Chart: Key Surprise Medical Billing Legislation

February 20, 2020

The following chart reflects WHG's analysis of the major congressional legislation intended to protect patients from surprise medical billing that have been introduced thus far in the 116th Congress. Specifically:

- **Consumer Protections Against Surprise Medical Bills Act of 2020 (H.R. 5826)**[1], advanced by House Ways and Means (W&M) Committee: Resolves payment disputes through an open negotiations process, and if unsuccessful, a mediated dispute process. Allows multiple services to be addressed in a single dispute.

- **Ban Surprise Billing Act (H.R. 5800)**[2], advanced by House Education and Labor (Ed & Labor) Committee: Resolves payment disputes using benchmark payments set at the median contracted rate, and independent dispute resolution for services for which the median contracted rate is at least $750 in 2022. Allows multiple services to be addressed in a single dispute.

- **No Surprises Act, incorporated as Title III in the Lower Health Care Costs Act (S. 1895)**[3] and agreed upon by Senate Health, Education, Labor and Pensions (HELP) Committee Chairman Lamar Alexander (R-TN) and House Energy and Commerce (E&C) Committee Chairman Frank Pallone (D-NJ) and Ranking Member Greg Walden (R-OR): Resolves payment disputes using benchmark payments set at the median contracted rate, and independent dispute resolution for services for which the median contracted rate is greater than $750 in 2022.

Bill	H.R. 5826 (W&M)	H.R. 5800 (Ed & Labor)	S. 1895 (HELP & E&C)
Original Co-sponsors	House W&M Chairman Richard Neal (D-MA), Ranking Member Kevin Brady (R-TX)	House Ed & Labor Chairman Bobby Scott (D-VA), Ranking Member Virginia Foxx (R-NC)	Senate HELP Chairman Lamar Alexander (R-TN)
Status	W&M favorably reported H.R. 5826, as amended, by a unanimous voice vote on February 12, 2020	Ed & Labor favorably reported H.R. 5800, as amended, by a roll call vote (32-13) on February 11, 2020	Agreed upon by Senate HELP Chairman Alexander, House E&C Committee Leaders Pallone and Walden on December 8, 2019
Implementation Date	January 1, 2022	January 1, 2022	*Effective beginning the second plan year after the date of enactment*
CBO Score	Saves $17.8 billion over 10 years, according to formal CBO estimate	Saves $23.9 billion over 10 years, according to formal CBO estimate	Saves $24 billion over 10 years, according to informal CBO estimate
Covered Plans	• Group health plans • Group or individual health coverage offered by health insurance issuer • Grandfathered health plans	• Same, plus FEHBP	• Same, plus FEHBP
State Preemption	Does not preempt a State law that establishes method to determine amount to be paid by state-regulated plan or issuer	Same	Same
Balance Billing Prohibited in the Following Scenarios	• Emergency services furnished by an out-of-network provider or at an out-of-network facility[4]	• Emergency services furnished by an out-of-network provider or at an out-of-network facility[8]	• Emergency services furnished by an out-of-network provider or at an out-of-network facility

Bill	H.R. 5826 (W&M)	H.R. 5800 (Ed & Labor)	S. 1895 (HELP & E&C)
	• After the individual is stabilized, certain additional services furnished by an out-of-network provider or at an out-of-network facility as part of outpatient observation or an inpatient or outpatient stay during visit[5] • Non-emergency services furnished by an out-of-network specified provider[6] (including an ancillary provider) at an in-network facility • Non-emergency services furnished by an out-of-network provider (excluding those furnished by a specified provider) at an in-network facility, if notice and consent requirements are not met • Plan or issuer inaccurately notifies the consumer in the Advanced Explanation of Benefits that the provider or facility furnishing services is in-network, if the provider was out-of-network when service was furnished [7] • Plan or issuer fails to provide the consumer with the Advanced Explanation of Benefits	• After the individual is stabilized, certain additional services furnished by an out-of-network provider or at an out-of-network facility (who determines such services are needed)[9] • Non-emergency ancillary services[10] furnished by an out of-network provider at an in-network facility • Non-emergency services (excluding ancillary services) furnished by an out-of-network provider at an in-network facility, if notice and consent requirements are not met • Air ambulance services furnished by an out-of-network provider • Plan or issuer inaccurately notifies the consumer that the provider furnishing services is in-network, if the provider was out-of-network at the time the service was furnished	• Certain ancillary services furnished by an out-of-network provider at an in-network facility • Non-emergency services furnished by an out-of-network at an in-network facility, if notice and consent requirements are not met • Air ambulance services furnished by an out-of-network provider • Plan or issuer inaccurately notifies the consumer that the provider furnishing services is in-network, if the provider was out-of-network at the time the service was furnished
Consumer Protections	• **Cost-Sharing.** Holds patient responsible for the cost-sharing amount that would have been charged if the service was furnished in-network; and applies cost-sharing towards deductible or out-of-pocket maximum • **Continuity of Care.** If there are contract changes (e.g., termination), requires health plan to: (1) notify affected enrollee about right to elect continued transitional care from provider or facility; (2) provide individual with an opportunity to notify the plan or issuer of need for transitional care; and (3) permit individual to continue receiving covered care under same terms or conditions (maximum 90 days); and (4) requires provider or facility to accept payment from plan or issuer as if termination had not occurred[11] • **Tax Deduction.** Provides tax deduction at an amount equal to the lesser of: (1) the excess of surprise billing expenses[12] over $600; or (2) the applicable percentage of taxpayer's adjusted gross income (currently 10 percent)	• **Cost-Sharing.** Same • **Continuity of Care.** Same • **Primary Care.** Requires plan or issuer to permit each consumer to choose any in-network primary care provider as designated primary care provider • **Pediatric Care.** Same • **Obstetrical and Gynecological Care.** Same	• **Cost-Sharing.** Same • **Timing.** Holds patient harmless of bills received more than 60 calendar days after services were furnished; and requires providers and facilities to give patients at least 35 days after the postmark date to pay bills.

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	• **External Review.** Allows individuals access to an external review process, based on NAIC standards, to appeal any adverse determination by a plan or issuer arising from a surprise medical bill (beginning Jan. 1, 2022) • **Patient-Provider Dispute Resolution.** Requires HHS to establish patient-provider dispute resolution process to allow uninsured individual (or individual who chooses not to use coverage) to dispute charges if the billed amount is substantially greater than the good faith estimate (made by the provider or facility) and seek a determination from a selected certified independent dispute resolution entity (by July 1, 2021)[13] • **Pediatric Care.** Requires plan or issuer to permit each individual with a child to choose any in-network pediatric care provider as the child's designated primary care provider • **Obstetrical and Gynecological Care.** Prohibits plan or issuer from requiring authorization or referral if a female individual seeks coverage for obstetrical and gynecological care from in-network provider		
Payment Mechanism	Two-step process to resolve payment dispute for services furnished in the last year, including a 30-day negotiation period and arbitration if negotiations fail • Requires plan or issuer to pay the balance of the **recognized amount** for the out-of-network service and the cost-sharing amount at the in-network rate: o If service is furnished in a State with a surprise medical billing law, then amount determined by that law; o If service is furnished in a State without a surprise medical billing law, then median contracted rate; o If service is furnished in a State with an All-Payer Model Agreement (CMMI waiver), then amount	Dual approach of benchmark payments based on the median contracted rate for services < $750 and independent dispute resolution (i.e., arbitration) for services ≥ $750) <u>Benchmark Payments</u> • Requires plan or issuer to pay the balance of the **recognized amount** for the out-of-network service and the cost-sharing amount at the in-network rate: o If service is furnished in a State with a surprise medical billing law[18], then amount determined by that law; o If service is furnished in a State without a surprise medical billing law, then median contracted rate; or	Dual approach of benchmark payments based on the median contracted rate for services < $750 and independent dispute resolution (i.e., arbitration) for services ≥ $750) <u>Benchmark Payments</u> • Requires plan or issuer to pay the median contracted rate <u>Independent Dispute Resolution (IDR)</u> • Each party submits its best and final offer for the payment amount for the disputed service furnished in the last year to be selected by a certified independent entity (determination is binding) • **Threshold.** Restricts IDR to services for which the median contracted rate in

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	approved by State under such agreement; or o If a self-insured group health plan has an agreement with the State on a method for determining payment for the out-of-network service, then amount determined in accordance with such method <u>Open Negotiation Process</u> • Allows parties to dispute the default payment for a service furnished in the last year and negotiate an alternative amount that the plan or issuer will pay the out-of-network provider or facility • **Timing.** May begin on the day the provider or facility receives a response from the plan or issuer regarding a claim (30 days total) • **Information Exchange.** Requires each party to exchange information regarding median contracted rate and median reimbursement (due 5th business day)[14] <u>Mediated Dispute Process</u> • Each party submits its best and final offer for the payment amount for the disputed service to be selected by a certified independent entity (30 days total) • **Rulemaking.** Requires HHS, Labor, and Treasury to establish a 30-day mediated dispute process • **Timing.** May be initiated during the two-day period after the 30-day open negotiation process ends • **Settlement.** Allows parties to continue negotiations throughout the mediated dispute process **(no limit)**[15] • **Batching.** Allows parties to resolve payment for multiple services in a single mediated dispute process[16] • **Offers.** Requires both parties to submit respective offers and related information to independent entity (due 10th business day)	o If service is furnished in a State with an All-Payer Model Agreement (CMMI waiver), then amount approved by State under such agreement <u>Independent Dispute Resolution (IDR)</u> • Each party submits its best and final offer for the payment amount for the disputed service furnished in the last year to be selected by a certified independent entity (determination is binding) • **Rulemaking.** Requires HHS, Labor, and Treasury to establish a 30-day IDR process in which the recognized amount paid to an out-of-network provider or out-of-network emergency facility is disputed and resolved (by 1 year after enactment) • **Timing.** An out-of-network provider or out-of-network emergency facility must submit IDR request no later than the date on which the appeal has been resolved or 30 days after the provider or facility files an appeal under the appeals process of the plan or issuer (whichever is sooner) • **Threshold.** Restricts IDR to services for which the median contracted rate in 2022 is at least $750 (or at least $25,000 for air ambulances)[19] • **Settlement.** Allows parties to negotiate settlement for a period **not to exceed 10 days** (which counts towards 30-day limit) • **Batching.** Allows parties to resolve payment for multiple services in a single IDR[20] • **Considerations.** Requires certified IDR entity to consider the median contracted rates and other information submitted by the parties (e.g., provider training, quality and outcome measurements, market share, patient acuity, complexity of services, demonstration of good faith efforts made by the provider or facility or plan or issuer);	2022 is greater than $750 (or greater than $25,000 for air ambulances) • **Considerations.** Requires IDR entity to consider information submitted by the parties (e.g., training, education, and experience of the provider; market share of the parties; patient acuity; complexity of services)[22] • **Limitations.** Prohibits party that submitted the initial IDR request from submitting a subsequent IDR request, during the **90-day period** following the determination, involving the same party with respect to the same service that was the subject of the initial request

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	• **Considerations.** Requires independent entity to consider the median contracted rate for the service and other related information relating submitted by each party; and **prohibits consideration of (1) usual and customary charges; and (2) billed charges** • **Fees.** Requires party whose offer was not chosen to pay all fees charged by the entity (due no later than 5 days after receiving notification of determination); and **requires each party to pay an administrative fee** to HHS, Labor, Treasury for participating in the mediated dispute process[17]	and **prohibits consideration of billed charges**[21] • **Limitations.** Prohibits party that submitted the initial IDR request from submitting a subsequent IDR request, during the **90-day period** following the determination, involving the same party about the same service disputed in initial request • **Fees.** Requires party whose offer was not chosen to pay all fees charged by the entity. Parties split fees if settlement is reached • **Payment.** Requires alternative payment to be made **no later than 30 days** after determination	
Median Contracted Rate	• **Rulemaking.** Directs HHS, in consult with Labor and Treasury, to establish: (1) methodology the plan or issuer will use to determine median contracted rate for each business line[23]; and (2) information the plan or issuer will share with out-of-network provider (due July 1, 2021) • **2022.** Defines median contracted rate as the median of the total maximum payment for the same or similar services in the same geographic region in 2019, increased by the percentage increase in the CPI-U over 2019, 2020, and 2021 • **2023-2026.** Increases the median contracted rate (determined in the previous year) by percentage increase in the CPI-U over the previous year • **2027 and every other 5 years (rebasing year).** Defines median contracted rate as the median of the total maximum payment for the same or a similar service in the same geographic region for that year • **Substitute Rate.** Requires HHS to develop a methodology to determine a substitute rate (i.e., median contracted rate offered by all plans or issuers in the same line of business in the same region or similarly situated geographic region) if insufficient information exists to determine the median contracted rate	• **Rulemaking.** Directs HHS, in consult with Labor and Treasury, to establish: (1) methodology the plan or issuer will use to determine median contracted rate for each business line; (2) information the plan or issuer will share with out-of-network provider or facility; (3) geographic region applied (with input from NAIC); and (4) process to receive complaints of violations (due July 1, 2021)[24] • **2022.** Defines median contracted rate as the median of the total maximum payment (including cost-sharing amount and amount to be paid by the plan or issuer) for the same or similar services in the same geographic region on January 31, 2019, consistent with established methodology, and increased by the percentage increase in CPI-U over 2019, 2020 and 2021 • **2023 and beyond.** Increases the median contracted rate (determined in the previous year) by percentage increase in the CPI-U over the previous year • **Substitute Rate.** Requires HHS to develop a methodology to determine a substitute rate if insufficient information exists to determine the median contracted rate	Not specified

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Independent Entity	• **Certification.** Requires HHS to establish or recognize a process to certify and recertify entities.[25] • **Selection.** Provides parties with the opportunity to jointly select a certified independent entity. If unable to agree by the **3rd business day**, then HHS, Labor, and Treasury will select an entity on their behalf (no later than the 6th business day) • **Oversight and Transparency.** Requires an independent entity to submit information to HHS, Labor, and Treasury on the mediated dispute process, certification requirements, payment determinations to be made publicly available (due quarterly) (see Publication of Information)	• **Certification.** Requires HHS, Labor, Treasury to certify applicant entities (who must be a nongovernmental entity that agrees with fee limits), considering whether the entity is unbiased and unaffiliated with health plans, facilities, and providers and is free of conflicts of interests • **Fee Limitations.** Requires Departments to establish limitations for the amount a certified IDR entity may charge parties • **Selection.** Provides parties with the opportunity to jointly select a certified IDR entity. If unable to agree by a **date yet to be specified**, then Departments will randomly select an entity on their behalf • **Oversight and Transparency.** Requires independent entity to submit information on IDR to Departments to be made publicly available (see Publication of Information)	Not specified
Notice and Consent	• Allows out-of-network provider (excluding a specified provider, such as an ancillary health care provider) at an in-network facility to balance bill for non-emergency services, if the following criteria are met: (1) the provider gives the individual a written notice[26] no later than **48 hours** before services are to be furnished; (2) the individual signs and dates the notice confirming receipt of the notice and consent for services to be furnished by an out-of-network provider; and (3) the provider gives a copy of the signed and dated notice to the plan or issuer	• Allows out-of-network provider or out-network facility to balance bill for non-emergency services (excluding ancillary services), if the following criteria are met: (1) out-of-network provider (or in-network facility on behalf of out-of-network provider) or out-of-network facility gives the individual on the date on which the service is furnished or the appointment is scheduled (if applicable) an oral explanation of the written notice and a written notice[27] (paper or electronic); and (2) obtains individual's consent to be treated by an out-of-network provider or facility no later than **72 hours** before services are to be furnished • Requires the out-of-network facility or in-network facility (with respect to an out-of-network provider) to retain the notice for at least a 2-year period after the date on which the service is furnished	• Allows certain out-of-network providers to balance bill patients, if the following criteria are met: (1) out-of-network provider gives individual notice of their network status and an estimate of charges no later than **72 hours** before services are to be furnished; and (2) the patient provides consent to receive out-of-network care
Oversight, Enforcement, and Civil Monetary Penalties	<u>Audits</u> • **Rulemaking.** Requires HHS, in consult with Treasury, Labor, and NAIC, to establish process for HHS to audit plans and issuers **(no**	<u>Audits</u> • **Rulemaking.** Requires HHS, in consult with State agencies, Labor, and Treasury, to establish process for HHS or State to	<u>Federal Enforcement</u> • **Providers and Facilities.** Imposes a civil monetary penalty (not to exceed $10,000 per violation)[31]

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	annual max) for compliance with requirement to apply median contracted rate (due July 1, 2021)[28] Federal Enforcement • **Providers and Facilities.** Imposes a civil monetary penalty (not to exceed $10,000 for each violation)	audit plans and issuers **(max 25 per year)** for compliance with requirement to apply median contracted rate (due July 1, 2021)[29]; • **Report.** Requires HHS to annually report to Congress the number of audited plans and issuers (beginning for 2022) State Enforcement • **Providers and Facilities.** Allows State to enforce requirements applicable to providers and facilities; and if a State fails to substantially enforce requirements, then HHS is required to enforce them • **Plans and Issuers.** Allows State to notify Labor about violations by plans or issuers and enforcement actions taken against providers or facilities Federal Enforcement • **Providers and Facilities.** Imposes a civil monetary penalty (not to exceed $10,000 per violation)[30]; and requires HHS, in consult with Labor, to establish a process to receive consumer complaints of violations and to resolve such complaints within 60 days of receipt • **Plans and Issuers.** Authorizes Labor to investigate violations involving plans and issuers flagged by State or HHS; and requires Labor to establish through rulemaking a process to: (1) receive complaints from individuals enrolled in plans or coverage offered by issuers; and (2) transmit complaints to States or HHS for potential enforcement (by Jan. 1, 2022)	
Transparency Requirements and Other Obligations	Health Plans and Issuers • **Provider Directory.** Requires each plan and issuer to: (1) establish process to verify every 90 days **a random sample of at least 10 percent** of providers and facilities in the provider directory; (2) establish a protocol to respond to individual information requests no	Health Plans and Issuers • **Provider Directory.** Requires each plan and issuer to: (1) establish a business process to ensure all enrollees receive proof of a provider's network status upon a telephone inquiry no later than 1 business day **via written electronic or oral**	Health Plans and Issuers • **Provider Directory.** Requires plan and issuer to establish up-to-date directory of in-network providers, which will be available to patients online, or within 1 business day of an inquiry

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	later than 1 business day **via written electronic or paper form** (and retain communication records **for at least 2 years)**; and (3) establish a database of in-network providers and facilities on public website (beginning Jan. 1, 2022) • **Public Website.** Requires each plan and issuer to make available in plain language on public website: (1) federal requirements and prohibitions of the provider or facility relating to balance billing in certain circumstances; (2) if applicable, State requirement regarding the amounts an out-of-network provider or facility may charge an individual; and (3) information on contacting State and Federal agencies about a suspected violation (beginning Jan. 1, 2022) • **Advanced Explanation of Benefits.** Requires each plan and issuer to provide an Advanced Explanation of Benefits to individual no later than 1 business day after the date on which the plan or issuer is notified by the provider about the scheduled service[32] • **Price Comparison Tool.** Requires plan or issuer to employ an individual to offer price comparison guidance or make available online a price comparison tool (with cost-sharing amounts based on historic claims data from in-network providers) • **Membership Cards.** Requires plan or issuer to provide the following information on each physical or electronic health insurance membership card: (1) the nearest in-network hospital; (2) a telephone number or website to access information on in-network hospitals and urgent care facilities; (3) any deductible applicable; (4) any out-of-pocket maximum applicable; and (5) any cost-sharing obligations applicable for a visit to an in-network emergency department or urgent care facility	**communication** (and retain communication records for **at least 5 years**) and in real-time through an online provider directory; and include in any print directory a list of categories of ancillary service providers for which the health plan has no in-network providers; and (2) verify and update provider directory at least once every 90 days (beginning 1 year after enactment) • **Public Website.** Requires each plan and issuer to make available in plain language on a public website: (1) federal requirements and prohibitions of the provider or facility relating to balance billing in certain circumstances; (2) if applicable, State requirement regarding the amounts an out-of-network provider or facility may charge an individual; and (3) information on contacting State and Federal agencies about a suspected violation • **Provider Directory.** Requires plan and issuer to: (1) establish a business process to ensure all enrollees receive proof of a provider's network status upon a telephone inquiry no later than 1 business day after such inquiry and in real-time through an online provider directory; and include in any print directory a list of the categories of providers of ancillary services for which the health plan has no in-network providers; and (2) verify and update the provider directory at least once every 90 days (beginning 1 year after enactment) • **Cost-Sharing.** Requires plan and issuer to provide enrollees with good faith estimates of expected cost-sharing obligations, no later than 2 business after request; and requires HHS to make available in multiple languages a model form for conveying this information in easily understandable terms (effective 18 months after enactment) • **Membership Cards.** Requires plan or issuer to clearly provide on any plan or	• **Explanation of Benefits and Membership Cards.** Requires plan and issuer to include in their explanation of benefits or insurance identified card the amount of the in-network and out-of-network deductibles and the in-network and out-of-network out-of-pocket maximum limitation • **Timely bills.** Requires plan and issuer to adjudicate bill no later than 20 calendar days after receiving the bill from the provider or facility • **Cost-Sharing.** Requires plan and issuer to provide good faith estimates of expected out-of-pocket costs for specific services, and any other services that could reasonably be furnished, within 2 days of request *Providers and Facilities* • **Timely Bills.** Requires provider and facility to: (1) give patients a list of services no later than 15 calendar days after discharge or date of visit; (2) submit to the plan or issuer the bill no later than 20 calendar days after discharge or date of visit; and (3) send the adjudicate bill to the patient no later than 20 calendar days after receiving the adjudicated bill from the plan[40] • **Cost-Sharing.** Requires provider and facility to provide good faith estimates of expected out-of-pocket costs for specific services, and any other services that could reasonably be furnished, within 2 days of request • **Brokers and Consultants.** Requires brokers and consultants to disclose to plan sponsors any indirect compensation the brokers and consultants may receive for referral of services.

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	Providers and Facilities • **Provider Directory.** Requires providers and facilities to establish a process under which they will furnish provider directory information to all group or individual insurance issuers with whom they have contracted (due 1 year after enactment)[33]; • **Cost-Sharing.** Requires providers and facilities to be prepared to: (1) inquire as to whether an individual scheduling an appointment with them is insured and if they intend to use coverage for the appointment or services provided; and (2) provide a good faith estimate of the expected charges to the plan or issuer, or the individual (if uninsured or not using coverage) (by Jan. 1, 2022)[34]	insurance ID card: the (1) in-network and out-of-network deductible amounts; and (2) the plan's in-network and out-of-network out-of-pocket maximum limitations; and directs HHS, in consult with Labor and Treasury, to issue implementation guidance (effective Jan. 1, 2022) • **Brokers and Consultants. For group health plans**, requires brokers and consultants to disclose in writing, direct and indirect compensation[35] for their services.[36] • **Brokers and Consultants. For issuers offering coverage in the individual market,** requires brokers and consultants to disclose compensation (1) prior to an individual finalizing plan selection; and (2) within any documentation confirming enrollment; and requires issuers annually report such compensation to HHS before open enrollment.[37] Providers and Facilities • **Public Website.** Requires each provider and facility to make available in a plain language 1-page notice on a public website: (1) federal requirements and prohibitions of the provider or facility relating to balance billing in certain circumstances; (2) if applicable, State requirement regarding the amounts an out-of-network provider or facility may charge an individual; and (3) information on contacting State and Federal agencies regarding a suspected violation.[38] • **Provider Directory.** Requires providers to submit provider directory information to a plan or issuer, at a minimum: (1) when the provider begins a network agreement with a plan or with an issuer with respect to certain coverage; (2) when the provider terminates a network agreement; (3) when there are material changes to the content of the provider directory information; and (4)	

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		every 90 days through the duration of the network agreement.[39] • **Cost-Sharing.** Requires in-network providers to provide enrollees accurate and complete cost-sharing information for a service within 2 business days of request (effective 18 months after enactment) • **Nondiscrimination.** Requires HHS, Labor, and Treasury to issue interim final rules implementing protections that prohibit a plan or issuer from discriminating against providers who act within their scope of practice under their respective State	
Other Reports to Congress	• **Median Contracted Rate.** Requires Health, Labor, and Treasury to submit to Congress a report on the following: (1) the extent to which the payment amount determined through arbitration differs from the median contracted rate, including the number of times such determined amount exceeds such median contracted rate; and (2) the effect of the difference on cost-sharing for the item or service (beginning no later than July 1, 2023) • **Provider Network Adequacy.** Requires GAO to submit to Congress a report on the effects of the legislation, including on provider network participation and adequacy, and the impact of state-level surprise billing legislation and network adequacy standards on provider and facility participation in provider networks (due 2 years after enactment)	• **Private Equity.** Requires GAO to submit to Congress a report including an analysis of potential financial relationship between providers and facilities that utilize the IDR process and private equity investment firms • **Provider Network Adequacy.** Requires GAO to submit to Congress a report on provider network adequacy and recommendations to improve network adequacy (due Jan. 1, 2023) • **Provider Access.** Requires GAO to submit to Congress a report on the effects of the legislation on provider access, including in rural and underserved communities and health professional shortage areas, and legislative and regulatory recommendations to address any shortage	• **Impact.** Requires HHS, in consult with FTC and AG, to conduct a study on the effects of the legislation (by January 1, 2023 and annually thereafter for the following 4 years) • **Group Health Plans.** Requires Labor to conduct a study on the effects of the legislation on premiums, out-of-pocket costs, and network adequacy in group health plans (no later than 1 year after enactment annually thereafter for 5 years) • **Access to Care.** Requires GAO to submit to Congress a report on the impact of the legislation on access to care and State All Payer Claims Databases
Publication of Information	• Requires Health, Labor, and Treasury to make publicly available a summary of the following, on a quarterly basis: (1) information on the mediated dispute process, including the number of payment determination, a description of each service included in a determination, the amount of each offer, the amount of each determination, and the length of time in making each determination; (2) the amount of expenditures made by the Secretary during such year to administer the mediated dispute process; (3)	• Requires HHS, Labor, and Treasury to make annually available on a public website the following: (1) number of IDR requests submitted; (2) practice size of providers and facilities submitting IDR requests; (3) number of such requests to which a final determination was made; (4) average response time under the process, after the first sign of billing discrepancies between the involved providers, facility, plans, and issuers; (5) information comparing the average period for resolving such a billing	See other sections

Bill	H.R. 5826 (W&M)	H.R. 5800 (Ed & Labor)	S. 1895 (HELP & E&C)
	total amount of administrative fees paid to the Secretary during such quarter; and (4) total amount of compensation paid to selected independent entities during such quarter	discrepancy between provider, facility, plan or issuer and the average period for resolving discrepancy between parties during the most recent year before the date of enactment; and (6) information on IDR, including a description of each disputed service; the geographic region in which the services were provided; the offers submitted expressed as percentage of the median contracted rate; whether the selected offer was submitted by the plan or issuer or by the provider or facility and the amount selected expressed as percentage of the median contracted rate; the category and practice specialty of each provider or facility; and the identity of the health plan or issuer, provider or facility (beginning for 2022)	
Air Ambulance	• **Providers.** Requires emergency air ambulance provider to annually submit to HHS and Transportation a report on: (1) cost data; (2) number and locale of provider's air ambulance bases; (3) number and type of aircraft operated; (4) number of air ambulance transports, disaggregated by payer mix; (5) number of claims denied by plan or issuer; and (6) number of emergency and nonemergency transports; and make publicly available • **Plans and Issuers.** Requires plan or issuer to annually submit to HHS a report on: (1) air ambulance claims data by provider type (hospital-owned/sponsored), network status, emergent/nonemergent, rural/urban, aircraft type; (2) and other information specified by HHS; and make publicly available • **Transportation.** Allows Transportation to use provider-submitted information to determine if provider engaged in unfair competition • **GAO Report.** Requires GAO to submit to Congress a report on options to set quality, patient safety, service reliability, and clinical capability standards for each clinical capability level of air ambulances (due 1 year after enactment)	• **Balance Billing.** Prohibits balance billing for air ambulance services furnished by an out-of-network provider • **Advisory Committee.** Requires HHS, Labor, Treasury to jointly establish an advisory committee that will review options to improve the disclosure of charges and fees for ground ambulance services, better inform consumers of insurance options for such services, and protect consumers from balance billing (no later than 60 days after enactment); and submit recommendations[41] to Departments and congressional committees (due no later than 180 days after the date of the first meeting of the advisory committee)	• **Balance Billing.** Prohibits balance billing for air ambulance services furnished by an out-of-network provider • **Providers.** Requires providers to submit 2 years of related cost data to HHS and Transportation to be made publicly available • **Plans and Issuers.** Requires plan or issuer to submit 2 years of related claims data to be made publicly available • **Advisory Committee.** Establishes an advisory committee on air ambulance quality and patient safety

[1] This chart summarizes the approved AINS to H.R. 5826.
[2] This chart summarizes the approved AINS to H.R. 5800 and additional amendments adopted during the markup. Individual amendments are hyperlinked in the chart.
[3] This chart summarizes the section-by-section (Title III and relevant provisions of Title II) released following the announcement of the compromise reached by Senate HELP Committee Chairman Alexander and House E&C Committee Leaders Pallone and Walden, and includes several assumptions (italicized) based on the legislative text advanced by the Senate HELP Committee by roll call vote (20-3), on June 19, 2019.
[4] Plan or issuer is also prohibited from requiring prior authorization or imposing any limitation on coverage that is more restrictive than those that would apply to emergency services furnished by an in-network provider or facility.
[5] Balance billing is prohibited for the additional service if: (1) the services would otherwise be covered if furnished by an in-network provider or at an in-network facility; and (2) services are furnished to main, improve or resolve the individual's stabilization, unless any of the following circumstances occur: (1) in-network provider with privileges at the facility assumes responsibility for the care of the individual; (2) in-network provider assumes responsibility for the care of the individual through transfer of the individual; (3) plan and provider reach an agreement concerning care for the individual; or (4) individual is discharged. Balance billing is permitted if: (1) the provider or facility gives written notice that states (a) the provider of facility is out-of-network; (b) estimate of out-of-network rate; (c) the individual may seek service from an in-network provider or facility; (2) the individual is in a condition to receive (as determined in accordance with guidance issued by HHS) the information and to confirm notice of receipt; and (3) the individual signs and dates such notice confirming receipt of the notice before the service is furnished.
[6] Specified providers mean ancillary health care providers (e.g., emergency medicine providers or suppliers, anesthesiologists, pathologists, radiologists, neonatologists, assistant surgeons, hospitalist, intensivist or other providers determined by the Secretary), as well as any provider furnishing an item or service at such hospital if there is no in-network provider at such hospital who can furnish those items or services.
[7] The health plan is required to calculate a consumer's cost-sharing amount based on the in-network contracted rate – using (1) the most recent contracted rate in effect between the health plan and the out-of-network provider or facility; or (2) the "recognized amount" if no contracted rate exists. The health plan is required to pay the out-of-network provider or facility: (1) the most recent in-network contracted rate in effect between the health plan and the out-of-network provider or facility; or (2) the out-of-network rate, if no in-network contracted rate exists.
[8] See note 4
[9] Balance billing for the additional services would be permitted if the following conditions are met: (1) the provider or facility determines the individual is able to travel using nonmedical transportation or nonemergency medical transportation; (2) the provider furnishing additional services satisfies the notice and consent criteria; and (3) the individual is in a condition to provide informed consent.
[10] Ancillary services are services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether or not provided by a physician or non-physician practitioner, and services provided by assistant surgeons, hospitals, and intensivists; diagnostic services (including radiology and laboratory services); services provided by other specialty practitioners identified by the Secretary through rulemaking; and a service furnished by an out-of-network provider because an in-network provider at that facility is not available. The Secretary has the authority to establish a list of advanced diagnostic laboratory tests that will not be included as an ancillary service.
[11] A continuing care patient means an individual who: (1) is undergoing a course of treatment for a serious and complex condition; (2) undergoing a course of institutional or inpatient care; (3) is scheduled to undergo nonelective surgery, including receipt of postoperative care with respect to such surgery; (4) is pregnant and undergoing a course of treatment for the pregnancy; or (5) is or was determined to be terminally ill and is receiving treatment for such illness.
[12] The deduction applies only to surprise billing expenses paid during the period beginning on January 1, 2020 and ending on the date which is 1 year after the day before January 1, 2022.
[13] The Secretary is required to establish a fee to participate in the patient-provider dispute resolution process in such a manner as to not create a barrier to an uninsured individual's access to such process.
[14] Plan or issuer is required to notify the out-of-network provider or facility of the median contracted rate for the disputed item or service and year. Provider or facility is required to notify the plan or issuer of the median of the total amount of reimbursement (including any cost-sharing) for the disputed item or service paid to the provider or facility at the time such provider or facility was in-network, based on the most recent and available information. If this information is unavailable, the out-of-network provider or facility must provide the plan or issuer with information specified by the Secretary. The Secretary may also require additional information.
[15] If the parties agree to an amount before the independent entity determines the amount, then the mediated dispute process is required to provide a method to determine how the two parties will allocate payment to compensate the independent entity.
[16] Multiple services are allowed to be batched together and considered jointly as part of a single mediated dispute process if: (1) the services are furnished by the same provider or facility; (2) payment is required by the same plan or issuer; and (3) the services are related to the treatment of a single condition. If a service is included by the provider or facility as part of a bundled payment, then the payment dispute for such service may be resolved in a single mediated dispute process.
[17] HHS will establish guidelines on compensating the selected independent entity. The administrative fee will be based on the amount of expenditures estimated to be made by the Secretary for administering the mediated process.
[18] The surprise billing law must provide for a method for determining the amount of payment that is required to be covered by the health plan or issuer.
[19] For subsequent years, the threshold increased by the percentage increase in the CPI-U over the previous year.

[20] Multiple services are allowed to be batched together and considered jointly as part of a single IDR if: (1) the services are furnished by the same provider or facility; (2) payment is required by the same health plan; (3) the items and services are related to the treatment of a single condition; and (4) all items and services were furnished within a 30-day period.
[21] Regarding ambulance services, additional information is required to be considered by the certified IDR entity include ambulance vehicle type and population density of the pick-up location.
[22] See note 21
[23] Line of business is one of the following: (1) individual market; (2) small group market; (3) large group market; and (4) in the case of a self-insured group heath plan, other self-insured group health plans.
[24] The HHS Secretary is required to consider non-fee-for-service payments made by health plans or issuers, and is permitted to consider relevant payment adjustments that consider quality or facility type (e.g., higher acuity settings, case mix of various facility types.
[25] Certification criteria includes having (1) sufficient medical, legal, and other expertise, as well as sufficient staffing to make determinations on a timely basis; and (2) no affiliations with a health plan, provider, facility, or related professional or trade associations. A certification lasts for a 5-year period and may be revoked if the entity exhibits a pattern or practice of noncompliance. The certification process must allow an individual, provider, facility, or health plan to petition for a denial of a certification or a revocation of a certification for noncompliance.
[26] The notice must include the following: (1) a statement that the provider is out-of-network; (2) the estimated amount that the provider may charge for the individual for services; and (3) a statement that the individual may seek such items or services from an in-network provider.
[27] The written notice must: (1) clearly state that consent to receive services from an out-of-network provider or out-of-network facility is optional and that the individual may instead seek care from an in-network provider or at an in-network facility; and (2) be available in the 15 most common language in the geographic region, and if the individual does not speak one of those languages, a good faith effort must be made to provide such notice orally, among other information..
[28] HHS may audit health plans and issuers for which the HHS Secretary has received any complaints involving compliance with requirement to apply median contracted rates. No maximum is set.
[29] HHS is required to audit a sample of claims data from no more than 25 group health plans and health insurance issuers and may audit health plans and issuers for which the HHS Secretary has received any complaints involving compliance with requirement to apply median contracted rates.
[30] The civil monetary penalty is waived if a facility or provider that does not knowingly violate, and should not have reasonably known it violated requirements, if the facility or provider withdraws within 30 days the bill that was in violation and reimburses the health plan or individual an amount equal to the different between the amount billed and the amount allowed to be billed, plus interest, at an interest rate determined by the HHS Secretary. The HHS Secretary is also authorized to establish a hardship exemption to penalties.
[31] The civil monetary penalty is waived if a facility or provider that does not knowingly violate, and should not have reasonably known it violated requirements, if the facility or provider withdraws within 30 days the bill that was in violation and reimburses the health plan or individual an amount equal to the different between the amount billed and the amount allowed to be billed, plus interest, at an interest rate determined by the HHS Secretary. The HHS Secretary is also authorized to establish a hardship exemption to penalties.
[32] If the appointment is scheduled at least 10 days prior, health plans will have 3 business days after the date on which the health plan is notified by the provider about the scheduled service to provide the required information. The notification must include: (1) the network status of the provider or facility; (2) in-network rate (if applicable); (3) information on in-network services (if out-of-network); and (4) good faith estimate of the amount the plan or issue is responsible for paying, the individual cost-sharing amount, and the amount that the individual has incurred toward meeting in-network deductible and out-of-pocket maximum; (5) whether the service is subject to a medical management technique; (6) a disclaimer that the information is only an estimate and is subject to change; (7) a statement the individual make services from an in-network provider or facility.
[33] This information must be available at any time, including upon request by insurer, and must be updated when there are material changes, including changes in address, phone number, etc., and at any other time determined appropriated by the provider, facility, or HHS. A provider or facility that fails to transmit required information will be subject to a civil monetary penalty of $1,000 per day.
[34] Specifically, providers will be required to provide this information within one business day, so long as the individual schedules at least 3 business days prior the appointment. In the event that the appointment is scheduled at least 10 days prior, providers will then have 3 business days to provide the required information.
[35] Direct compensation means compensation received directly from the plan, and indirect refers to anything received from any source other than the plan and not in connection to the services rendered.
[36] Specifically, the bill requires that the brokerage or consulting service provider disclose in writing, to the responsible plan fiduciary the following: (1) a description of the services to be provided to the plan pursuant to the contract; (2) a description of all direct and indirect compensation, either in the aggregate or by service, that the service provider, an affiliate, or a subcontractor reasonably expects to receive in connection with the services to be provided; (3) a description of whether such compensation is set on a transaction basis, such as commissions, finder's fees, or other similar incentive compensation based on business placed or retained, etc.; (4) a description of any compensation that the service provider, an affiliate, or a subcontractor reasonably expects to receive in connection with termination of the contract or arrangement, and how any prepaid amounts will be calculated and refunded upon termination.
[37] This process, and the form and manner in which issuers will be required to make the disclosures, must be further delineated by HHS through notice and comment rulemaking no less than one year after enactment of the bill.
[38] The HHS Secretary, in consultation with the Secretary of Labor, is required to issue guidance on the requirements of the one-page notice (due 6 months after enactment).
[39] A provider that fails to comply with the provider directory requirements will be imposed a civil monetary penalty of not more than $10,000 for each violation. HHS may waive the penalty if the provider rescinds the bill involved, and if applicable, reimburses the enrollee within 30 days of the date on which the provider billed the enrollee. If the enrollee pays the bill, then the provider will reimburse the enrollee for the full amount paid plus interest, at an interest rate determined by HHS.
[40] HHS is required to promulgate regulations regarding hardship exemptions.
[41] The advisory committee is required to make recommendations that address, at a minimum: (1) options, best practices, and identified standards to prevent instances of balance billing; (2) steps that can be taken by the State; and (3) legislative options for Congress.