US Congress Proposed Legislation to Address Surprise Medical Balance Bills

	Lower Health Care Costs (Proposed Sections)	Ways and Means Committee Surprise Medical Billing Plan (Proposal)	**Lower Health Care Costs Act (S. 1895)**	**No Surprises Act (HR 3630)**	**Protecting People from Surprise Medical Bills Act (HR 3502)**	**STOP Surprise Medical Bills Act of 2019 (S. 1531)**	**Consumer Health Insurance Protection Act of 2019 (S. 1213)**	**Reducing Costs for Out-of-Network Services Act of 2019 (S. 967)**	**Protecting Patients from Surprise Medical Bills Act (HR 4223, S. 1266)**	**End Surprise Billing Act of 2019 (HR 861)**	**Proposal to Committee on Ways and Means (letter)**
Last Action	December 2019	December 2019	July 2019	July 2019	June 2019	May 2019	April 2019	April 2019	September 2019	January 2019	September 2019
Sponsors	Alexander (R-TN), Pallone (D-NJ), Walden (R-OR)	Neal (D-MA), Brady (R-TX)	Alexander (R-TN), Murray (D-WA)	Pallone (D-NJ), Walden (R-OR)	Ruiz (D-CA), Roe (R-TN)	Cassidy (R-LA), Bennet (D-CO)	Warren (D-MA)	Shaheen (D-NH)	Spano (R-FL), Scott (R-FL)	Doggett (R-TX)	Neal (D-MA), Brady (R-TX)
Effective	Unspecified	Unspecified	Second plan year after enactment	Plan year 2021	Jan. 1, 2021	Cost-sharing disclosure: Jan. 1, 2020; Price information: Jan. 1, 2021	Plan Year 2021			12 months after enactment	
Insurer Applicability											
Group health plans	Unspecified	Unspecified	✔ [1]	✔	✔ [2]	✔ [3]	✔	*[4]	✔ [5]	✔ [6]	
Individual health insurance	Unspecified	Unspecified	✔ [7]	✔ [8]	✔	✔	✔	✔		✔ [9]	
Prohibits Balance Billing in these Cases											
Emergency Services	✔	Unspecified	✔ [10]	✔	✔	✔	✔ [11]		✔	✔	
Out-of-network (OON) services delivered at an in-network facility	✔	Unspecified	✔ [12]	✔ [13,14]	✔ [15]	✔				✔ [16]	✔
OON Services provided without a consumers' consent	✔	Unspecified									

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Post-emergency services		Unspecified	✔ [17]	✔ [18]	✔ [19]	✔ [20]					
Inability of consumer to choose an in-network provider		Unspecified							✔		
A certain date after the service was rendered	✔	✔			✔ [21]						
Air ambulance services	✔	Unspecified	✔								
When faulty provider information was provided		Unspecified	✔								
Facility definition	Unspecified	Unspecified	Hospitals, hospital out-patient departments, critical access hospitals, ambulatory surgery centers, laboratories, radiology clinics, freestanding emergency rooms, any facility that	A hospital, critical access hospital, ambulatory surgical center, laboratory, radiology facility or imaging center.	Hospital, critical access hospital, ambulatory surgical center, laboratory, radiology or imaging center, any other facility that provides services covered under health insurance coverage, any other facility specified by the Secretary of the Department of Health and Human Services.				An entity providing health care services as licensed or authorized by a state.		

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			provides services covered by a health insurer.								
Dispute Resolution and Reimbursement											
Deference to state law		✔	✔	✔	✔	✔[22]					
Reimbursement standard	Insurers must pay median in-network rates (based on negotiated rates in the geographic region where service was delivered).		Health plans' median negotiated rate for similar services in the same geographic region.	Health plan's median negotiated rate for similar services in the same geographic region.	Insurer must first pay a commercially reasonable rate. Provider or insurer may initiate a negotiation to adjust that payment. If a negotiated sum is not reached, they provider or insurer may initiate an independent dispute resolution process.	Health plan's median negotiated rate for similar services in the same geographic region.		Requires states to select one of the following as payment maximum: • 125% of Medicare rate; • 80th percentile of usual, customary, and reasonable rate; or • 100% of allowed charges based on the average actual allowed rate for all participating providers.	In the case of out-of-network services where patient did not have a choice of services: • The amount of the claim made by the provider; • The usual and customary rate; or • An amount mutually agreed to by the plan and provider.		Would require the departments of Health and Human Services, Labor, and Treasury, and a committee of stakeholders to identify rates.

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								If a state does not select a rate, the rate will default to 125% of Medicare rate or a rate established by the Department of Health and Human Services. Providers may not charge more than: • The payment maximum in the case of an insured consumer without out-of-network (OON) coverage; • The payment maximum minus cost-sharing and payments made by the insurer in the case of a consumer with OON coverage; or • The lower of the			

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								maximum rate set by the state or an amount otherwise allowed under state law.			
Establishes a dispute resolution entity	✔	✔			✔ [23]	✔			✔ [24]		
Arbitration details	Baseball arbitration (arbiter will select the most reasonable bid put forth by the insurer or provider). Applies where payment is >$750, This amount is increased to >$25,000 in the case of air ambulance services Reasonableness determined by: • Training, education, and	Will be designed to protect against inadvertently raising health care costs. A surcharge will be applied to providers and plans that use the process in excess of certain pre-determined thresholds. Reasonableness determined by: • Payments made to similar providers for similar services in			Baseball arbitration (arbiter will select the most reasonable bid put forth by the insurer or provider). Reasonableness determined by: • Commercially reasonable rate for comparable services in the same geographic area • Usual and customary cost of service—80th percentile of charges for comparable services in that geographic region as determined by	Baseball arbitration (arbiter will select the most reasonable bid put forth by the insurer or provider). Reasonableness determined by: • Commercially reasonable rates for comparable services or services in the same geographic area; • Level of training, expertise, quality, and outcome metrics of the provider					Would require the departments of Health and Human Services, Labor, and Treasury, and a committee of stakeholders to identify a process for dispute resolution.

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	experience of the provider • Market share of the parties, • Other extenuating factors, such as patient acuity and the complexity of furnishing the item or service. • Location and population density of where the patient was picked up (for air ambulance bills • Vehicle type and medical capabilities (for air ambulance bills)	similar areas.			a medical claims database • Level of training, education expertise, and outcome metrics of the provider • Circumstances and complexity of the case • Providers' quality and outcome metrics • Provider's usual out-of-network charge for comparable services • Individual patient characteristics and/or • Other relevant economic and clinical circumstances	• Circumstances and complexity of the case • Market share of the insurer or out-of-network provider • Good faith efforts to contract and negotiate rates; and/or • Other relevant economic factors					

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Data sources used to calculate reimbursements:	Grant program to create and improve state all-payer claims databases. Data must be made available to authorized users, including researchers, employers, health insurance issuers, third-party administrators, and health care providers for quality improvement and cost-containment purposes.	Unspecified	Creation of national nonprofit claims database $100 million in-state grants to establish or maintain all-payer claims databases. If insurer cannot complete calculation, then shall demonstrate it will use a conflict-free database to determine the rate.	Provides $50 million in state grants to establish or maintain all-payer claims databases. If an insurer cannot complete reimbursement calculations, then it shall demonstrate it will use a conflict-free database to determine the rate.	Insurers must submit to departments of Health and Human Services and Labor data on the: • Number of in-network and out-of-network (OON) claims • Patient out-of-pocket costs for OON services • Number of claims for emergency services and OON care delivered at an in-network facility.	Insurers must submit to the departments of Health and Human Services and Labor data on the: • Number of in-network and out-of-network (OON) claims • Patient out-of-pocket costs for OON services • Number of claims for emergency services and OON care delivered at an in-network facility.					
Accountability											
			Civil monetary penalties up to $10,000 per violation.	Empowers states to place requirements on providers and facilities to satisfy requirements of this law. If a state does not enforce the requirements, it	Civil monetary penalties as determined by the Health and Human Services Secretary.		Civil monetary penalties as determined by the Health and Human Services Secretary.	Civil monetary penalties up to $10,000 per violation		Makes requirements on hospitals a condition of participation in Medicare.	

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				empowers HHS to enforce the act with civil monetary penalties up to $10,000 per violation. The Health and Human Services Secretary shall establish a process to receive and resolve consumer complaints within 60 days.						
Transparency											
Establishes requirements to maintain and update provider directories	✔	Unspecified	✔	✔	✔				✔		
Requires distribution of balance billing policies		✔	✔ [25]	✔ [26]		✔ [27]			✔	✔ [28]	✔ [29]
Requires the printing of out-of-network cost-sharing on insurance cards	✔	Unspecified			✔	✔					

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Provides consumers with cost estimates	✔	✔	✔			✔ [30]				✔	
Requires providers to disclose potential for out-of-network services		✔	✔ [31]	✔ [32]							

Notes

[1] Includes grandfathered health plans.
[2] Includes federal employee health plans.
[3] Includes grandfathered health plans, enables states to impose balance billing protections on fully-insured plans.
[4] Grants to states for the purposes of studying the effects of limitation of charges made by group health plans.
[5] Specifically to self-insured group plans.
[6] Requirements apply specifically to providers, but are enforced for consumers regardless of coverage type.
[7] Includes grandfathered health plans.
[8] Includes grandfathered health plans.
[9] Requirements apply specifically to providers, but are enforced for consumers regardless of coverage type.
[10] Includes post-labor services received prior to individual being in a stable and in a condition able to receive notice about the potential for out-of-network (OON) services.
[11] Prohibition applied specifically to providers.
[12] Includes ancillary services at an in-network facility (e.g., diagnostic services). Does not include non-ancillary services delivered when proper notice and consent are given.
[13] Except where proper notice and consent are given.
[14] Includes use of equipment and devices, telemedicine services, imaging, laboratory, or other items as defined by the HHS secretary regardless of whether the provider furnishing the service is at the facility.
[15]Includes imaging or lab services ordered by an in-network provider
[16] Includes services rendered by a provider of services or supplier that furnishes items or services at a hospital or critical access hospital. Exception when consumer consent is acquired.
[17] Except where proper notice and consent are given. Includes post-labor services received prior to mother being determined stable.
[18] When the patient cannot travel without medical transport.
[19] When the patient cannot travel without medical transport.
[20] When the patient cannot travel without medical transport and patient has not been given proper notice and consent.
[21] Applies only to health care providers.
[22] Only if state law is stricter than federal law.
[23] By 2010, the HHS secretary, with DOL, shall establish a process or resolving payment disputes. Any entity wishing to participate as a dispute resolution entity shall request certification. To be certified, HHS secretary may consider if the entity is unbiased, unaffiliated with health plans and providers, and free of cost of living indexing (CPI).

[24] To enter into arbitration, claim must be no less than $3,000 (for facilities) and $500 for professional services. (To be adjusted annually based on CPI.)

[25] Must provide consumers upon intake about the prohibition of balance billing and whom consumers should contact for recourse if they are sent a balance bill.

[26] Required of both providers and insurers.

[27] Insurers may not contract with providers that do not agree to provide network disclosures to their beneficiaries.

[28] Requires hospitals to disclose if the hospital or any provider of services to the consumer is in or OON.

[29] Proposal will include "related policies that strengthen consumer protections, provide more information and access for patients, and enhance transparency within the health care system".

[30] Provide estimates of cost sharing for elective health services within 48 hours of a beneficiary's request. Must post out-of-pocket cost and benefit information for all in-network providers.

[31] Post-stabilization, when patient is of sufficient mental capacity to receive information. Patient must affirmatively agree to any OON services and cost responsibility. Must include information on in-network alternatives available to the patient.

[32] Upon making an appointment for services. The provider must receive a signed consent form no less than 24 hours prior to delivering services.