Chart: Key Surprise Medical Billing Legislation

July 18, 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 thus far in the 116th Congress.[1] Specifically:

- **Stopping the Outrageous Practice (STOP) of Surprise Bills Act of 2019 (S. 1531)[2] by Sens. Bill Cassidy (R-LA), Michael Bennet (D-CO) and others:** 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.

- **Reauthorizing and Extending America's Community Health (REACH) Act (H.R. 2328)[3], including the No Surprises Act by Reps. Frank Pallone, Jr. (D-NJ) and Greg Walden (R-OR):** Prohibits balance billing when emergency services are furnished by an out-of-network provider or at an out-of-network facility; and non-emergency services are furnished by a facility-based out-of-network provider at an in-network facility. Resolves payment disputes using a "median contracted rate" based on 2019 plan rates, adjusted by the Consumer Price Index for All Urban Consumers (CPI-U), and allows arbitration as a backstop for services for which the median contracted rate exceeds $1,250 in 2021.

- **Protecting People from Surprise Medical Bills Act (H.R. 3502)[4] by Reps. Raul Ruiz (D-CA), Joseph Morelle (D-NY), Van Taylor (R-TX) and others:** Prohibits balance billing when emergency services are furnished by an out-of-network provider or at an out-of-network facility; non-emergency 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.

- **Lower Health Care Costs Act (S. 1895)[5] by Sens. Lamar Alexander (R-TN) and Patty Murray (D-WA):** Prohibits balance billing when emergency services are furnished by an out-of-network provider or at an out-of-network facility; non-emergency ancillary services are furnished by out-of-network providers at in-network facilities; additional non-emergency services furnished by an out-of-network provider or at an out-of-network facility if the patient is admitted before being stabilized; and certain non-emergency services if notice and consent requirements are not met. Resolves payment disputes using a "median in-network rate."

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[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* legislative text at: https://www.cassidy.senate.gov/imo/media/doc/STOP%20Surprise%20Medical%20Bills%20Act%20-%20Final%20text.pdf; see section-by-section of the bill at: https://www.cassidy.senate.gov/imo/media/doc/SMB%20Section%20by%20Section%20NW.pdf.

[3] The No Surprises Act was packaged in an amendment in the nature of a substitute to the REACH Act in Title IV. *See* legislative text at: https://docs.house.gov/meetings/IF/IF00/20190717/109829/BILLS-116-H2328-EC-FC-ANS_01-P000034-Amdt-3.pdf. An amendment, incorporating arbitration, is available at: https://docs.house.gov/meetings/IF/IF00/20190717/109829/BILLS-116-SURPRISEBILL-IDR-AMD_01-R000599-Amdt-26.pdf.

[4] *See* legislative text at: https://vantaylor.house.gov/uploadedfiles/protecting_people_from_surprise_medical_bills_act_bill_text.pdf; section-by-section of the bill available at https://vantaylor.house.gov/uploadedfiles/protecting_people_from_surprise_medical_bills_act_section_by_section.pdf.

[5] *See* approved manager's amendment at: https://www.help.senate.gov/imo/media/doc/S.1895%20Manager's%20Amendment.pdf. Original legislative text available at: https://www.help.senate.gov/imo/media/doc/Lower%20Health%20Care%20Costs%20Act1.pdf; section-by-section of the original bill available at: https://www.help.senate.gov/imo/media/doc/LHCC%20Act%20section%20by%20section%206.19.pdf

Bill Title	Stopping the Outrageous Practice (STOP) of Surprise Bills Act of 2019 (S. 1531)	REACH Act (H.R. 2328), including No Surprises Act	Protecting People from Surprise Medical Bills Act (H.R. 3502)	Lower Health Care Costs Act of 2019 (S. 1895)
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 E&C Committee Chairman Frank Pallone, Jr. (D-NJ) and Ranking Member Greg Walden (R-OR)	Reps. Raul Ruiz (D-CA), Joseph Morelle (D-NY), Van Taylor (R-TX), Phil Roe (R-TN), Ami Bera (D-CA), Larry Buchson (R-IN), Donna Shalala (D-FL), and Brad Wentsrup (R-OH)	Senate HELP Committee Chairman Lamar Alexander (R-TN) and Ranking Member Patty Murray (D-WA)
Status	Introduced May 16, 2019	House E&C Committee passed, by voice vote, on July 17, 2019	Introduced June 26, 2019	Senate HELP Committee passed, by roll call vote (20-3), on June 19, 2019
Implementation Date	Not specified	January 1, 2021	January 1, 2021	Effective beginning the second plan year after the date of enactment
Covered Plans	Self-funded plans, Federal Employees Health Benefits Program (FEHB) plans; and fully-insured plans in states with no related balance billing laws or regulations	Group and individual health insurance, including self-funded plans	Self-funded plans; FEHB; and fully-insured plans in states with no related balance billing laws or regulations	Self-funded plans; FEHB; fully-insured plans in states with no related balance billing laws or regulations; and grandfathered plans
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-	• 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-	• Emergency services furnished by an out-of-network provider or at an out-of-network facility; • Non-emergency services furnished by an out-of-network provider at an in-network facility[7]; • Additional non-emergency services furnished by an out-	• Emergency services furnished by out-of-network providers or at an out-of-network facility – including at a freestanding emergency room[8]; • Non-emergency ancillary services[9] (including referred diagnostic services) furnished by out-of-network providers at an in-network facility[10];

[7] Health care facility is defined as a hospital, critical access hospital, ambulatory surgical center, laboratory, radiology or imaging center, any other facility that provide in-network services, and "any other facility specified by the Secretary."
[8] Cost-sharing protections in the case of emergency services apply to patients "regardless of the State in which the patient resides."
[9] Ancillary services are defined as non-emergency services provided by "anesthesiologists, pathologists, emergency medicine providers, intensivists, radiologists, neonatologists, hospitals, and assistant surgeons, whether the care is provided by a physician or non-physician practitioner"; diagnostic services, including radiology and lab services; and "other specialty practitioner not typically selected by the patients receiving the care, which the Secretary may add periodically to such definition through rulemaking."
[10] Facility is defined to include "hospitals, hospital outpatient departments, critical access hospitals, ambulatory surgery centers, laboratories, radiology clinics, and any other facility that providers services that are covered under a group health plan or health insurance coverage" as well as emergency departments.

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	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 after the patient is stabilized if the patient is unable to travel without medical transport	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; and services furnished by an out-of-network provider when an in-network provider at the facility is not present to deliver those services; and • Additional non-emergency (i.e., poststabilization) services furnished by an out-of-network provider or at an out-of-network facility after the patient is stabilized <u>if</u> the patient is unable to travel without medical transport <u>and</u> the out-of-network provider or facility complies with notice and consent requirement (see details on consent below)[6]	of-network provider or at an out-of-network facility after the patient is stabilized if the patient is unable to travel without medical transport; and • Out-of-network imaging or lab services requested by an in-network provider	• Non-emergency, non-ancillary services furnished by out-of-network providers at an in-network facility <u>if</u> notice and consent requirements are not met (see details on consent below); • Additional non-emergency services furnished by an out-of-network provider or at an out-of-network facility <u>if</u> the patient is admitted before being stabilized[11]; • Additional non-emergency services furnished by an out-of-network provider or at an out-of-network facility <u>after</u> the patient is stabilized and admitted but is not provided with written or electronic notice and the option for referral to an in-network provider or facility and does not give consent (see details on consent below)[12]; and • Air ambulance services furnished by out-of-network providers
Patient Cost-Sharing	• Holds patients responsible for the cost-sharing amount they would have been charged if	• Holds patients responsible for the cost-sharing amount they would have been charged if	• Holds patients responsible for the cost-sharing amount they would have been charged if	• Holds patients responsible for the cost-sharing amount they would have been charged if

[6] Poststabilization services "include[s] such items and services…that such a provider or facility determines are needed to be furnished to such individual during the visit in which such individual is so stabilized after such stabilization.

[11] The protection applies to out-of-network services furnished after services for "maternal care for a woman in labor."

[12] The protection applies to out-of-network services furnished after services for "maternal care for a woman in labor."

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	the service was provided in-network; and • Applies cost-sharing towards their in-network deductible or out-of-pocket maximum	the service was provided in-network[13]; and • Applies cost-sharing towards their in-network deductible or out-of-pocket maximum	the service was provided in-network; and • Applies cost-sharing towards their in-network deductible or out-of-pocket maximum	the service was provided in-network; and • Applies cost-sharing towards their in-network deductible or out-of-pocket maximum
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; • 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	• Establishes a multi-phase process to resolve payment disputes: • The insurer is required to pay out-of-network providers a "median contracted rate" based on the in-network rate for the services in the geographic region in which the service was delivered that is adjusted by the percentage increase in the consumer price index for all urban (CPI-U) consumers over the previous year[15]; • Out-of-network providers and facilities and plans have 30 days after a plan makes a payment to the provider or facility to pursue arbitration for services for which the	• Establishes a multi-phase process to resolve payment disputes: • The insurer is required to pay out-of-network providers "a commercial reasonable rate" determined by insurers within 30 days; • Out-of-network providers and insurers have 30 days to appeal the initial payment amount and resolve payment disputes through direct negotiation; and • If no agreement is reached, the parties can use the "independent dispute resolution process"[21]; losing party is required to pay the legal fees of the winning party. If a settlement is	• Establishes a "median contracted rate" based on the in-network rate for the services in the geographic region in which the service was delivered; • Directs HHS Secretary to determine the methodology for plans to calculate the median contracted rate; the information for plans to share with out-of-network providers regarding rate calculation; and the applicable geographic regions through the rulemaking process within one year after enactment[22]; and • Gives plans the option to use "a database free of conflicts of interest that has sufficient

[13] In states with no established payment mechanism for balance billing, the cost-sharing amount is based on the total amount set at the median contracted rate. In states with an established payment mechanism for balance billing, the cost-sharing amount is based on the total amount set at the lesser of the following: (1) the amount determined by the state; or (2) the median contracted rate.

[15] For 2021, the median contracted rate from 2019 will be adjusted by the percentage increase in the CPI-U over 2019 and 2020. Beginning 2022, the median contracted rate for the previous year will be adjusted by the CPI-U over the previous year.

[21] Final decisions made by the arbiter are binding and cannot be appealed unless the HHS Secretary, in consultation with the Labor Secretary, determine information submitted by one party was fraudulent.

[22] The bill directs the HHS Secretary to consider "adequate access to services in rural areas and health professional shortage areas" and to consult the National Association of Insurance Commissioner when establishing "geographic regions" to determine the median in-network rate for applicable out-of-network services, including air ambulance services. The bill directs the HHS Secretary to determine the methodology for plans to calculate the median contracted rate for ambulance services through the rulemaking process within six months after enactment. In addition, a different definition for "geographic regions" may be applied for the purposes of determining the median contracted rate for ambulance services. Lastly, the bill allows plans to establish separate calculations of a median-network rate for services delivered in nonhospital facilities, including freestanding emergency rooms.

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	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[14]; • 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; and	median contracted rate exceeds $1,250[16]; • The arbiter is required to determine payment amount within 30 days but gives parties 10 days to negotiate a settlement.[17] The losing party is required to pay the legal fees of the winning party. If a settlement is reached, then the parties split costs. Payment (difference between initial payment and determined amount) is due no later than 30 days after payment determination; • Directs Secretaries of HHS and Labor to establish the arbitration process through rulemaking within one year of enactment; • Instructs arbiter to consider the median contracted rates for comparable services in the geographic area; professional background and performance of the out-of-network provider; and "other extenuating circumstances."	reached, then the parties split costs. Payment is due no later than 15 days after payment determination; • Directs Secretaries of HHS and Labor to establish the arbitration process through rulemaking by January 1, 2021; • Allows parties to appeal multiple claims at one time, 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 60 days of each other"; • Requires parties to submit final offers within 30 days of the IDR request, and requires the arbiter to determine payment amount within 60 days of the IDR request; • Instructs arbiter to consider commercially reasonable rates for comparable services in the applicable geographic	information reflecting allowed amounts paid to individual health care providers for relevant services provided in the applicable geographic region" if they lack sufficient data to calculate a median in-network rate for out-of-network services in a particular geographic area

[14] Final decisions made by the arbiter are binding and cannot be appealed unless the HHS Secretary, in consultation with the Labor Secretary, determines information submitted by one party was fraudulent.

[16] For subsequent years, the $1,250 threshold will be adjusted by the CPI-U over the previous year. The bill prohibits providers, facilities and plans from packaging multiple claims if (1) they were not furnished by the same provider of facility; (2) payment for such claims were made by multiple plans; (3) services are not related to the treatment of the same condition; or (4) services were not furnished within 30 days of the earliest claim.

[17] Final decisions made by the arbiter are binding and cannot be appealed unless the HHS Secretary, in consultation with the Labor Secretary, determines information submitted by one party was fraudulent.

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	• Requires payment amounts selected by the arbiter to be publicly available	• Prohibits arbiter from considering "billed charges"; • Directs the Department of Health and Human Services (HHS), in consultation with appropriate State agencies, to establish a process to audit plans' compliance with applying the median contracted rates through rulemaking by July 1, 2020[18]; • Directs the HHS Secretary, through rulemaking, (1) to require plans with insufficient data to use an appropriate "database free of conflicts of interest" to determine a median contracted rate; and (2) to require plans that did not offer coverage in a specific geographic region in 2019 to use a specified methodology for calculating the median contracted rate for the first plan year[19]; and • Directs the HHS Secretary to determine the methodology for plans to calculate the median in-network rate; the information for plans to share with out-of-network providers regarding rate calculation; and the applicable geographic	area (including in-network rates); the usual and customary rate (i.e., 80th percentile for the applicable geographic region); the provider's usual out-of-network charge for comparable services; professional background and performance of the out-of-network provider; and case-specific conditions relating to patient characteristics and relevant economic and clinical circumstances; and • Requires HHS to publish aggregated results of arbitration by geographic region to guide providers and plans, as well as for arbiters to consider when making a final decision	

[18] HHS is limited to conducting audits of claims data from no more than 25 health plans in a year. In addition, HHS may adult plans if the Secretary received a complaint about the plan's compliance with requirements for applying a median contracted rate.

[19] For subsequent plan years, the median contracted rate will be based on the median contracted rate for the previous year, adjusted by the CPI-U.

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		regions through rulemaking by July 1, 2020[20]		
Interaction with State Laws	• Does not preempt state laws that set the payment mechanism for fully insured plans, provided the state laws comply with the proposed cost-sharing protections	• Does not preempt state laws that set the payment mechanism for fully insured plans, provided the state laws comply with the proposed cost-sharing protections	• Does not preempt state laws that set the payment mechanism for fully-insured plans, provided the state laws comply with the proposed cost-sharing protections	• Does not preempt state laws that set the payment mechanism for fully insured plans
Notice and 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 transport – that the provider or facility is out-of-network and the estimated cost-sharing amount for the out-of-network services; and obtain written consent in order to balance bill patients	• Requires out-of-network providers not considered "facility-based" and facilities to provide patients with written and oral notice – when the patient schedules their appointment and when services are furnished – that the provider is out-of-network and the estimated amount for the services; and obtain written consent at least 72 hours before the services are furnished in order to balance bill patients[23]; and • Directs the HHS Secretary to determine the written notice form and other requirements through the rulemaking process by July 1, 2020[24]	No provision	• Requires out-of-network providers at an in-network facility to provide patients with paper or electronic notice – at least 48 hours in advance of the scheduled, non-ancillary service – that states the provider is out-of-network and the estimated cost-sharing amount for the out-of-network services; and obtain written consent in order to balance bill patients[25]; • Requires out-of-network providers and facilities to provide patients with paper or electronic notice – after being stabilized (described as "having sufficient mental capacity") and admitted, and before the patient receives non-emergency services – that the provider or facility is out-of-network and the

[20] The bill instructs the HHS Secretary to consider the needs of rural and underserved areas, including health professional shortage areas. In addition, the bill states that the methodology may account for "relevant payment adjustments that take into account facility type (including higher acuity settings and the case-mix of various types) that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities."

[23] Notice and consent requirements do not apply to poststabilization services and services furnished for "unforeseen medical needs that arise at the time such covered item or service is furnished."

[24] The bill specifies that the written notice inform patients that the provider or facility is out-of-network; give an estimated out-of-pocket amount; and provide a list of appropriate in-network facilities and the option to receive a referral. Out-of-network providers and facilities are required to maintain documentation of notice and consent in the patient's record for two years after the date of service.

[25] Facilities are required to maintain documentation of notice and consent in the patient's record for two years after the date of service.

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				estimated cost-sharing amount for the out-of-network services; and obtain written consent in order to balance bill patients; • Requires insurers to provide patients with paper or electronic notice – <u>after</u> being stabilized and admitted, and <u>before</u> the patient receives non-emergency services – that the provider or facility is out-of-network, a list of in-network providers or facilities, and information about limitations, such as prior authorization, that may apply; and obtain written consent in order to balance bill patients[26]; and • Requires facilities to provide patients with a written notice upon intake at the emergency room or when admitted at the facility about the ban on balance billing and who to contact for recourse if they receive a balance bill in violation of the provisions; and obtain their signature[27];
Civil Monetary Penalties (CMPs)	• Subjects providers and insurers who violate the	• Subjects providers who violate the provisions to	• Subjects providers and facilities who violate the	• Subjects providers and facilities (including air

[26] The bill requires that the notice: "does not exceed one page in length; is readily identifiable for its purpose and as a contract of consent; clearly states that consent to potential out-of-network charges is optional and that the enrollee has the choice to transfer to an in-network facility; includes an estimate of the amount that such provider will charge the participant, beneficiary, or enrollee for such items and services involved; be available in the 15 most common languages in the facility's geographic area, with the facility making a good faith effort to provide oral notice in the enrollee's primary language if it is not one of such 15 languages." The bill directs the HHS Secretary to determine the notice and consent requirements, and to issue regulations to clarify the timing of such requirements and how to determine a patient is stabilized within six months after enactment.

[27] The bill directs the HHS Secretary to issue regulations within six months of enactment on the notice and consent requirements.

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	provisions to CMPs (amount not specified); and • Exempts providers and insurers that "unknowingly" balance bill patients and reimburse patients within 30 days	CMPs not to exceed $10,000 for each violation[28]; • Exempts providers and facilities that do not "knowingly" balance bills patients and within 30 days of the violation, rescind the bill or reimburse the patient or insurer the applicable amount, plus interest at a rate determined by the HHS Secretary	provisions to CMPs at an amount determined by the HHS Secretary; and • Exempts providers and entities that reimburse patients "not later than 30 days after the date the provider or facility knew or should have known such excess payment was in violation"	ambulances) who violate the provisions to CMPs not to exceed $10,000 for each violation[29]; and • Exempts providers and facilities that do not "knowingly" balance bill patients and within 30 days of the violation, rescind the bill or reimburse the patient or insurer the applicable amount, plus interest at a rate determined by the HHS Secretary
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-	• Requires providers and facilities to establish a process for transmitting provider directory information to plans that they participate in[30]; and • Requires providers and facilities to publish on their websites, in plain language, information on balance billing prohibitions and cost-sharing protections as well as information of state and federal agencies for patients to contact if they believe a violation was made	• Requires insurers to print the in-network and out-of-network deductible amounts and the out-of-pocket maximum limit on insurance cards, beginning one year after enactment; • 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	• Requires insurers to provide a list of categories of ancillary services for which in-network providers are unavailable[31] Title III includes the following transparency provisions related directly to surprise medical billing: • Requires group and individual plans to, within one year of enactment, ensure the accuracy of provider network status information (1) through the maintenance of an online

[28] The bill notes that the federal government will enforce balance billing prohibitions and cost-sharing protections if states fails to substantially enforce such requirements. In addition, the bill directs the HHS Secretary, through rulemaking, to establish a process to receive consumer complaints and resolve them within 60 days of receipt. The bill also authorizes the HHS Secretary to establish a "hardship exemption" to civil monetary penalties for violations.

[29] The bill also authorizes the HHS Secretary to establish a "hardship exemption" to civil monetary penalties for violations and to waive federal penalties if state penalties have been enforced. In addition, the bill requires the HHS Secretary to waive federal penalties if state penalties are enforced.

[30] Providers and facilities are required to transmit such information when they join a plan; when they terminate participation; when there are significant changes to the provider directory information; and any other appropriate time, as determined by the provider, facility, or the HHS Secretary.

[31] The Senate HELP Committee approved this amendment, offered by Sens. Cassidy, Hassan, and Murkowski. Amendment available at: https://www.cassidy.senate.gov/imo/media/doc/cassidy%20s1895%20amendment%203.pdf.

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	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 • Requires hospitals to publicly disclose financial relationships with physician groups, itemize ancillary services (e.g., laboratory services) in bills sent to patients		determined by the Secretary (compliance due: January 1, 2022); and • Requires insurers to annually submit data to HHS and Labor, beginning plan year 2021, regarding in-network and out-of-network claims, the number of claims paid and denied, out-of-pocket costs for out-of-network claims, the number of out-of-pocket claims for emergency services, and the number of out-of-network claims from in-network facilities	provider directory; (2) through written electronic communication within 24 hours of inquiry; and (3) through oral confirmation by the insurer and documented in the patient's file for at least two years; and to apply in-network cost-sharing in specified cases; and • Requires facilities to provide patients a list of services rendered no later than five days after discharge or date of visit and to provide bills no later than 45 days after discharge or date of visit. No payment due earlier than 35 days of receipt or refunds to the patient would be made with interest. CMPs would apply for violations
Other Provisions	• Directs the HHS Secretary to deliver a Report to Congress on the feasibility of facilities and providers sending patients a single bill (i.e., 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	• Directs GAO to deliver a Report to Congress on profit- and revenue-sharing in commercial health care markets and to describe federal oversight of profit- and revenue-sharing relationships (due: one year after enactment)[32]; • Authorizes the HHS Secretary to make available $50 million in one-time grants for states to	• Directs the HHS Secretary to deliver a Report to Congress on the feasibility of facilities and providers sending patients a single bill (i.e., bundling all services furnished for an episode of care) (due: three years after enactment); • Directs the HHS Secretary to deliver a Report to Congress on the effects of the	• Requires the HHS Secretary, in consultation with the Federal Trade Commission and the Attorney General, to deliver a Report to Congress on the effects of the provisions on vertical or horizontal integration, health care costs, and access to services in rural areas and health professional shortage areas; and to provide recommendations to address

[32] Specific examples relationships of interest include: "physician groups that practice within a hospital included in the profit- or revenue-sharing relationship, or refer patients such hospital; laboratory, radiology, or pharmacy services that are delivered to privately insured patients of such hospital; surgical services; hospitals or group purchasing organizations; or rehabilitation or physical therapy facilities or services; and include revenue- or profit-sharing whether through a joint venture, management or professional services agreement, or other gain-sharing contract."

Bill Title	Stopping the Outrageous Practice (STOP) of Surprise Bills Act of 2019 (S. 1531)	REACH Act (H.R. 2328), including No Surprises Act	Protecting People from Surprise Medical Bills Act (H.R. 3502)	Lower Health Care Costs Act of 2019 (S. 1895)
	the provisions relating to patient cost-sharing and administrative costs of arbitration; the extent to which out-of-network services are delivered; and the frequency on which arbitration is used and other provisions (due: three years after enactment)	establish or maintain an all payer claims database (APCD) that may include "medical claims, pharmacy claims, dental claims, and eligibility and provider files, which are collected from private and public payers"; • Requires air ambulance services to submit to the HHS Secretary specified information claims and cost data, denoting the cost of air travel and the cost of emergency medical services and supplies (due: one year after enactment and annually thereafter)[33]; • Directs the HHS and Labor Secretaries to each deliver a Report to Congress on the effects of the provisions relating to cost-sharing, provider network adequacy, and other necessary provisions (due: one year after enactment and annually for the following five years); • Directs the HHS and Labor Secretaries to publish information on disputes, such as the number of specified claims filed; payment amount	provisions relating to patient cost-sharing, administrative costs of arbitration, and overall health care costs; the extent to which out-of-network services are delivered; network adequacy; a comparison of different claims databases used and their impact; the frequency to which direct negotiation and arbitration are used; and the financial impact of arbitration on premiums and deductibles (due: three years after enactment); and • Prohibits providers from seeking reimbursements from patients for services furnished more than one year after date of service, and subjects violations to CMPs at an amount determined by the HHS Secretary	anti-competitive behavior; and • Applies patient protections regarding choice of health care professional and coverage of emergency services to grandfathered plans and FEHB

[33] Examples of specified information include claims "identified as paid by health insurance coverage offered in the group or individual market or a group health plan j(including a self-insured plan); identified as paid for non-emergent transport requiring prior authorization and emergency transport' identified as paid for hospital-affiliated providers and independent providers." The bill directs the HHS Secretary to determine the form and submission process through rulemaking no later than one year after enactment. Violations are subject to CMPS not to exceed $10,000 for each violation. The HHS Secretary is also required to deliver a Report to Congress summarizing such information (due: July 1, 2023). The bill directs GAO to deliver a Report to Congress that includes an analysis of cost variation of air ambulance services by geography and status and recommendations on the adequate reimbursement amount for such services (due: July 1, 2023).

Bill Title	Stopping the Outrageous Practice (STOP) of Surprise Bills Act of 2019 (S. 1531)	REACH Act (H.R. 2328), including No Surprises Act	Protecting People from Surprise Medical Bills Act (H.R. 3502)	Lower Health Care Costs Act of 2019 (S. 1895)
		determined by arbiter; offers submitted by plans and out-of-network providers and facilities; and the specialties of involved providers and facilities[34]; • Directs GAO to deliver a Report to Congress on the impacts of the provisions on the incidence and prevalence of surprise medical bills; provider shortages; number of grants for state APCDs and their use; and • Prohibits providers, facilities, and plans from seeking reimbursements from patients for services furnished more than one year after date of service, and subjects violations to CMPs at an amount determined by the HHS Secretary		

[34] Published information will not identify providers, facilities, and plans with respect to their specified claims.