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Surprise Billing Background and Comparison – Updated February 25, 2020

Overview. Congress spent much of 2019 working on surprise billing with a goal of passing legislation by the end of the year. While that did not happen, the momentum around passing surprise billing legislation has continued into 2020 with the introduction of two new surprise billing proposals in early 2020. In total, there are now three primary pieces of legislation being considered:

1. A compromise between HELP Chairman Lamar Alexander (R-TN) and leadership from the House Energy and Commerce Committee was announced in December 2019. While no bill text has been formally introduced, a summary of the bill is available. This is based on two other bills that the respective committees had put forward: (1) The No Surprises Act (HR 3630) was introduced by the leaders of the House Energy and Commerce Committee, and then incorporated in the Reauthorizing and Extending America's Community Health Act (HR 2328) in July 2019. HR 2328 has passed out of the Energy and Commerce Committee; and (2) The Lower Health Care Costs Act (S 1895) was introduced by the leaders of the Senate Health, Education, Labor and Pensions (HELP) Committee in July 2019. S 1895 has passed out of the HELP Committee.
2. The Consumer Protections Against Surprise Medical Bills Act of 2020 (HR 5826) was introduced by the leaders of the House Ways and Means Committee in February 2020. HR 5826 has passed out of the Ways and Means Committee and awaits floor action in the House.
3. The Ban Surprise Billing Act (HR 5800) was introduced by the leaders of the House Education and Labor Committee in February 2020. HR 5800 has passed out of the Education and Labor Committee and awaits floor action in the House.

We compare the three leading proposals in the below chart. There is considerable alignment among the different proposals, with the most notable distinction around setting a specific payment rate for services that fall under the ban on balance billing and the process by which providers and health plans can challenge that rate. Specifically, the compromise HELP/Energy and Commerce legislation includes a minimum benchmark rate for insurers to pay providers and also includes an arbitration process for insurers and providers to settle payment disputes for claims over $750. The Education and Labor bill would create a similar system, while the Ways and Means package does not include a benchmark payment rate, nor does it set a minimum dollar limit for providers and insures to enter into an arbitration process.

Background on Congressional Action. In the House, Energy and Commerce Committee Chairman Frank Pallone (D-NJ) and Ranking Member Greg Walden (R-OR) originally 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, Pallone and Walden formally introduced a new version of the bill. Following that, on July 11, 2019, the Energy and Commerce Health Subcommittee held a markup of a number of bills, including the No Surprises Act. During the markup, there was unanimous support to address surprise billing and protect patients. However, some members raised concerns about the benchmark rate approach. On July 17, 2019, the Energy and Commerce Committee held a markup of 26 bills, which included the No Surprises Act. A last-minute agreement was reached to amend the benchmark rate by adding an arbitration process to address payment disputes for certain surprise billing situations. The arbitration amendment was pushed by Representatives Raul Ruiz (D-CA) and Larry Bucshon (R-IN), and reflected a delicately crafted compromise with the bill sponsors, Pallone and Walden. The addition of an arbitration process accommodated some of the concerns that physicians and hospitals have regarding the benchmark rate approach. This amendment was added with no opposition. The House Energy and Commerce Committee also voted to combine its surprise billing legislation within a larger health extender bill (HR 2328), which included funding for the Medicare and Medicaid programs including the community health centers, special diabetes program, the teaching health centers and the Medicaid DSH allotments. 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. Although Alexander originally expressed hope that the Senate would vote on the bill before the end of July 2019, no vote has occurred. On December 8, 2019, Alexander, along with Pallone and Walden, announced a compromise. The compromise attempts to reconcile differences between the House and Senate bills, specifically how much insurers will pay providers that are not covered in their network. The compromise requires that all bills under $750 would be paid according to the median in-network price for the service in the geographic region. Meanwhile, bills over $750 would be eligible for baseball-style arbitration. Although this compromise has received bipartisan support, it is worth noting that Senate HELP Committee Ranking Member Patty Murray (D-WA) has not expressed support for this approach.

On February 7, 2020, leadership from both the House Ways and Means and House Education and Labor committees released bipartisan legislation addressing surprise medical billing. The House Ways and Means proposal does not set a benchmark rate, nor does it set a minimum dollar threshold to initiate the arbitration process. The House Education and Labor proposal largely aligns with the HELP/Energy and Commerce compromise. Both pieces of legislation add new transparency requirements for both health plans and providers, including requiring that additional information be included on insurance cards, and that provider directories be regularly maintained and available for patients.

On February 11, 2020, the Education and Labor Committee held a markup of its bill. Fifteen amendments were offered and nine were accepted. Notably, provisions were added that would require a Government Accountability Office report evaluating the relationship between private equity backed providers and facilities and the utilization of the indirect dispute resolution process. Private equity firms have come under fire recently by some members of Congress who express concern that private equity-owned provider groups are more likely to be out-of-network, and patients are more likely to receive higher surprise medical bills from these types of providers. While this amendment only includes a report on such groups, it is the only mention of private equity in any proposed surprise billing legislation. HR 5800, the "Ban Surprise Billing Act" as amended was reported favorably to the full House by a vote of 32-13.

On February 12, 2020, the Ways and Means Committee held a markup of its bill. Rep. Doggett offered but then withdrew three amendments and an amendment in the nature of the substitute was offered and adopted to make technical changes. HR 5826, the "Consumer Protections Against Surprise Medical Bills Act," as amended, was reported favorably to the full House by a voice vote.

After the Ways and Means Committee markup on February 12, 2020, President Trump, on Twitter, urged Congress to reach a bipartisan compromise ending surprise billing. However, the administration has previously signaled opposition to the Ways and Means approach, saying that overuse of arbitration could drive up healthcare costs.

The savings generated by the varying approaches is a significant factor in the ongoing negotiations, as many lawmakers are hoping to use a surprise billing deal to offset the cost of other funding priorities. The Congressional Budget Office (CBO) found that the Lower Healthcare Costs Act (S 1895) surprise billing provisions would save the most money at $25 billion over 10 years, while the No Surprises Act (HR 2328) would save $20 billion over 10 years. CBO estimates that the Ways and Means (HR 5826) and Education and Labor (HR 5800) proposals would save $18 billion and $24 billion, respectively, over 10 years. Overall, bills that include a benchmark rate save more than those that do not. 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.

Next Steps. As there was no compromise in 2019, lawmakers now face the next deadline of May 22, 2020, to extend funding for a number of expiring healthcare programs. There is an opportunity to use the surprise billing policies along with potential drug pricing reform legislation to pay for a long-term extension of the expiring healthcare programs. However, it remains unclear if, and how, the committees will resolve their differences. With so many different proposals on the table, Congress has their work cut out for them to find a compromise. After the deadline to pass the healthcare extenders package this spring, there remains little opportunity to pass any major legislation during the remainder of this election year.

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Details of the Major Surprise Billing Proposals

Provision	Senate HELP and House E&C Compromise: "Lower Health Care Costs Act"*	House Ways and Means: HR 5826 "Consumer Protections Against Surprise Medical Bills Act of 2020"	House Education and Labor: HR 5800 "Ban Surprise Billing Act"
Introduced	December 8, 2019, the Senate Health Education Labor Pensions (HELP) Committee Chairman Lamar Alexander (R-TN) and House Energy and Commerce Committee Chairman Frank Pallone (D-NJ) and Ranking Member Greg Walden (R-OR) released a compromise surprise billing proposal. The information below is based on the section-by-section summary of the compromise.	February 7, 2020, released as a discussion draft by Reps. Richard Neal (D-MA) and Kevin Brady (R-TX). On February 12, 2020, the committee marked up the legislation. The information below is based on the AINS to HR 5826, which was adopted by the Ways and Means Committee on February 12, 2020.	February 7, 2020, introduced by Reps. Bobby Scott (D-VA) and Virginia Foxx (R-NC). An updated version was released on February 11, 2020, in preparation for a markup. The information below is based on the most recent version.
Effective Date (unless otherwise stated)	Not yet specified	January 1, 2022	January 1, 2022
Markets Affected	Individual and group market	Individual and group market	Individual and group market
Definition of Facility	Not yet specified	The term 'health care facility' or 'facility' includes hospitals, critical access hospitals, ambulatory surgical centers, laboratories, radiology facilities or imaging centers, independent free-standing emergency departments, or any other facility specified by the Secretary. The term 'nonparticipating facility' means, with respect to an item or service and a health plan, a healthcare facility that does not have a contractual relationship with the plan for furnishing such item or service. The term 'participating facility' means, with respect to an item or service and a health plan, a healthcare facility that has a contractual relationship with the plan for furnishing such item or service. The term 'nonparticipating provider' means, with respect to an item or service and a health plan, a physician or other healthcare provider who does not have a contractual relationship with the plan for furnishing such item or service under the plan. The term 'participating provider' means, with respect to an item or service and a health plan, a physician or other healthcare provider who has a contractual relationship with the plan for furnishing such item or service under the plan.	The term 'health care facility' or 'facility' includes hospitals, hospital outpatient departments, critical access hospitals, ambulatory surgery centers, and any other facility that provides services that are covered under a group health plan or health insurance coverage. The term 'nonparticipating emergency facility' means, with respect to an item or service and a health plan, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship with the plan (or, if applicable, issuer offering the plan) for furnishing such item or service under the plan. The term 'participating emergency facility' means, with respect to an item or service and a health plan, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relationship with the plan (or, if applicable, issuer offering the plan) for furnishing such item or service under the plan. The term 'participating health care facility' means, with respect to an item or service and a group health plan or health insurance issuer offering health insurance coverage in the group or individual market, a healthcare facility that has a contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such an item or service at the facility. The term 'nonparticipating facility' means, with respect to an item or service and a health plan, a healthcare facility that does not have a contractual relationship with the plan for furnishing such item or service. The term 'participating facility' means, with respect to an item or service and a health plan, a healthcare facility that has a contractual relationship with the plan for furnishing such item or service. The term 'nonparticipating provider' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, a physician or other healthcare provider who is acting within the scope of practice of that provider's license or certification under applicable state law and who does not have a

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			contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively. The term 'participating provider' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, a physician or other healthcare provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who has a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.
Billing in Emergency Situations	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	Prohibits certain out-of-network providers at an in-network facility from balance billing patients unless the provider gives the patient notice of their network status and an estimate of charges 72 hours prior to receiving out-of-network services and the patient provides consent to receive out-of-network care.	If a patient receives out-of-network, non-emergency 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 non-participating provider 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 on or before the date of the item or service being furnished, then the patient can receive higher cost-sharing obligations than if the service were provided by an in-network practitioner or facility. The provider must also share the signed agreement with the patient's health plan. This is known as the 'notice and consent' criteria related to balance billing.	Prohibits certain out-of-network providers at an in-network facility from balance billing. Patients would be responsible for in-network cost-sharing amounts. However, if the non-participating provider (or the participating facility on behalf of the non-participating provider) provides notice within 72 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 on or before the date of the item or service being furnished, than the patient can receive higher cost-sharing obligations than if the service were provided by an in-network practitioner or facility. This is known as the 'notice and consent' criteria related to balance billing.
Billing Out-of-Network Ancillary Services	Patients are only required to pay the in-network cost-sharing amount for certain ancillary services provided by out-of-network providers at in-network facilities, and for out-of-network care provided at in-network facilities without the patient's informed consent.	Patients are only required to pay the in-network cost-sharing amount for out-of-network ancillary services. Unlike other out-of-network providers, ancillary service providers are not eligible for exemptions from balance billing prohibitions through notice and consent policies. Specific ancillary services include emergency medicine providers or suppliers, anesthesiologists, pathologists, radiologists, neonatologists, assistant surgeons, hospitalists, intensivists or other providers determined by the Secretary.	Patients are only required to pay the in-network cost-sharing amount for certain ancillary services provided by out-of-network providers at in-network facilities. Specific ancillary services that are prohibited from balance billing include services related to emergency medicine, anesthesiology, pathology, radiology, neonatology and diagnostic services. The Secretary of HHS has the authority to create a list of advance diagnostic laboratory tests that would not be considered ancillary services and would thus would be able to eligible for the notice and consent exemptions mentioned above.
Billing for Services Following Emergency Care	Not yet specified	Prohibits balance billing for a patient's total episode of care, including health services and items furnished as part of inpatient stabilization or outpatient observation.	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.
Billing for Specialty Care	Not yet specified	No provision	No provision
Payment Methodology	Health plans would be required to pay at minimum the market-based median in-network negotiated rate for the	There is no required minimum median in-network rate specified. The provider or facility and the health plan have 30 days from the day the claim is received to negotiate an agreement on payment.	Health plans 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 2022, the

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	service in the geographic area where the service was delivered. If the median in-network rate payment is above $750, the provider or health plan may elect to go to baseball-style, binding arbitration—referred to as independent dispute resolution (IDR). If a bill goes to arbitration, the arbitrator is required to consider information brought by the parties related to the training, education, and experience of the provider, the market share of the parties and other extenuating factors such as patient acuity and the complexity of furnishing the item or service. Following arbitration, the party that initiated the arbitration may not take the same party to arbitration for the same item or service for 90 days following a determination by the arbitrator.	Within five business days of the initial 30-day period: 1) the health plan has to provide the median contracted rate to the provider/facility, and 2) the provider/facility has to provide the median of the total reimbursement paid to the provider/facility for the item/service by the health plan. If 30 days pass with no resolution, both parties have two business days to initiate a mediated dispute process. Once initiated, the entities (the provider and the plan) have three days to agree on the mediator. If not picked, Secretary will choose for them. The mediators are certified by the Secretary through a process established by rulemaking. Once mediator is picked, entities have 10 days to submit offers. The arbitrator must consider the offers submitted by each party as well as the median contracted rate for the item or service. The legislation sets out a detailed methodology for determining this rate. The arbitrator may not consider the usual and customary charge or the billed charges. The mediator has to conclude within 30 days. The loser of the mediator conclusion will pays the fees for the mediator/process. Mediators are required to provide quarterly reports to the Secretary on information related to the dispute outcomes, which the Secretary will make public.	median contracted rate would be based on 2019 rates and adjusted for inflation using the urban consumer price index (CPI) for 2019, 2020 and 2021. For an item or service furnished during and after 2023, the rate would be determined by the previous year's median contracted rate, again adjusted for inflation using the urban CPI. If the median in-network payment rate is above $750, either the plan or provider may initiate an independent dispute resolution (IDR) process within 30 days of the claim being processed. No later than one year after the passage of this statute, the Secretary of HHS is directed to promulgate regulation further clarifying the IDR process.
Air Ambulance Transportation Provisions	Patients are held harmless from surprise air ambulance medical bills. Patients are only required to pay the in-network cost-sharing amount for out-of-network air ambulances. Air ambulances are barred from sending patients "balance" bills for more than the in-network cost-sharing amount. Resolves payment between air ambulance providers and health plans by requiring that the plan to pay, at minimum, the market-based median in-network negotiated rate for the service in the geographic area where the service was delivered. If the median in-network rate payment is above $25,000, the air ambulance provider or health plan may elect to go to IDR.	This bill does not contain any ban on balance billing for air ambulances. [Note: Emergency air medical service providers must submit to the Secretary of HHS information specifying how services are paid, location of transport (rural or urban), the type of aircraft (rotor or fixed wing transport) and network coverage status for transport. Health plans also have to submit claims data to the Secretary around emergency or non-emergency, urban or rural and the contractual relationship with the plan, among other things. The Secretary will make the information publicly available through an official report and assessment.]	Patients are held harmless from surprise air ambulance bills. Patients are only required to pay the in-network cost-sharing amount for out-of-network air ambulances. Air ambulance providers can submit a request under the IDR process for services above $25,000 (in 2022) or above the median contracted rate (subsequent years). Air ambulances are subject to the same timing requirements as other providers and facilities.
Health Plan Transparency	Requires health plans to include on their plan or insurance identification card issued to the enrollee, the amount of the in-network and out-of-network deductibles and the in-network and out-of-network out-of-pocket maximum limitation.	Requires health plans to include on their plan or insurance identification card issued to the enrollee the amount of the in-network and out-of-network deductibles, any out-of-pocket maximum, cost sharing obligations for emergency services, telephone number for customer assistance to obtain in-network rates and the nearest in-network hospital to the primary residence of the health plan enrollee. 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 written electronic communication. Health plans must keep any communication in the enrollee's file for a minimum of two years.	Requires health plans to include on their plan or insurance identification card issued to the enrollee the amount of the in-network and out-of-network deductibles and the in-network and out-of-network out-of-pocket maximum limitation for coverage. 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 five years. The health plan must also have a list available of the categories of providers of ancillary services for which there are no in-network providers.

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		Plans must verify and update, at least once every 90 days, the provider directory information for a random 10% sample of providers included in the online healthcare provider directory search tool and the information for providers who have not submitted a claim in the previous 12 months. The plan must establish a procedure to remove providers for which they are unable to verify information. If a patient provides documentation that they received incorrect information from a health plan 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 maintain an online price comparison tool to compare the amount of cost sharing that a patient would be responsible for paying under such a plan. Using historical claims data, this price comparison tool must be updated each plan year per geographic region. The plan must also publicly disclose patient protections against balance billing. Requires health plans to give patients good faith estimates of their expected out-of-pocket costs for specific healthcare services for scheduled services, whether or not providers are out-of-network, information about how to receive information about in-network providers and whether there are any utilization management requirements for coverage.	Plans must verify and update, at least once every 90 days, the provider directory information for all providers included in the online healthcare 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 a health plan about a provider's network status no more than 30 days prior to a visit, the patient will only be responsible for the in-network cost-sharing amount. Requires health plans to give patients good faith estimates of their expected out-of-pocket costs for specific healthcare services, and any other services that could reasonably be provided within two business days of a request. The Secretary is required to develop a template for health plans to disseminate this information, however, health plans are required to provide this information regardless of whether the model form has been developed or made available.
Provider and Facility Transparency	Not yet specified	Providers and facilities are required to provide a health plan with a "good faith" estimate for scheduled healthcare services for a plan enrollee. If this estimate is inaccurate, the health plan will pay the provider most recent contracted rate. No later than one year after enactment, providers and facilities who have a contractual relationship with a health plan must submit directory information. Information must be updated when there are material changes in information or when an information update is requested by a health plan. At least three days before a scheduled service, and within one business day of scheduling (if scheduled 10 days out, three business days is acceptable) providers and facilities must provide a good faith estimate to a patient's health plan, including any item or service that is reasonably expected to be provided in conjunction with the scheduled service.	Providers shall implement business processes to ensure the timely provision of provider directory information to plans. A provider must update contact information when a new contract begins, when a contract is terminated, if there are any material changes made and at least once every 90 days during the network agreement. Requires providers to give patients good faith estimates of their expected out-of-pocket costs for specific healthcare services, and any other services that could reasonably be provided within two business days of a request.
Civil Monetary Penalties	Not yet specified	If a healthcare facility or practitioner balance bills a patient more than in-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 failing to submit required cost reporting information.	If a healthcare facility or practitioner balance bills a patient more than in-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.

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		Providers and facilities who fail to provide good faith estimates for scheduled procedures or fail to comply with continuity of care for certain patients after a change in contract status with a health plan, will be subject to a civil monetary penalty of not more than $10,000 for each act constitution a violation. Providers and facilities that fail to provide directory information with a contracted health plan will be subject to a civil monetary penalty of $1,000 for each day such provider or facility fails to transmit such information.	Any provider that does not provide directory information or takes actions that prevent a health plan from complying with reporting requirements shall be subject to a civil monetary penalty not exceeding $10,000. Health plans or providers who fail to comply with reporting requirements related to independent dispute resolutions for purposes of publicly disclosing the information shall be subjects to a civil monetary penalty not to exceed $10,000 for each violation.
Reports	Requires the Secretary of HHS, in consultation with the Federal Trade Commission and Attorney General, to conduct a study no later than January 1, 2023, and annually thereafter for the following four years on the effects of the provisions in the Act. Requires the Secretary of Labor, not later than one year after enactment and annually for five years, to conduct a study on the effects of the provisions in the Act on premiums, out-of-pocket costs, and network adequacy in group health plans. Requires GAO to submit to Congress a report on the impact of the provisions in the Act on access to care and State All Payer Claims Databases.	Not later than two years after the date of enactment, the US Government Accountability Office will conduct a study evaluating the impact of the legislation network adequacy, provider participation, contract rates and fee schedules and amounts for healthcare services.	Within 60 days after the date of enactment the Secretaries of the Departments of Labor, Health and Human Services, and Treasury shall establish an advisory committee comprised of relevant experts and stakeholders to provide a recommendation about the disclosure of charges and fees, coverage and consumer protection related to ground ambulance transportation. This committee will issue a report to the Secretaries and relevant committee in Congress within 180 of the first meeting of the advisory committee. In 2022 and each subsequent year, the Secretaries must also publish the number of requests submitted under the independent dispute resolution process each year, including information about the practice size of providers and facilities submitting requests, description of item or service included in the request, specialty of the non-participating provider, final determination and the identity of the health plan, provider or facility with respect to the request. The Secretaries must also publish the average response time under the IDR process and the comparison from the average period of resolving billing discrepancies prior to the enactment of this act. Not later than 180 days after the date of enactment, the Secretaries shall publish interim final rules to implement protections against provider nondiscrimination. Not later than 2023, the Comptroller General shall submit a public report to Congress evaluating the adequacy of provider networks in health plans and include any legislative recommendations to improve the adequacy of such networks. Not later than 2023, the Comptroller General shall submit a public report to Congress evaluating the effect of these provisions on access to healthcare provider, including in rural and underserved communities and in health professional shortage areas and include any legislative recommendations. No later than 2023, the Comptroller General shall conduct a study and submit a report to Congress on the IDR process evaluating any financial relationships between providers utilizing the indirect dispute resolution process and private equity firms.

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