Detailed Comparison of Surprise Billing Legislation, as Reported by Committees

Topic	Senate HELP Committee (S. 1895)	House Energy and Commerce Committee (H.R. 2328)
Overview		
General approach	• Amends the Public Health Service (PHS) Act, ERISA, the Internal Revenue Code and the law governing the Federal Employees Health Benefits Program (FEHBP). • Prohibits surprise bills, including out-of-network (OON) cost-sharing and balance billing amounts, under certain emergency and nonemergency circumstances of individuals covered by group health plans or health insurance coverage[1] offered by issuers in the group or individual market. • Establishes a federal payment standard to determine payment to affected OON facilities and providers.	• Amends the Public Health Service (PHS) Act. • Prohibits surprise bills, including out-of-network (OON) cost sharing and balance billing amounts, under certain emergency and nonemergency circumstances for individuals covered by "health plans" which are defined to include group health plans or health insurance coverage offered by issuers in the group or individual market. • Establishes a federal payment standard to determine payment to affected OON facilities and providers. • Provides for an Independent Dispute Resolution (IDR) process to resolve payment disputes (over a certain dollar threshold) between the OON facility or provider and the health plan.
Consumer Protections		
Consumer "hold harmless" protections against plan out-of-network cost-sharing and provider balance billing	Protects enrollees in group health plans and health insurance coverage offered by issuers of individual and group coverage from both OON cost-sharing amounts imposed by their health plans and balance billing charges of certain OON facilities and providers that would be charged to the enrollee for emergency and certain nonemergency services. Applies these consumer safeguards through amendments to the PHS Act, ERISA, and IRC in the following situations: • Emergency services provided at an OON hospital (including freestanding ERs[2]) furnished by OON providers. • Poststabilization emergency care at an OON facility (and services provided by its providers). • OON ancillary services[3] at in-network facility (including referrals for diagnostic services). • Nonemergency, nonancillary services provided at an in-network facility.	Protects enrollees in health plans from both OON cost-sharing amounts imposed by their health plans and balance billing charges of certain OON facilities and providers that would be charged to the enrollee for emergency and certain nonemergency services. Applies these consumer safeguards through amendments the PHS Act in such a way as to also apply to group health plans under ERISA and the Internal Revenue Code: • Emergency services provided at an OON hospital (or independent freestanding EDs[4]) furnished by OON providers. • Poststabilization emergency care at an OON facility (and services provided by its providers). • Nonemergency services performed by nonparticipating "specified providers"[5] at a participating facility.[6]
Protection: in-network cost sharing for OON services	Yes. Applies the in-network deductible, copayments, and coinsurance. Also applies these amounts to the annual out-of-pocket (OOP) maximum.	Yes. Applies in-network copayments and coinsurance.[7] Also applies the deductible, copayment, and coinsurance amounts to the annual out-of-pocket (OOP) maximum.
Protection: in-network rates as basis for deductible, coinsurance, and OOP maximums	Any plan coinsurance or deductible would have to be based on in-network rates established by this bill. The state payment standard, if one exists, would determine the amount of coinsurance.	Any cost-sharing for such in-network amounts would have to be based on the in-network payment rate established by this bill or, if in a state with a payment standard in effect, the lesser of the amount determined based on the state's method or the in-network rate established by this bill.
Protection: any exceptions for notice and consent	Provides for an exception to the consumer hold harmless protections when receiving OON services for the following situations if the enrollee receives a notice that meets specific requirements and consents to paying the OON cost-sharing, including any balance bills: • OON services furnished by an OON facility after emergency services if the individual is not stabilized, but in a condition to receive the notice information, and then is admitted to an OON facility for care.	Provides for an exception to the consumer hold harmless protections when receiving OON services for the following situations if the enrollee receives a notice that meets specific requirements and consents to paying the OON cost-sharing, including any balance bills: • OON poststabilization services, if the individual is stable and able to travel using nonmedical or nonemergency medical transportation. • OON nonemergency services furnished by nonparticipating providers who are not "specified providers" at in-network facilities. The notice and consent requirement would not

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	• OON poststabilization services, if the enrollee is in condition to receive the notice, including having sufficient mental capacity. • Nonemergency, nonancillary services provided by an OON provider at an in-network facility.	apply if the furnished service resulted from unforeseen medical needs at the time of the service.
Markets and Plans		
Markets	• Individual and group health insurance coverage: Yes • Self-insured group health plans: Yes • Grandfathered plans: Yes • Nonfederal governmental health plans: Can elect to opt into the bill's federal payment standard • FEHBP plans: Yes	• Individual and group health insurance coverage: Yes • Self-insured group health plans: Yes • Grandfathered plans: Yes The above are all considered "health plans" • Nonfederal governmental health plans: No provision • FEHBP plans: No provision
Types of plans	Applies to all types of group health plans and health insurance coverage offered by issuers of individual and group coverage so long as they meet the applicable underlying statutory definitions of group health plans and health insurance coverage.	Applies to all types of group health plans and health insurance coverage offered by issuers of individual and group coverage so long as they meet the applicable underlying statutory definitions of group health plans and health insurance coverage.
Emergency Services Setting		
Emergency setting: facilities	Yes. Hospitals, critical access hospitals, ambulatory surgery centers, laboratories, radiology clinics, freestanding emergency rooms.	Yes. Hospitals, critical access hospitals, ambulatory surgery centers, laboratories, radiology facilities, imaging centers, and independent freestanding emergency departments. Also includes ancillary services routinely available to the emergency department to evaluate an emergency medical condition.
Emergency setting: health care professionals	Yes. OON providers who furnish emergency and poststabilization services in emergency care facilities.	Yes. OON providers who furnish emergency and poststabilization services in emergency care facilities.
Emergency setting: ground ambulance	No.	No.
Emergency setting: air ambulance	Yes. Prohibits an air ambulance provider from billing an enrollee for amounts beyond the cost-sharing amounts that apply for in-network air ambulance services.	No. But requires air ambulance bills to include separate charges for cost of air travel and cost of emergency medical supplies.
Nonemergency Services Setting in In-Network Facilities		
Nonemergency setting: health care professionals	Yes. Anesthesiologists, pathologists, emergency medicine providers, intensivists, radiologists, neonatologists, hospitalists, and assistant surgeons, whether a physician or nonphysician practitioner; or specialty providers not typically selected by the patients receiving the care, which the Secretary may add through rulemaking.	Yes. Anesthesiologists, pathologists, emergency medicine providers, intensivists, radiologists, neonatologists, hospitalists, assistant surgeons, or other providers determined by the Secretary; and includes a nonparticipating provider if there is no participating provider at the facility who can furnish the needed service.
Nonemergency setting: labs, imaging, etc.	Yes. Diagnostic services, including radiology and lab services.	Yes. Laboratories and radiology facilities or imaging centers when "during a visit to facility."[8]
Payment Standard		
Payment standard: main approach	Payment is based on the median in-network amount determined by the rates for the same or similar services offered by the plan or issuer in the same geographic area. Requires the Secretary to define geographic areas considering adequate access to services in rural and health professional shortage areas.	Payment is based on the median contracted (in-network) amount determined by the rates for the same or similar services in 2019 offered by the health plan in the same geographic area. Increases the median contracted amount by the percentage increase in the CPI-U over the previous year. Requires the Secretary to define geographic areas considering adequate access to services in rural and health professional shortage areas.
Payment standard: data sources	Group health plans and issuers without sufficient data are to use a database (such as a state all-payer claims database or a national database) that is free of conflicts to determine median contracted rates. (See also "Transparency" below.) Authorizes and appropriates federal funding for the creation of state all-payer claims databases.	Health plans without sufficient data are to use a database (such as a state all-payer claims database) that is free of conflicts to determine median contracted rates. Authorizes federal funding for grants to the states for state all-payer claims databases.

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Dispute Resolution		
Dispute resolution: main approach	No provision	Baseball style of arbitration whereby each party submits a final payment offer to an Independent Dispute Resolution (IDR) entity, and the entity determines which offer is most reasonable. IDR can be initiated by the nonparticipating provider, nonparticipating emergency facility, or health plan. The IDR entity's determination is final and not subject to judicial review (with exceptions for fraud). The losing party pays fees for the cost of the arbitration.
Dispute resolution: factors to be considered	No provision.	Median contracted rates for comparable items and services in same geographic area as the disputed claim; level of training, education, experience and quality and outcomes measurements of provider or facility; any other extenuating circumstances relating to acuity of patient or complexity of furnishing the patient's services. The IDR entity may not consider billed charges.
Dispute resolution: types of restrictions	No provision.	Limited to disputed claims for which the median contracted rate is at least $1,250 (in 2021), indexed for inflation (CPI-U)
Transparency		
Transparency: provider directories	Requirements on health plans and providers to ensure accessible updated and accurate provider directories. Limits cost sharing to the in-network amount if the enrollee demonstrates reliance on the provider directory and that information turned out to be wrong.	Requirements on health plans and providers to ensure accessible updated and accurate provider directories.
Transparency: time limit on billing	Requires facilities and providers to furnish all adjudicated bills to the patient as soon as practicable but no later than 45 calendar days after discharge or visit. Prohibits requiring a patient to pay a bill for services any earlier than 35 days after the postmark of a bill for a service. If the facility or practitioner bills the patient after the 45-day period, it must report to the Secretary and refund the patient for the full amount paid with interest.	Prohibits a provider, facility or health plan from initiating a process to seek reimbursement more than 1 year after the date of service.
Transparency: federal database	Authorizes and funds the creation by a nonprofit entity of a database that receives and uses health care claims and related information and issues reports about costs and quality that are submitted to HHS and are available to the public (more detailed data to authorized users). The database would also share data with any state all-payer claims databases or regional databases, at cost, using a standardized format, if the state or regional database submits claims data to the national database. A state could require payers to submit claims data to the national database. Authorizes and appropriates funds for this purpose.	No provision.
Interaction with State Laws		
Interaction with state laws: hold harmless protections	No provision.[9]	Permits a state to continue in effect or establish its own laws providing for more protective balance billing and OON cost-sharing protections for those enrolled in state-regulated health insurance coverage to the extent that such laws do not interfere with the application of federal law. Where a state provider payment standard is in effect, cost sharing is based on the lesser of the amount determined by the state payment standard or the amount determined by the federal payment standard.

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Interaction with state laws: payment standards and dispute resolution	Preserves a state's ability to determine its own payment standard for state-regulated issuers of group and individual insurance. Provides that the federal standard applies to group health plans that are not state-regulated and to all issuers in states that have not established their own payment standards.	Preserves a state's ability to determine its own payment standard for state-regulated issuers of group and individual insurance.
Enforcement		
Enforcement on facilities or providers of consumer hold harmless and provider payment standards	Provides that a facility or provider that violates a requirement under the balance billing prohibitions or fails to provide the bill's required enrollee notice or consent be subject to a civil money penalty (CMP) of not more than $10,000 for each violation. The Secretary shall waive such penalties if enforcement has already occurred under state law.	Federal enforcement if the Secretary determines that a state has failed to substantially enforce them. Authorizes the Secretary to impose a CMP of not more than $10,000 per violation.
Enforcement on plans or issuers of consumer hold harmless and provider payment standards	No specific provision. The underlying PHS Act provides for enforcement by the states (for state-regulated insurance). Federal government enforcement applies where a state has failed to enforce or for group health plans not regulated by the states.	No specific provision. The underlying PHS Act provides for enforcement by the states (for state-regulated insurance). Federal government enforcement applies where a state has failed to enforce or for group health plans not regulated by the states.
Effective Dates		
Effective dates	For most provisions: the second plan year that begins after the date of enactment.	For most provisions: on or after January 1, 2021.
Other		
Other	Requires by two years after enactment that the Secretary, in consultation with the Federal Trade Commission and the Attorney General, conduct a study on the effects of the bill on vertical or horizontal integration of health care facilities, providers, group health plans, or health insurance issuers; overall health care costs; access to services, including specialty services, in rural areas and health professional shortage areas; and recommendations for effective enforcement. The report is to be submitted to relevant committees of Congress.	Requires HHS and Department of Labor to report annually on the effects of the surprise billing hold harmless protections in the group, individual and small group markets on premiums and OOP costs, adequacy of provider networks, and on other relevant implications.

Notes

[1] "Health insurance coverage" is defined under section 2791(b) of the PHS Act to mean "benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer." This definition applies both to S. 1895 and H.R. 2328.

[2] Protection against OON cost sharing for emergency services was added to the PHS Act by the Affordable Care Act but S. 1895 amends sec. 2719(b) of the PHS Act to add freestanding ERs to hospitals and hospital emergency departments.

[3] "Ancillary services" mean nonemergency care services provided by types of providers (listed in the bill) and diagnostic services.

[4] Protection against OON cost sharing for emergency services was added to the PHS Act by the Affordable Care Act but H.R. 2328 amends sec. 2719(b) of the PHS Act to add independent freestanding emergency departments to hospitals and hospital emergency departments.

[5] "Specified providers" are defined as facility-based providers, as listed in the bill.

[6] H.R. 2328 generally refers to "participating" and "nonparticipating" facilities and health care providers instead of "in-network" and "out-of-network" facilities and providers. In both cases, the terms employed by H.R. 2328 convey the presence or absence of a contractual relationship with the health plan to provide the health plan's covered services in return for an agreed upon payment (or methodology for determining that payment).

[7] Unlike S. 1895, H.R. 2328 does not amend section 2791A(b) of the PHS Act to add "deductible" in the underlying provision that requires the plan's cost-sharing requirements for qualified emergency services to be no greater than they would be if the services were provided in-network. However, this may be a drafting omission since the bill does require the plan to count the qualified services toward the OOP maximum.

[8] "During a visit" in H.R. 2328 means, with respect to items and services furnished by a nonparticipating provider to an individual for nonemergency care at a participating health care facility, "equipment and devices, telemedicine services, imaging services, laboratory services, and such other items and services as the Secretary may specify, regardless of whether or not the provider furnishing such items or services is at the facility."

[9] Underlying section 2724(a) of the PHS Act (42 USC 300 gg-23) preserves state flexibility in this regard "except to the extent that such standard or requirement prevents the application of a requirement of this part."