Chart: Key Surprise Medical Billing Legislation

May 21, 2019

The following chart reflects WHG's analysis of the major Congressional (Senate and House) legislation intended to protect patients from surprise medical billing that have been introduced/released thus far in the 116th Congress.[1] Specifically:

- **Stopping the Outrageous Practice (STOP) of Surprise Bills Act of 2019 (S. 1531)[2]:** Prohibits balance billing when emergency services are furnished by an out-of-network provider or an out-of-network facility; "elective health care services" are furnished by an out-of-network provider at an in-network facility; additional non-emergency services following emergency care are furnished and the patient is unable to be transported to an in-network facility; and out-of-network laboratory or imaging services are requested by an in-network provider. Resolves payment disputes through arbitration.

- **No Surprises Act (House Discussion Draft)[3]:** Prohibits balance billing when emergency services are furnished by an out-of-network provider or at an out-of-network facility; and when non-emergency services are furnished by a facility-based out-of-network provider at an in-network facility. Resolves payment disputes by establishing a "median contracted rate."

- **End Surprise Medical Billing (House Legislative Outline)[4]:** Prohibits balance billing when "unanticipated out-of-network care" is furnished. Resolves payment disputes through a multi-phase process, involving direct negotiation, interim direct reimbursement, and arbitration.

Bill Title	Stopping the Outrageous Practice (STOP) of Surprise Bills Act of 2019 (S. 1531)	No Surprises Act (Discussion Draft)	End Surprise Medical Billing (Legislative Outline)
Original Co-sponsors	Sens. Bill Cassidy (R-LA), Michael Bennet (D-CO), Todd Young (R-IN), Maggie Hassan (D-NH), Lisa Murkowski (R-AK), Tom Carper (D-DE), Dan Sullivan (R-AK), Sherrod Brown (D-OH), Kevin Cramer (R-ND), Ben Cardin (D-MD), John Kennedy (R-LA), and Bob Casey (D-PA)	House Energy and Commerce Chairman Frank Pallone, Jr. (D-NJ) and Ranking Member Greg Walden (R-OR)	Reps. Joseph Morelle (D-NY) and Van Taylor (R-TX)
Date Introduced/Released	May 16, 2019	May 14, 2019	May 20, 2019

[1] Lawmakers have introduced several other less comprehensive bills this Congress to address surprise medical billing. They include the Consumer Health Insurance Protection Act (S. 1213), by Sen. Elizabeth Warren (D-MA); and the End Surprise Billing Act of 2019 (H.R. 861), by Rep. Lloyd Doggett (D-TX).

[2] *See* section-section of the bill at: https://www.cassidy.senate.gov/imo/media/doc/SMB%20Section%20by%20Section%20NW.pdf. Legislative text is available at: https://www.cassidy.senate.gov/imo/media/doc/STOP%20Surprise%20Medical%20Bills%20Act%20-%20Final%20text.pdf.

[3] *See* discussion draft at: https://s3-prod.modernhealthcare.com/2019-05/SURPRISEBILL_02_xml.pdf; and summary of the measure at: https://s3-prod.modernhealthcare.com/2019-05/Pallone%20Walden%20Surprise%20Billing%20Discusion%20Draft%20Summary%20051419.pdf.

[4] *See* legislative outline of bill at https://vantaylor.house.gov/uploadedfiles/ending_surprise_medical_billing_proposal.pdf. A press release is available at: https://vantaylor.house.gov/news/documentsingle.aspx?DocumentID=2249. Note that legislative text has not yet been formally introduced as of the date of writing.

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Implementation Date	Not specified	January 1, 2021	January 1 (one year after enactment)
Covered Plans	Group and individual health insurance, including self-funded plans; Federal Employees Health Benefits Program (FEHB) plans; and fully-insured plans in states with no related laws	Group and individual health insurance, including self-funded plans	Self-funded plans and fully-insured plans in states with no related laws
Balance Billing Prohibited in the Following Scenarios	• Emergency services furnished by an out-of-network provider or at an out-of-network facility – including at state-accredited emergency departments, hospital outpatient departments, and ambulatory surgery centers; • Non-emergency services furnished by an out-of-network provider at an in-network facility ("including the use of equipment, devices, telemedicine, services, or other treatments or services"); and • Additional non-emergency services furnished by an out-of-network provider or at an out-of-network facility furnished after the patient is stabilized if the patient is unable to travel without medical transport	• Emergency services furnished by an out-of-network provider or at an out-of-network facility – including at a hospital outpatient department that provides emergency services and an independent freestanding emergency department; and • Non-emergency services furnished by an out-of-network "facility-based provider," defined to include "emergency medicine providers, anesthesiologists, pathologists, radiologists, neonatologists, assistant surgeons, hospitalists, intensivists, or other providers as determined by the Secretary," at an in-network facility	• "Unanticipated out-of-network care" (services were not specified)
Patient Cost-Sharing	• Holds patients responsible for the cost-sharing amount they would have been charged if the service was provided in-network; and • Applies cost-sharing towards their in-network deductible or out-of-pocket maximum	• Holds patients responsible for the cost-sharing amount they would have been charged if the service was provided in-network; and • Applies cost-sharing towards their in-network deductible or out-of-pocket maximum	• Holds patients responsible for the cost-sharing amount they would have been charged if the service was provided in-network
Payment Mechanism	• Automatically pays providers the "median in-network rate"; • Allows providers and plans to appeal payment within 30 days through the "independent dispute resolution (IDR) process" (i.e., "baseball-style" arbitration), and requires the losing party to pay the legal fees of the winning party. If a settlement is reached, then the parties split costs;	• Establishes a "median contracted rate" based on the in-network rate for the services in the geographic region in which the service was delivered; and • Directs the Department of Health and Human Services (HHS) Secretary to determine the methodology for plans to calculate the median contracted rate; the information to be shared with out-of-	• Establishes a multi-phase process to ensure claims are paid within 90 days: (1) Out-of-network providers and insurers have 30 days to resolve payment disputes through direct negotiation (2) If no agreement is reached, then the insurer pays the out-of-network provider the "interim direct

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	• Directs Secretaries of HHS and Labor to establish the arbitration process through rulemaking; • Allows parties to appeal multiple claims, provided they "involve identical plan or issuer and provider or facility parties; involve claims with the same or related current procedural terminology codes relevant to a particular procedure; and involve claims that occur within 30 days of each other"; • Requires arbiter to determine payment amount within 30 days, but gives parties 10 days to negotiate a settlement • Instructs arbiter to consider in-network rates for the applicable geographic region, but may also consider other factors relating to the professional background and performance of the out-of-network provider; case-specific conditions; the out-of-network provider's market share; the out-of-network provider's "good faith efforts" to negotiate rates; economic conditions; and previous payment amounts determined through arbitration; • Requires payment amounts selected by the arbiter to be publicly available	network providers regarding rate calculation; and the applicable geographic regions through the rulemaking process by July 1, 2020	reimbursement" – set at the "median in-network rate" for the services in the geographic region in which the service was delivered (3) Parties can appeal reimbursement through the "independent dispute resolution" process (i.e., "baseball-style" arbitration); losing party is required to pay the legal fees of the winning party. If a settlement is reached, then the parties split costs • Directs Secretaries of HHS and Labor to establish the arbitration process through rulemaking; and • Instructs arbiter to consider the usual and customary rate (i.e., 80th percentile for the applicable geographic region); the difference between out-of-network and in-network rates; professional background and performance of the out-of-network provider; out-of-network provider's customary charge for similar services; and case-specific conditions
Interaction with State Laws	• Does <u>not</u> preempt state laws that set the payment mechanism for fully insured plans, provided the state laws comply with the proposed cost-sharing protections	• Does <u>not</u> preempt state laws that set the payment mechanism for fully insured plans, provided the state laws comply with the proposed cost-sharing protections	• Does <u>not</u> preempt state laws that set the payment mechanism for fully insured plans
Consent	• Requires out-of-network providers and facilities to provide patients with written notice – when the patient receives non-emergency services after being stabilized and is able to travel without medical	• Requires out-of-network providers not considered "facility-based" to provide patients with written and oral notice – when the patient schedules their appoint and when services are furnished – that the provider is	• Requires "arranging" providers to notify patients on the "network status" of other providers who may furnish care for non-emergency services (i.e., services scheduled at least 12 hours in advance)

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	transport – that the provider is out-of-network and the estimated amount for the services, and obtain written consent in order to balance bill patients	out-of-network and the estimated amount for the services, and obtain written consent at least 24 hours before the services are furnished in order to balance bill patients; and • Directs the HHS Secretary to determine the written notice form and other requirements through the rulemaking process by July 1, 2020	
Civil Monetary Penalties (CMPs)	• Subjects providers and plans who violate the law (i.e., balance bill patients) to CMPs (amount not specified); and • Exempts providers and insurers that "unknowingly" balance bills patients but reimburses patients within 30 days	• Subjects providers who violate the law (i.e., balance bill patients, or do so without obtaining written consent) to CMPs (amount not specified)	No provision
Transparency Requirements	• Requires plans to notify contracted providers of new covered products within seven days of the product being offered; • Prohibits insurers from contracting with providers that do not provide an estimated amount for the services when non-emergency services are scheduled or within 48 hours of the request; • Requires plans to provide patients with a "good faith estimate of the enrollee's cost-sharing" within 48 hours of the request (effective January 1, 2020); and to make cost-sharing information electronically available (effective January 1, 2021); • Requires group plans to submit data to HHS regarding in-network and out-of-network claims, the number of claims paid and denied, out-of-pocket costs for out-of-network claims, and balance billing amount paid by plans; and	No provision	• Directs the HHS Secretary to establish "transparency standards" for insurers that require online and print in-network provider directories; annual audits of such directories; monthly updates of online directories; and other provisions as determined by the Secretary

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	• Requires hospitals to publicly disclose financial relationships with physician groups, itemize ancillary services (e.g., laboratory services) in bills sent to patients		
Other Provisions	• Directs the HHS Secretary to study the feasibility of facilities and providers sending patients a single bill, bundling all services furnished for an episode of care (due: one year upon enactment); and • Directs the HHS Secretary, in consultation with the DOL Secretary, to deliver a report to Congress on the effects of the provisions relating to patient cost-sharing and administrative costs; the extent to which out-of-network services are delivered; the frequency on which arbitration is used and other provisions (due: three years upon enactment)	• Authorizes $50 million in grants for states to establish an all payer claims database that may include "medical claims, pharmacy claims, dental claims, and eligibility and provider files, which are collected from private and public payers"	No provision