 Lower Health Care Costs Act (Cost Containment Package)
Introduced	July 9, 2019, by Reps. Frank Pallone (D-NJ) and Greg Walden (R-OR)	May 16, 2019, by Sens. Bill Cassidy (R-LA), Michael Bennet (D-CO), Todd Young (R-IN), Maggie Hassan (D-NH), Lisa Murkowski (R-AK) and Tom Carper (D-DE)	June 19, 2019, Sens. Lamar Alexander (R-TN) and Patty Murray (D-WA) released S 1895, Lower Health Care Costs Act. An updated version of this bill was released on June 24, 2019, which was marked up on June 26, 2019. The information below is based off of the June 24 version.
Markets Affected	Individual and group market	Individual and group market	Individual and group market
Billing in Emergency Situations	Beginning January 1, 2021, prohibits balance billing for all emergency services. Patients would be responsible only for the amount they would have paid in-network.	Prohibits balance billing for all emergency services. Patients would be responsible only for the amount they would have paid in-network.	Prohibits balance billing for all emergency services. Patients would be responsible only for the amount they would have paid in-network.
Billing in Non-Emergency Situations	Beginning January 1, 2021, patients should be provided with written and oral notice about whether their providers will be in- or out-of-network and what charges they must face. If patients do 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. If patients sign the consent, they can be charged more than the in-network rate.	Prohibits balance billing for elective procedures at an in-network facility by an out-of-network provider. Patients would be held responsible only for the amount they would have paid in-network.	If a patient receives out-of-network, non-emergency services that are not ancillary services, from an out-of-network provider at an in-network facility, the patient would be responsible only for the amount they would have paid in-network. However, if the in-network facility provides notice within 48 hours prior to the service of any out-of-network care and an estimate of the patient's costs for out-of-network care, and the enrollee signs the notice, then the patient can receive higher cost-sharing obligations than if the service were provided by an in-network practitioner or facility.
Billing in Non-Emergency	No provision	No provision	Patients are only required to pay the in-network cost-sharing amount for out-of-network ancillary services.

Situations			
Billing for Services Following Emergency Care	Beginning January 1, 2021, prohibits balance billing for post-stabilization services related to emergency services. Patients would be responsible only for the amount they would have paid in-network, unless the patient is able to travel using non-medical transportation or non-emergency medical transportation, or the provider is in compliance with notice and consent requirements.	Prohibits surprise billing for services following emergency care at an out-of-network facility when the patient cannot travel without medical transport.	If a patient receives emergency services (or maternal care for a woman in labor) in the emergency department of an out-of-network facility and has not been stabilized, and is subsequently admitted to the out-of-network facility for care, the cost-sharing requirement for any out-of-network services would be equal to the in-network rates. If a patient receives emergency services (or maternal care for a woman in labor) in the emergency department of an out-of-network facility and has been stabilized, and is subsequently admitted to the out-of-network facility for care, the cost-sharing requirement is equal to the in-network rate unless the patient receives advance notice that the provider or facility is out-of-network, estimated costs, a list of in-network providers in the geographic area, and information on prior authorization or other care management limitations that may be required by in-network facilities.
Billing for Specialty Care	Beginning January 1, 2021, prohibits balance billing from providers that patients could not reasonably be expected to choose themselves, such as anesthesiologists, radiologists, pathologists, neonatologists, assistant surgeons, hospitalists and intensivists.	No provision	No provision
Payment Methodology	Insurers would be required to make a minimum payment to out-of-network providers for services rendered. The minimum payment would be set at the median contracted (in-network) rate for the geographic area. For	The out-of-network provider will automatically be paid 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	The health plan will pay the practitioner or facility based on the median in-network contracted rate for services in that geographic area. The median in-network contract rate is the total maximum payment for the service minus the in-network cost-sharing for such service under the plan or coverage, for the same or similar service that is provided by a provider in the same or similar specialty and in the geographic region in which the service is furnished.

	2021, the median contracted rate would be based on 2019 rates and adjusted for inflation using the urban consumer price index for 2019 and 2020. For 2022 and each following year, the median contracted rate would be based on the previous year and adjusted for inflation using the urban consumer price index over the previous year. These provisions apply to states that do not have a balance billing or related law.	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	No provision	Health plans/issuers must clearly list on any insurance card issued to plan enrollees the amount of the in-network and out-of-network deductibles. Plans/issuers also 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 must make price information available online for services provided at different sites of care within their network. All group health plans also must annually	Requires health plans to have up-to-date directories of their in-network providers, which shall be available to patients online, within one business day of an inquiry, and through an oral confirmation that is documented by the health plan and kept in the enrollee's file for a minimum of two years. Plans must verify and update, at least once every 90 days, the provider directory information for all providers included in the online health care provider directory search tool. If a provider has not verified the directory information within the previous six months or the plan has been unable to verify the provider's network participation, the plan must remove that provider from the online directory search tool. If a patient provides documentation that they received incorrect information from an insurer about a provider's network status prior to a visit, the patient will only be responsible for the in-network cost-sharing amount. Plans must have good business practices in place to ensure provider requirements for timely bills can be implemented.

		report to the Secretary of Health and Human Services and Secretary of Labor the following information: • Total claims 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 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 • 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.	Requires health plans to give patients good faith estimates of their expected out-of-pocket costs for specific health care services, and any other services that could reasonably be provided within two business days of a request.
Provider Transparency	Not later than one year after the date of the enactment, each provider and facility is required to give provider directory information to plans with which they have a contractual relationship.	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.*,	Providers shall implement business processes to ensure the timely provision of provider directory information to plans. Requires health care facilities and providers to give patients a list of services received not later than five calendar days after discharge or date of visit. (If a facility or practitioner fails to provide a patient with a list of services rendered, the facility

	Each provider and facility is required to make publicly available, and post on a public website, information on balance billing and information on contacting appropriate state and federal agencies if a patient believes that a provider or facility has violated any requirement.	laboratory work), within 48 hours of request.	or practitioner shall report such failure to the Secretary.) Requires all bills to be sent to a patient within 45 calendar days. If a facility or practitioner bills a patient after 45 calendar days, the facility or practitioner shall report the bill to the Secretary of HHS and refund the patient for the full amount paid with interest, at a rate determined by the Secretary. Requires providers to give patients good faith estimates of their expected out-of-pocket costs for specific health care services, and any other services that could reasonably be provided, and contact information for any ancillary providers for a scheduled health care service within two business days of a request.
Hospital Transparency	Not later than one year after the date of the enactment, each provider and facility is required to give provider directory information to plans with which they have a contractual relationship. Each provider and facility is required to make publicly available, and post on a public website, information on balance billing and information on contacting appropriate state and federal agencies if a patient believes that a provider or facility has violated any requirement.	Hospitals must disclose on their websites and in printed materials any financial relationship or profit-sharing agreement with a physician group. Hospitals also are required to include ancillary services provided by individuals, such as phlebotomists, laboratory technicians and echocardiogram technicians, within the hospital bill sent to patients.	Providers shall implement business processes to ensure the timely provision of provider directory information to plans. Requires health care facilities and providers to give patients a list of services received not later than five calendar days after discharge or date of visit. (If a facility or practitioner fails to provide a patient a list of services rendered, the facility or practitioner shall report such failure to the Secretary.) Requires all bills to be sent to a patient within 45 calendar days. If a facility or practitioner bills a patient after 45 calendar days, such facility or practitioner shall report the bill to the Secretary of HHS and refund the patient for the full amount paid with interest, at a rate determined by the Secretary. Requires providers to give patients good faith estimates of their expected out-of-pocket costs for specific health care services, and any other services that could reasonably be provided, and contact information for any ancillary providers for a scheduled health care service within two business days of a request.
Civil Monetary Penalties	If a provider or facility fails to meet	If a patient is balanced billed in any of the	If a health care facility or practitioner balance bills a patient more than in-

	reporting requirements, the secretary may impose a civil monetary penalty in an amount not to exceed $10,000 per violation.	prohibited scenarios, the provider, hospital or health plan/issuer is subject to existing civil monetary penalties under the Public Health Service Act.	network rates in prohibited scenarios, the facility or practitioner shall be subject to a civil monetary penalty of not more than $10,000 for each act constituting such violation. Air ambulance providers are subject to a civil monetary penalty of not more than $10,000 for each act constituting a violation for billing an enrollee beyond cost-sharing amount. Providers that fail to support updated provider directory information to plans shall be subject to a civil monetary penalty of not more than $10,000 for each act constituting such violation. The Secretary may impose civil monetary penalties of up to $10,000 a day on any facility or practitioner that fails more than 10 times to provide a list of services, submits more than 10 bills outside of the 45-day billing period, fails to report to the Secretary about failures to provide patients list of services rendered, or fails to send bills within 45 calendar days. Providers that fail to give patients good faith estimates of their expected out-of-pocket costs for specific health care services, and any other services that could reasonably be provided, as well as contact information for any ancillary providers for a scheduled health care service, within two business days of a request, shall be subject to a civil monetary penalty of not more than $10,000 for each act constituting such violation.
Other	Not later than one year after the date of enactment, the US Government Accountability Office will conduct a study describing what is known about profit- and revenue-sharing relationships in the commercial health care markets, describe federal oversight of such	Includes a study by the US Department of Health and Human Services to examine the effects of this bill.	Patients are held harmless from surprise air ambulance bills. Additionally, patients' cost-sharing for out-of-network air ambulance services would be equal to the amount if such services were provided by an in-network practitioner, and any coinsurance or deductible shall be based on in-network rates. Additionally, a group health plan or health insurance issuer shall pay out-of-network air ambulance providers at the median in-network for that service in the same geographic area.

	relationships, and make recommendations to improve federal oversight of such relationships. Provides $50 million in grants for states looking to develop or maintain an all-payer claims database. Requires air ambulance providers to separate out costs of air ambulance transportation and medical costs in claims submitted to plans. (Failure to do so will result in a $10,000 civil monetary penalty for each violation.) Not later than one year after enactment, and annually each of the following five years, the Secretary of Labor will conduct a study on the effects of this law on premiums and out-of-pocket costs in group health plans, including out-of-pocket costs and the adequacy of provider networks in group health plans.		

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