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THE COUNCIL
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Federal Surprise Billing Legislative Packages

Legislation	Treatment of Services	Dispute Resolution	Plan Transparency	Miscellaneous
Lower Health Care Costs Act of 2019 (S. 1895) Sen. Lamar Alexander (R-TN) *June 26 – Approved by the Senate HELP Committee, as amended, by a vote of 20-3.* ***Note, in December 2019, the Senate HELP and House Energy & Commerce Committees announced a "compromise" on its surprise billing legislation. The committees only released a section-by section summary —text of the compromise***	***Emergency Services***. Prohibits balance billing for emergency services performed by an OON provider and/or at an OON facility. For patients initially admitted for emergency services or for maternal care for labor, prohibits balance billing for follow-up, non-emergency care unless, post-stabilization, the patient receives notice that the hospital/provider is OON and the patient consents the post-stabilization services. ***Non-Emergency Services***. Prohibits balance billing for OON services at an in-network facility. Prohibits balance billing for OON "ancillary, non-emergency services" (e.g., services provided by intensivists, radiologists, neonatologists, etc.) performed at in-network facilities, unless, within 48 hours, notice is provided to the patient that the service will be provided OON and the patient consents to receive the service.	Sets a benchmark payment rate for plans/insurers to pay providers based on the median in-network rate (i.e., the total maximum payment for the service less the in-network cost sharing for the service) in a geographic region. Requires HHS to determine the methodology a plan/insurer is required to use to determine the median in-network rate. If a plan/insurer lacks sufficient information to calculate the median in-network rate for a service/provider-type in a given geographic area, the plan/insurer must demonstrate that it will use a database (e.g., a state APCD) that has sufficient information reflecting "allowed amounts paid to individual health care providers for relevant services provided in the applicable geographic region" to determine the median in-network rate for a particular market. **[**Note, the ***reported "compromise"*** would modify this section. Per the section-by-section: • Requires the insurer to pay at a minimum the market-based median in-network negotiated rate for the service in the geographic area; • If that median rate is above $750, allows the provider or insurer to go to baseball-style, binding independent dispute resolution;	Requires plans to: • Establish business processes to ensure that all enrollees receive proof of a provider's network status upon request (including a real-time, online provider directory search tool maintained by the plan); • Establish business processes to verify and update—at least every 90 days—the provider directory information; • Receive a quarterly report on the costs, fees, and rebate information associated with their PBM contracts; • Provide plan participants with a "good faith" estimate of their cost-sharing responsibility for a specific service/item within 2 days of a request; • Report to HHS specific information regarding the health plan and associated drug claims (e.g., the beginning and end dates of the plan year, number of enrollees, 50 most frequently dispensed brand drugs for claims paid, etc.); and • Make available for access/use through APIs information on historical claims, directory information for all in-network providers, estimated out-of-pocket costs for common services, etc.	***Disclosure of Broker Compensation***. Requires brokers and consultants to disclose direct and indirect compensation to employer-sponsored health plans and individual market enrollees. ***Deductible/Out-of-Pocket Limit***. Requires emergency charges to be counted toward the patient's in-network deductible. ***State Law***. Maintains state surprise billing protections. ***Misinformation***. Limits cost-sharing to the in-network rate when the consumer relies on directory information that was incorrect at the time of treatment. Contains other provisions to: • Reduce costs of prescription drugs (e.g., biological product patent transparency, ensuring access to generic drugs, etc.); • Increase drug pricing transparency (e.g., requiring drug manufacturers to justify price increases, removing gag clauses on price/quality information, designation of a non-

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has not yet been released.	***Air Ambulance Services***. Prohibits balance billing for OON air ambulance services. ***Cost Sharing***. In situations when balance billing is prohibited, limits the consumer's responsibility/liability to the in-network cost-sharing amount.	• Requires arbitrators to consider information brought by the parties related to the training, education, and experience of the provider; market share of the parties; and other extenuating factors like patient acuity and complexity of the services; and • Following arbitration, restricts the initiating party from taking the same party to arbitration for the same item or service for 90 days following the decision.**]**	With respect to the directory, requires providers to have in place business processes to ensure the timely provision of provider directory information to plans to support maintenance of the provider directories.	governmental, non-profit transparency organization to lower health care costs, etc.) • Prohibit PBM spread pricing; • Require PBMs to pass on 100% of any rebates/discounts to the plan sponsor; • Improve public health (e.g., public awareness campaign on the importance of vaccinations); and • Improving the exchange of health information.
No Surprises Act (H.R. 3630) Rep. Frank Pallone (D-NJ) *July 17 – Approved by the House Energy & Commerce Committee, as amended, and incorporated into the Community Health Investment, Modernization, and Excellence Act of 2019 (H.R. 2328)*	***Emergency Services***. Prohibits balance billing for emergency services performed by an OON provider and/or at an OON facility. ***Non-Emergency Service***. Prohibits balance billing for non-emergency services by specified providers (e.g., anesthesiologists, pathologists, radiologists, neonatologists, etc.) performed by OON providers at in-network facilities. ***Air Ambulance Services***. NOT ADDRESSED ***Cost-Sharing***. In situations when balance billing is prohibited, caps cost-sharing obligations at in-network levels and requires plans to pay those providers the difference between the	Requires HHS and DOL to establish by regulation an independent dispute resolution (IDR) process to determine payment amounts that uses the following framework: • Allows either entity to request that the required payment amount be increased or decreased. • Selects/assigns an unbiased/unaffiliated third-party entity that is certified by HHS (i.e., a "certified IDR entity") to resolve the request. • If the certified IDR entity determines that a settlement is likely, allows the entity to direct the parties to attempt a good faith negotiation for settlement for—at most—10 days. • In the event that a settlement is not reached with respect to such request, requires both parties to submit a final offer to be considered. • Requires the certified IDR entity to determine an alternative payment following consideration of several factors (i.e., median contracted rates, level	Requires plans to: • Establish a verification process under which the plan verifies and updates its provider directory; • Establish a protocol to respond to covered individuals who request information on whether a provider/facility is in-network; • Develop a public database that contains (1) a list of each provider and facility with which the plan has a contractual relationship; and (2) provider directory information with respect to each provider/facility; and • Provide public disclosures on patient protections. With respect to the directory, requires providers to establish a process under which	***Elective OON Care***. Allows for elective OON care in non-emergency situations if notice and consent requirements are met. ***All Payer Claims Databases***. Requires HHS to make grants to states to establish APCDs, or maintain an existing APCD. ***Air Ambulance Billing***. Requires providers of air medical services to submit to plans a description of charges for such services that are separated by (1) the cost of air travel and (2) the cost of emergency medical services and supplies. Requires providers of air medical services to submit information to HHS on claims and cost data for the furnishing of air ambulance services.

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	patient's in-network rate and a benchmark minimum rate (established by the state or based on the median in-network/contracted rate for the plan within a particular geographic region for the same item or service).	of training/experience of the provider, and extenuating circumstances). Provides that a determination by a certified IDR entity is binding and not subject to judicial review. Prohibits submission of a request under the IDR process, unless the median contract rate for the item/service is at least $1,250 (adjusted for inflation). Limits the batching of items/services in a request for the IDR process. Publicizes information relating to the IDR process (e.g., number of requests submitted, practice size of providers submitting requests, etc.).	the provider transmits provider directory information to the plan.	***Deductible/Out-of-Pocket Limit***. Requires OON care received in a surprise billing scenario to be counted towards the in-network deductible or out-of-pocket maximum.
Consumer Protections Against Surprise Medical Bills Act of 2020 (H.R. 5826) Rep. Richard Neal (D-MA) *February 12 – Approved by the House Ways & Means Committee, as amended, by a unanimous voice vote.*	***Emergency Services***. Prohibits providers from sending balance bills to consumers that received emergency medical services from an OON provider and/or at an OON facility. ***Non-Emergency Services***. Prohibits providers from sending balance bills to consumers that received medical items/services other than emergency services from an OON provider and/or at an OON facility. ***Air Ambulance Services***. NOT ADDRESSED	Establishes a two-step dispute resolution process: • Step #1: Allows either party to initiate a 30-day "open" negotiation during which the plan and provider will exchange information (e.g., the median in-network rate, the median reimbursement amount, etc.). • Step #2: If the open negotiations fail, allows either party to initiate the mediated dispute process to resolve the dispute within 30 days. Though some details are left to HHS (e.g., batching of similar claims, creating a process to transition from the open negotiation to mediation, establishing a process to certify the third-party mediators, etc.), broadly requires: • Selection of and administration by an unbiased third party (i.e., a "selected independent entity");	Requires plans to: • Update and verify directory information for all in-network providers; • Make publicly available—and include on each EOB—information on statutory balance billing prohibitions; • Provide an "Advanced EOB" regarding scheduled services (i.e., a notification containing the provider's network status, applicable/anticipated rates, a "good faith" cost estimate, etc.) upon request; • Work to ensure continuity of care when contractual relationships between plans and providers change or are terminated;	***Misinformation***. Protects patients who have received incorrect information from their insurer regarding the network status of the provider from balance bills. ***Air Ambulance Data***. Establishes an air ambulance data reporting program, under which providers of emergency air medical services are required to submit certain claims data related to their provision of services to HHS.

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	Cost-Sharing. In situations when balance billing is prohibited, limits the consumer's responsibility/liability to the in-network cost-sharing amount and requires plans to pay those providers the difference between the patient's in-network rate and a benchmark minimum rate (established by the state, based on the median contracted rate, approved by the state, or—for self-insured group plans with agreements with the state—the amount payable as determined by the agreement).	• Each party—within 10 days of initiating the mediation—to put forth their "best and final" offer and supporting information to substantiate it; and • The "selected independent entity" to select/approve one of the offers following consideration of the median contracted rate and the supporting information provided by the parties. Requires no minimum dollar amount to bring cases, though each party must pay an administrative fee—to be set by HHS—to participate in the mediated dispute process.	• Distribute identification cards that disclose network and cost sharing information; and • Maintain a price comparison tool for consumers (i.e., an online portal that allows an individual consumer to view the anticipated cost-sharing amount associated with a specific item or service in a given geographic area based on historic claims data of participating providers).	
Ban Surprise Billing Act (H.R. 5800) Rep. Bobby Scott (D-VA) *February 11 – Approved by the House Education & Labor Committee, as amended, by a vote of 32-13.*	***Emergency Services***. Prohibits providers from sending balance bills to consumers that received emergency medical services from an OON provider and/or at an OON facility. ***Non-Emergency Services***. Prohibits providers from sending balance bills to consumers for certain ancillary services (e.g., services related to pathology, radiology, anesthesiology, and neonatology) from an OON provider and/or at an OON facility. ***Air Ambulance Services***. For plan years beginning Jan. 1, 2022, prohibits providers from sending balance bills to consumers for air	Requires HHS (with DOL and Treasury) to establish by regulation an independent dispute resolution (IDR) process to determine payment amounts that uses the following framework: • Requires providers/facilities to exhaust internal dispute resolution mechanisms (i.e., the provider/facility must have filed an appeal with the plan's appeals process to dispute the payment) and requires plans to notify providers/facilities of their intent to dispute the payment. • Allows either entity to then request that the required payment amount be increased or decreased. • Selects/assigns an unbiased/unaffiliated third-party entity that is certified by HHS (i.e., a "certified IDR entity") to resolve the request. • If the certified IDR entity determines that a settlement is likely, allows the entity to direct the	Requires plans to: • Establish business processes to ensure that all enrollees receive proof of a provider's network status upon request (including a real-time, online provider directory search tool maintained by the plan); • Establish business processes to verify and update—at least every 90 days—the provider directory information; • Provide plan participants with a "good faith" estimate of their cost-sharing responsibility for a specific service/item within 2 days of a request; and • Include on insurance identification cards the amount of the in-network and OON deductibles and out-of-pocket limitations under the plan.	***Disclosure of Broker Compensation***. Requires brokers and consultants to disclose direct and indirect compensation to employer-sponsored health plans and individual market enrollees. ***This language mirrors the Lower Health Care Costs Act.*** ***Misinformation***. Limits cost-sharing to the in-network rate when consumers rely in good faith on out-of-date directories and information from the plan. ***State Law***. Does not supersede any provision of state law that establishes/implements any requirement or prohibition.

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	ambulance services from an OON provider. ***Cost-Sharing***. In situations when balance billing is prohibited, limits the patient's responsibility to the in-network cost-sharing amount and requires plans to pay those providers the difference between the patient's in-network rate and a benchmark minimum rate (established by the state, based on the median in-network/contracted rate for the plan within a particular geographic region for the same item or service, or the amount approved by the state under its All Payer Model Agreement).	parties to attempt a good faith negotiation for settlement for—at most—10 days. • In the event that a settlement is not reached with respect to such request, requires both parties to submit a final offer to be considered. • Requires the certified IDR entity to determine an alternative payment following consideration of several factors (e.g., median contracted rates, level of training/experience of the provider, extenuating circumstances, demonstration of good faith efforts, etc.). Prohibits submission of a request under the IDR process, unless the median contract rate for the item/service is at least $750 (or, in the case of air ambulance services, $25,000) (adjusted for inflation). Restricts batching of items/services in a request for the IDR process. Publicizes information relating to the IDR process (e.g., number of requests submitted, practice size of providers submitting requests, average response/resolve time for billing discrepancies, etc.).	With respect to the directory, requires providers to have in place business processes to ensure the timely provision of provider directory information to plans to support maintenance of the provider directories.	***Elective OON Care***. Allows for elective OON care in non-emergency situations if notice and consent requirements are met. ***Deductible/Out-of-Pocket Limit***. Requires OON care received in a surprise billing scenario to be counted towards the in-network deductible or out-of-pocket maximum. ***Provider Transparency***. Requires OON providers/facilities to provide notice to consumers with information about the provider's network status, a good faith estimate of the anticipated charges, etc. ***Advisory Committee on Ground Ambulance and Patient Billing***. Requires HHS, DOL, and Treasury to establish an advisory committee to develop recommendations to protect consumers from ground ambulance balance bills. ***Non-Discrimination***. Requires HHS issue a rule on implementing non-discrimination requirements for group health plans, individual/group insurers, and providers. ***Study***. Requires GAO report to Congress on the IDR process and release a publicly available report on the adequacy of provider networks in group health

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				plans and group/individual coverage.