American Hospital Association™
Advancing Health in America

Comparison of the Major Surprise Billing Legislation Pending Before Congress

Provision	No Surprises Act of 2019 (Energy & Commerce Committee bill (HR 2328) as passed by committee on July 17, 2019)	Lower Health Care Costs Act of 2019 (Senate HELP Committee bill (S.1895) as passed by committee on June 26, 2019)
Surprise Billing		
Prohibit Balance Billing	Yes – Emergency and out-of-network physicians/ancillary providers at in-network facilities with some exceptions if notice requirements are met.	Yes – Emergency, out-of-network physicians/out-of-network ancillary providers and diagnostic services at in-network facilities, if notice requirements are not met.
Applies to Plans Regulated by the Employee Retirement Income Security Act (ERISA)	Yes	Yes
Associated Penalty	Civil monetary penalties up to $10,000 per violation. HHS may establish a hardship exemption. If a provider unknowingly violated any section of the legislation, they are required to reimburse, with interest, both patients and the plan in cases of erroneous balance billing.	Civil monetary penalties up to $10,000 per violation. HHS may establish a hardship exemption.
Addresses State Laws	Yes – Defers to state law for reimbursement remedy if such a state law exists for state-regulated products.	Yes – Applies to state-regulated products in states that have not taken action, but does not preempt state action for products they regulate.
Limits Cost-Sharing to In-Network Amount	Yes	Yes
Rate Setting	Yes – The benchmark rate is set at the median in-network contracted rate in that geographic region and trended forward by the Consumer Price Index for All Urban Consumers (CPI-U). Directs HHS to establish an audit process to ensure health plans are in compliance with the median in-network contracted rate requirements.	Yes – The benchmark rate is set at the median in-network contracted rate in that geographic region. Directs HHS to evaluate how network rate will impact access to care in rural areas.
Arbitration	Yes – Providers and facilities can use the arbitration process for claims with median in-network contracted reimbursement rates of more than $1,250. The arbitration process is baseball-style and binding. Batching of certain claims would be permitted although each individual claim must be above the $1,250 threshold. Arbiters would be instructed to take into account a limited set of factors. The Secretaries of HHS and Labor would make public general information about the arbitration process and decisions.	No

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Surprise Billing (Continued)		
Notice/Disclosure	Allows some out-of-network providers at in-network facilities to balance bill if they provide both oral and written notice to patients at the time of scheduling and on the date of service that they are out-of-network, as well as the estimated cost of the procedure. HHS would develop a standard form. Hospitals would be required to retain for two years their own signed notices, as well as those of any non-participating providers who are delivering services at their facilities.	Out-of-network providers could only charge if notice of network status and charges were provided to patient along with a list of in-network providers (including hospitals).
Transparency		
Transparency – Providers	Requires that providers and facilities must transmit to the health plan and issuer information on the following: when a plan contract was entered; when a plan contract is terminated; and when there are material changes to the plan contract. Providers and facilities must post on their websites the balance billing protections and requirements, information on any out-of-network pricing amounts and state and federal contacts regarding possible balance billing violations. Requires a study of profit and revenue-sharing relationships between hospitals, physician contract management groups, surgical services, and ancillary service providers. In addition, the report requires a description of current federal oversight. Also see Air Ambulance section below.	Requires providers to respond to patient pricing inquires within two business days or be subject to a CMP up to $10,000 per violation. Requires a study of profit and revenue-sharing relationships between hospitals, physicians and contract management groups, as well as federal oversight.
Transparency – Health Plans	Requires that health plans and issuers establish a provider directory process that would include a verification system, a patient response protocol, a database and printed copies. Plans and issuers are required to update their provider directory database every 90 days and respond to patient inquiries within one business day. Plans and issuers must post on their websites the balance billing protections and requirements, information on any out-of-network pricing amounts and state and federal contacts regarding possible balance billing violations.	Requires plans to provide enrollees with cost estimates within 48 hours of request. As adopted through the amendment process, requires insurance companies to post accurate lists of who is in-network. Requires plans to maintain accurate provider directories and requires patients be refunded if an error in the directory led a patient to inadvertently access out-of-network care (however, the penalty is on the provider for the refund). Requires commercial health insurers to make information – including health insurance claims data, in-network practitioners and expected out-of-pocket costs – available to patients through application programming interfaces. Ensures that patients have full, electronic access to their own health information and information on what they would pay out of pocket for specific care.

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Contract Provisions	No	Prohibits health plans from entering into contracts with providers that include restrictions on the sharing of price and quality data (so-called "gag clauses"), that prevent plans from steering patients and using incentives to encourage enrollees to use certain providers (tiering facilities), or that would require the plan to contract with all facilities in a system. Plans also could not require most favorable pricing. Some exemptions are included for HMOs and providers/plans in value-based network arrangements (as defined by the Secretary).
Other Provisions		
Billing Requirements	Providers and facilities may not seek reimbursement from an individual more than a year after the date of service.	Requires providers to bill patients within 45 days and provide each patient with an itemized bill or be subject to CMPs.
Air Ambulance Bills	The surprise billing protections do not extend to individuals using air ambulance services. Air ambulance providers will be required to report claims information to HHS. Failure to report would result in a CMP penalty of no more than $10,000 per reporting violation.	Yes – Would hold patients harmless from surprise air ambulance bills. Health plans would pay air ambulance providers a benchmark rate tied to the median in-network rate for geographic area. Patient cost sharing would be limited to in-network amount for air ambulance transport.
All-payer Claims Databases	Provides $50 million in grants to states to develop or maintain an all-payer claims database.	Establishes a national all-payer claims database and provides $100 million to states to develop their own.
Provider Consolidation	No	Requires Federal Trade Commission and Department of Justice to study impact of surprise billing solution on integration/consolidation and health care prices.