HHS | Hart Health Strategies Inc.

Surprise Insurance Gaps/Out-of-Network (OON) Legislative Comparison – Discussion Drafts

	No Surprises Act, Pallone (D-NJ) and Walden (R-OR) Discussion Draft	Lower Health Care Costs Act, Alexander (R-TN) and Murray (D-WA) Discussion Draft	Protecting People from Surprise Medical Bills Act, Ruiz (D-CA) and Roe (R-TN)
Relationship to bills introduced last Congress	--	-- (Note: This only summarizes Title 1 and sections 304 and 305, related to surprise billing.)	-- (Note: This is based upon a summary, not actual bill text.)
Key Elements	Prohibits balance billing and holds patients harmless for emergency services and certain OON services provided at certain in-network facilities. Prohibits balanced billing for all OON services, unless informed consent is received prior to the item or service being delivered.	The committee has included three separate options (i.e., in-network guarantee, independent dispute resolution or IDR, and benchmark for payment).	Bans the practice of billing patients for unanticipated out-of-network care. Implements a 'baseball-style' arbitration model. Improves transparency by requiring health plans to clearly identify in-network providers and patients' deductibles.
Status	Discussion draft; Dated May 13, 2019 - comments due by May 28.	Discussion draft; Released May 23, 2018 – comments due by June 5.	Bill summary released May 23.
Cosponsors	--	--	6 bipartisan cosponsors (thus far)
Applicable market	ACA, ERISA, and private market plans	Per principles, ERISA plans will always be covered. ACA, ERISA, and private market plans.	ERISA, FEHBP, and all private market plans in States without patient protections.
Provider applicability	Physicians and other health care professionals licensed in the state; emergency departments (including freestanding emergency departments); hospitals (including CAH), ASCs, laboratories, and radiology or imaging centers.	For the in-network guarantee model, all facilities that provide services that are covered under a group health plan or health insurance coverage. For IDR model and the benchmark for payment model, all facilities and practitioners providing services.	Unclear, likely all providers.
Prohibition on balanced billing	Yes, for emergency services, "facility-based providers" (i.e., emergency medicine providers, anesthesiologists, pathologists, radiologists, neonatologists, assistant surgeons, hospitalists, intensivists, or	Yes, for emergency services, after emergency care if no notice is provided, and OON services provided in in-network facilities.	Yes, for emergency care, scheduled care with unanticipated OON providers, after emergency care when a patient cannot travel without medical transport, OON imaging or lab services ordered by an in-network provider.

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	other providers as determined by the Secretary), and for OON providers who do not document patient consent for balance billing.		
Penalty for balanced billing	CMPs (not specified), with the possibility for those amounts being different in emergency versus non-emergency circumstances.	CMPs, with the potential to waiver if "unknowingly" and the patient is reimbursed within 30 days	CMPs if the patient has not been reimbursed the amount that they were balanced billed within 30 days of the entity being made aware of the error.
Patient protection -out-of-network services treated as in network	Yes, for emergency services and certain OON providers at certain facilities (i.e., hospital, ASC, laboratory, and radiology or imaging center).	Yes, for emergency services, certain OON providers in in-network facilities, and after emergency care if no notice is provided.	Yes, for emergency care, scheduled care with unanticipated OON providers, after emergency care when a patient cannot travel without medical transport, and OON imaging or lab services ordered by an in-network provider.
Emergency services	Patient only required to pay the cost-sharing amount required by their health plan for in-network services. No balanced billing. Any costs in excess of this amount will be paid by the health plan, either (a) In accordance with State law or (b) An amount based on the median in-network amount.	Patient only required to pay the cost-sharing amount required by their health plan for in-network services. No balanced billing. Any costs in excess of this amount will be paid by the health plan. Payment depends on the model (e.g., in-network guarantee, IDR, or benchmark for payment).	Patient only required to pay the cost-sharing amount required by their health plan for in-network services. No balanced billing.
Non-emergency services	No balance billing for facility-based providers for covered non-emergency services if the services are provided at an in-network facility. Patient only required to pay the cost-sharing amount required by their health plan for in-network services. No balanced billing. Any costs in excess of this amount will be paid by the health plan, either (a) In accordance with State law or (b) An amount based on the median in-network amount.	No balance billing for facility-based providers for covered non-emergency services if the services are provided at an in-network facility. Patient only required to pay the cost-sharing amount required by their health plan for in-network services. No balanced billing.	Yes, for scheduled care with unanticipated OON providers, after emergency care when a patient cannot travel without medical transport, and OON imaging or lab services ordered by an in-network provider.

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	No balance billing for non-emergency services if informed consent is not documented and retained.		
Capped payment amount	Any costs in excess of the patient's required payment will be paid by the health plan, either (a) In accordance with State law or (b) An amount based on the median in-network amount.	For in-network guarantee model, the in-network rate applies. For the IDR model, any costs in excess of the patient's required payment will be paid by the health plan, either the median in-network amount negotiated by health plans or a rate determined by an IDR. IDR is only available to claims of $750 or more (adjusted for inflation). Includes language re: benchmark database. For benchmark for payment model, the median in-network payment applies.	Any costs in excess of the patient's required payment will be paid by the health plan, either (a) commercially reasonable rate within 30 days or (b) amount determined by IDR.
Review process for surprise billing	--	For IDR model, IDR process will involve certified entities, resolution within 30 days and payment due 30 days after resolution. After 10 days of good faith negotiation, then the IDR entity can make final, binding determination and state who pays for the IDR process. Factors for determining final payment include in-network median rates. Final determinations will be made public; IDR entities must comply with privacy laws. No review process for the in-network guarantee or benchmark for payment models.	HHS will maintain database of IDR entities. Resolution within 60 days (30 days to submit and 30 days for response) and payment due 15 days after resolution. IDR entity makes final, binding determination and state who pays for the IDR process. If parties agree to payment prior to IDR completion, then the cost is split. Factors for determining final payment include (1) The usual and customary cost of the service; (2) history of commercial network contracting between the plan and the provider, (3) provider's quality and outcome metrics; (4) circumstances and complexity of the case, (5) physician's usual charge for

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			comparable services with regard to patients in health care plans in which the physician is not participating; (6) other economic and clinical circumstances relevant to the case; etc.
Assignment of benefits (Y/N)	Yes.	Not relevant with in-network guarantee. Yes, for the IDR model. Not specified within the benchmark for payment model.	Yes.
Notification of out-of-network services	For a provider to balance bill for certain services, a provider must provide the patient, at the time of making the appointment, with an oral and written notice that the provider is a non-participating provider and an estimated amount of the charge (including a statement that utilizing an in-network provider could result in a lower OOP costs and that such costs will not accrue toward the OOP limit).	Included for certain services after the patient has been stabilized (following an emergency).	--
Requirements of any notification	The patient must sign and date the written notice at least 24 hours before the item or service is delivered.	Notification cannot exceed one page, must be readily identifiable, provide an estimate of charges, be printed in the patient's primary language, etc.	--
Network adequacy provisions	--	Within one year of date of enactment, requires plans to provide real-time updates of in-network providers. Adds patient protections based on the provider directory. Includes enforcement provisions.	Requirement that the Secretary develop transparency requirements regarding in-network providers. Adds patient protections based on provider directory.
All Payers Claim Database	Authorizes $50M for one-time grants to States to establish or maintain an All Payer Claims Database	-- (Does reference an independent benchmarking database from time to time)	--
Air Ambulance	--	Requires air ambulance charges to be separated into (1) the cost of air travel and (2) the cost of emergency medical services (as further defined by	--

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		regulation). Includes CMPs. Effective date is 6 months after the rulemaking is finalized.	
Timely bills	--	Requires bills to be submitted to the patient within 30 days. Includes CMPs for any violation. Patient are not required to pay bills that are presented more than 30 days after the service.	A patient cannot be billed for the first time for any services after one year of services rendered by either the provider or the payer.
Study on the effect of the provisions	--	Study on the effect of key provisions.	Study on the effect of key provisions.
Other provisions	--	--	The Secretary of HHS will conduct a feasibility study on the provision of a single bill for all services provided for a single episode of care. HHS shall publish results of arbitration by geographic region in order to give more guidance to providers and plans.
Effect on State laws	Payment could be determined by the State law (unclear if that would affect ERISA plans).	Covers all ERISA plans per the options provided. For other plans covered by State law, if there's a process in place, then it is retained. For States without a separate process, the arbitration model will apply to their respective claims.	Applies to ERISA and FEHBP. Applies to fully-insured plans in states that do not have balanced billing laws or regulations (not required to have IDR).
Effective date	Rulemaking on the median contracted rate due July 1, 2020. General effective date for plan years beginning on or after January 1, 2021. Certain provisions apply to services provided on or after January 1, 2021.	Second plan year after date of enactment.	Regulations required within one year after date of enactment. Other provision in effect starting on January 1 that occurs after one year after date of enactment.

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Surprise Insurance Gaps/Out-of-Network (OON) Legislative Comparison – Introduced Bills

	End Surprise Billing Act (H.R. 861) Doggett (D-TX-35)	Reducing Costs for Out-of-Network Services Act (S. 967) Shaheen (D-NH)	Protecting Patients from Surprise Medical Bills Act (S. 1266) Scott (R-FL)	Stopping the Outrageous Practice (STOP) of Surprise Bills Act (S. 1531) Cassidy (R-LA), Bennet (D-CO)	Medical Billing Fairness Act of 2019 (S. 1607) Kennedy (R-LA)
Relationship to bills introduced last Congress	Policy identical to H.R. 817 (115th Congress). Companion legislation in the 115th Congress (S. 284), sponsored by Brown (D-OH), not yet re-introduced.	Nearly identical to S. 3541(115th Congress). Key changes include: (1) making some clarifications regarding allowed charges (highlighted in bold) below and (2) adding a study re: network adequacy,	--	--	--
Key Elements	Prohibits surprise billing in case of emergency; requires notice of potential out-of-pocket costs	Caps the amount hospitals and physicians can charge uninsured patients and out-of-network patients who have individual market coverage.	Prohibits balanced billing in all emergency services and certain non-emergency services. Sets payment rates for non-network emergency services and certain non-emergency services, along with the option for the provider to initiate binding arbitration.	Prohibits balance billing in case of emergency services, OON care at an in-network facility, and certain subsequent care after emergency care. Protects the patient from additional costs. Includes additional transparency and network adequacy provisions.	Provides the option for a person at an in-network hospital to request only in-network providers for non-emergency procedures. If such providers are unavailable, then the hospital must pay additional charges to health plan.
Status	Introduced and referred to House W&M and E&C Committees	Introduced & referred to Senate HELP Committee	Introduced & referred to Senate HELP Committee	Introduced & referred to the Senate HELP Committee	Introduced May 23, 2019. Referred to Senate Finance Committee.
Cosponsors	38 Democrats	2 Democrats	None.	11 bipartisan cosponsors	None.
Applicable market	Amends Medicare requirements for hospitals.	Uninsured, individual health insurance market (not ERISA "group health" plans)	Self-insured group health plans	ACA, ERISA, and private market plans	Amends Medicare requirements for hospitals.
Provider applicability	Hospitals and critical access hospitals (CAH)	Includes hospitals, CAHs, physicians, and others determined by the Secretary	Facility and facility-based provider (definition would likely cover providers with privileges)	Facilities include hospitals, emergency rooms, free-standing emergency departments, HOPDs, and	Applies to hospitals

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				ASCs (including lab and imaging).	
Prohibition on balanced billing	--	--	Yes, for emergency services and for certain non-emergency covered services.	Yes, for emergency services, after emergency care, and OON services provided in in-network facilities.	--
Penalty for balanced billing	--	CMPs	--	CMPs, which do not apply if the balanced bill is "unknowingly" and the patient is reimbursed within 30 days	--
Patient protection - out-of-network services treated as in network	For emergency services only.	No, but capped payment amounts are provided.	Yes, for emergency services only.	Yes, for emergency services, after emergency care, and OON services provided in in-network facilities.	Patient held harmless for OON care at in-network hospital for non-emergency services if the patient requests only in-network providers.
Emergency services	Prohibits hospitals from charging more than the individual would be required to pay for services furnished by an in-network or participating provider.	No separate discussion of emergency/non-emergency services.	Patient only required to pay the cost-sharing amount required by their health plan for in-network services. No balanced billing. No prior authorization. Details payment amount, along with a voluntary binding arbitration process.	Patient only required to pay the cost-sharing amount required by their health plan for in-network services. No balanced billing. Any costs in excess of this amount will be paid by the health plan, either the median in-network amount negotiated by health plans or a rate determined by an IDR.	--
Non-emergency services	With respect to an individual who has health benefits coverage and is seeking services, a hospital must provide	--	No balance billing for facility-based providers for covered non-emergency services if the services are provided at an in-network	Same as emergency.	Provides the option for a person at an in-network hospital to request only in-network providers for non-emergency procedures. If

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	notice as to: (1) whether the hospital, or any of the providers furnishing services to the individual at the hospital, is not within the health care provider network or otherwise a participating provider with respect to the individual's health care coverage; and (2) if so, the estimated out-of-pocket costs of the services to the individual. At least 24 hours prior to providing those services, the hospital must document that the individual: (1) has been provided with the required notice, and (2) consents to be furnished with the services and charged an amount approximate to the estimate provided. Otherwise, the hospital may not charge the individual more than the individual would have been required to pay if the services had been furnished by an in-network or participating provider.		facility and the patient did not have the ability or opportunity to select to receive such services from an in-network provider. Details payment amount, along with a voluntary binding arbitration process.		such providers are unavailable, then the hospital must pay additional charges to health plan.

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Capped payment amount	-- (Only applies to hospitals so it is unclear if it directly addresses provider payments.)	For patients with individual health insurance coverage that does not provide out-of-network benefits for a given service, patient charge capped at no more than rate selected by the applicable State authority, either: (1) 125% (200% for rural areas) of the allowed charges determined under the Medicare FFS program (2) 80% of the usual, customary, and reasonable charge; or (3) 100% of the allowed charges for the service **based upon the actual allowed rate under the coverage for all participating providers for such service in the health insurance issuer's participating provider network**. For patients with individual health insurance coverage that provides out-of-network benefits for a given service, patient charge capped at no more than the rate selected by the applicable State authority, minus (1) the sum of the payment made to the	For out-of-network emergency services and for certain non-emergency services, the payment amount should be based on either (1) the amount of the claim, (2) the UCR, or (3) amount mutually agreed to during the binding arbitration process (limited to 60 days).	Any costs in excess of the patient's required payment will be paid by the health plan, either the median in-network amount negotiated by health plans or a rate determined by an IDR.	--

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		health care provider, and (2) the out-of-network cost-sharing amount required under such coverage. Charges for uninsured individuals capped at no more than the lower of (1) the rate selected by the applicable State authority, either (a) 125% (200% in rural areas) of the allowed charges determined under the Medicare FFS program, or (b) 80% of the usual, customary, and reasonable charge), or (c) the rate otherwise allowed to be charged to such an individual under State law.			
Review process for surprise billing	--	--	Voluntary arbitration to be initiated by the provider. Secretary to have contract with arbitration organizations. Facility claims must be not less than $3k; professional services, $500 (adjusted for inflation). Arbitrator determines final amount after exchange of offers and determines which entity pays review costs. Sets daily penalty for non-payment of agreed amount.	IDR process will involve certified entities, resolution within 30 days and payment due 30 days after resolution. Batching of claims may occur. After 10 days of good faith negotiation, then the IDR entity can make final, binding determination and state who pays for the IDR process. Factors for determining final payment include commercially reasonable rates,	--

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				training/experience, complexity, market share, good faith effort, and past IDR decisions. Final determinations will be made public; IDR entities must comply with privacy laws.	
Assignment of benefits (Y/N)	--	--	Yes, for emergency services.	Yes.	-- (Hospital pays the plan.)
Notification of out-of-network services	Hospital must provide notice as to: (1) whether the hospital, or any of the providers furnishing service s to the individual at the hospital, is not within the health care provider network or otherwise a participating provider with respect to the individual's health care coverage; and (2) if so, the estimated out-of-pocket costs of the services to the individual.	--	--	Health plan can only contract with providers who will provide, within 48 hours, the expected cost-sharing of any in-network item or service. Insurer has similar requirements for any elective service (and must provide electronic access to such information).	--
Requirements of any notification	At least 24 hours prior to providing those services, the hospital must document that the individual: (1) has been provided with the required notice, and (2) consents to be furnished with the services and charged an amount	--	--	--	--

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	approximate to the estimate provided. Otherwise, the hospital may not charge the individual more than the individual would have been required to pay if the services had been furnished by an in-network or participating provider.				
Network adequacy provisions	--	Requires a report every two years (starting in 2022) regarding network adequacy laws and the effective of this bill.	Requires a self-insured group health plan to publish on their website and update monthly a list of network providers. Provide annual notice to patients concerning the potential for balanced billing when using out-of-network providers.	--	--
All Payers Claim Database	--	--	--	See study information below.	--
Study on the effect of the provisions	--	Provides for grants to States for the purpose of studying the potential for imposing limitations on charges for health care services provided to individuals enrolled in group health plans or group health insurance coverage offered by a health insurance issuer that are similar to the limitations of this bill.	--	Calls for a study to examine the financial impact on patient responsibility for health care spending and overall health care spending; the incidence and prevalence of the delivery of OON health care service, network adequacy, connecting reimbursement to claims databases, number of claims through the IDR process, and	--

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				administrative costs of the IDR process (and the effect on premiums and deductibles).	
Other provisions	--	--	--	Requires notification to providers of new products, additional transparency provisions for group health plans (including access to deductible information) and hospitals. Allows insurers to deduct the cost of the IDR process as part of the medical loss ratio calculation.	--
Effect on State laws	--	--	--	States could enact laws to affect certain fully insured plans but could not alter the payment rates under the bill for ERISA plans or FEHBP. Bill would apply to plans normally regulated by States (e.g., fully insured plans and individuals plans) if no State law provides similar protections.	--
Effective date	12 months after date of enactment.	--	--	Cost sharing disclosures related to plans are effective as of January 1, 2020. Cost-sharing disclosures related to hospitals/providers effective as of January 1, 2021.	On the date of the enactment and apply to contracts entered into or renewed on or after the date that is six months after such date of enactment.