Surprise Billing Comparison Table

Note: A Glossary of Key Terms and Acronyms is included at the end of this document. An asterisk (*) is used to denote a term that is in the glossary.

Topic	Senate HELP (S. 1895 as reported)	House Energy and Commerce (H.R. 2328 as reported)	House Education and Labor (H.R. 5800 as reported)	House Ways and Means (H.R. 5826 as reported)
Overview				
General approach	Amends the Public Health Service (PHS) Act, ERISA, the Internal Revenue Code (IRC) 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 for individuals covered by health plans. 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. 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 (for amounts over $1250, indexed for inflation) between the OON facility or provider and the health plan.	Amends the Public Health Service (PHS) Act, ERISA, the Internal Revenue Code (IRC) 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 for individuals covered by health plans. 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 (for amounts over $750 ($25,000 in the case of ambulance services)), indexed for inflation, between the OON facility or provider and the health plan.	Amends the Public Health Service (PHS) Act, ERISA, the Internal Revenue Code, the Social Security Act (SSA), and, with respect to establishing a patient-provider dispute resolution process, 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 for individuals covered by health plans. Does not set a federal payment standard. Relies, instead, on an "open negotiation" between affected parties (providers, facilities, health plans) to arrive at a payment amount for OON facilities/providers. Provides for a mediated dispute (i.e., IDR) process to resolve payment disputes between affected parties. Does not establish a threshold amount to qualify for IDR.

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Consumer Protections				
Consumer "hold harmless" protections against plan out-of-network cost sharing and provider balance billing; protections are subject to exceptions, shown below NOTE: Protection against OON cost sharing for emergency services in emergency departments of hospitals was added to the PHS Act by the Affordable Care Act but all four bills amend sec. 2719(b) of the PHS Act to include independent freestanding emergency departments (EDs).	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 to the PHS Act, ERISA, and IRC in the following situations. • Emergency services provided at an OON hospital (including independent freestanding emergency departments (EDs) furnished by OON providers. • Post-stabilization care at an OON facility (and services provided by its providers). • OON ancillary services* 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 to the PHS Act in such a way as to also apply to group health plans under ERISA and the IRC in the following situations. • Emergency services provided at an OON hospital (including independent freestanding EDs) furnished by OON providers. • Post-stabilization care at an OON facility (and services provided by its providers). • Nonemergency services performed by OON specified providers* 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 to the PHS Act, ERISA, and IRC in the following situations. • Emergency services provided at an OON hospital (including freestanding EDs) furnished by OON providers. • Post-stabilization care at an OON facility (and services provided by its providers). • OON ancillary services * at an 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 imposed by 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, IRC and title XI of the SSA in the following situations. • Emergency services provided at an OON hospital (including independent freestanding EDs) furnished by OON providers. • Post-stabilization care at an OON facility (and services provided by its providers) unless certain conditions are met, such as when the patient comes under the care of an in-network provider. • OON ancillary services* at in-network facility (including referrals for diagnostic services). • Nonemergency, nonancillary services performed by OON specified providers* at an in-network facility.

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Protection: in-network cost sharing for OON services	Yes. Applies the in-network deductible, copayments, and coinsurance. Also applies these amounts to the annual OOP maximum.	Yes. Applies in-network copayments and coinsurance.[1] Also applies these amounts to the annual OOP maximum.	Yes. Applies the in-network deductible, copayments, and coinsurance. Also applies these amounts to the annual OOP maximum.	Yes. Applies the in-network deductible, copayments, and coinsurance. Also applies these amounts to the annual 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 in the case of State-regulated insurance.	Any cost-sharing 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 (limited to plans regulated by the States).	Any cost-sharing 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 in the case of State-regulated insurance.	Any coinsurance would be based on either the reimbursement rate established under state law for state-regulated insurance or the health plan's median in-network rate based on a methodology to be established by the Secretaries of HHS, Treasury, and Labor. Any copayment, deductible or OOP maximum would apply as if the services were provided in-network.
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. • OON post-stabilization	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 post-stabilization services, if the individual is stable and able to travel using nonmedical or nonemergency medical transportation. • OON nonemergency services furnished by OON providers who are not "specified providers" at in-network	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 nonemergency services provided in an in-network facility that are not ancillary services provided by the in-network facility. The notice and consent would not apply if the furnished service resulted	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 emergency and post-stabilization services, furnished on an inpatient observation or inpatient or outpatient stay (for reasons other than stabilization) and the individual is in a condition to receive, confirm notice of receipt, provide

[1] 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.

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	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.	facilities. The notice and consent requirement would not apply if the furnished service resulted from unforeseen medical needs at the time of the service.	from unforeseen, urgent medical needs arising at the time of the service. • OON post-stabilization services, if the individual is stable and able to travel using nonmedical or nonemergency medical transportation and is in a condition to receive, provide informed consent. • OON nonemergency, nonancillary services provided in an in-network facility.	signed consent. • OON nonemergency services furnished by OON providers who are not "specified providers" at in-network facilities.
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	• Individual and group health insurance coverage – Yes • Self-insured group health plans – Yes • Grandfathered plans – Yes • Nonfederal governmental health plans – No provision • FEHBP plans – Yes	• Individual and group health insurance coverage – Yes • Self-insured group health plans – Yes • Grandfathered plans – Yes • Nonfederal governmental health plans – No provision • FEHBP plans – Not for surprise billing prohibitions but requires creation of a patient-provider dispute resolution process.
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.	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.

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Emergency Services Settings				
Emergency setting: facilities	Yes. Hospitals and independent freestanding emergency departments. Consumer hold harmless and cost-sharing protections continue until notice/consent exceptions apply. (*See "Protection: any exceptions for notice and consent" above*)	Yes. Hospitals, hospital outpatient departments that provide emergency services, and independent freestanding emergency rooms. Consumer hold harmless and cost-sharing protections continue until notice/consent exceptions apply. (*See "Protection: any exceptions for notice and consent" above*)	Yes. Hospital emergency departments, hospital outpatient departments that provide emergency services, and independent freestanding emergency departments. Consumer hold harmless and cost-sharing protections continue until notice/consent exceptions apply. (*See "Protection: any exceptions for notice and consent" above)*	Yes. Hospital emergency departments, hospital outpatient departments that provide emergency services, and independent freestanding emergency departments. Consumer hold harmless and cost-sharing protections continue until notice/consent exceptions apply. (*See "Protection: any exceptions for notice and consent" above)*
Emergency setting: health care professionals	Yes. OON providers who furnish emergency and post-stabilization services in emergency care facilities.	Yes. OON providers who furnish emergency and post-stabilization services in emergency care facilities.	Yes. OON providers who furnish emergency and post-stabilization services in emergency care facilities.	Yes. OON providers who furnish emergency and post-stabilization services in emergency care facilities.
Emergency setting: ground ambulance	No.	No.	No but requires the establishment by the Secretaries of HHS, Labor and Treasury to establish a new federal advisory committee to study options for addressing surprise billing and submit a report to Congress and the 3 departments with recommendations.	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. Requires air ambulance bills to include separate charges for cost of air travel and cost of emergency medical supplies.	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. Requires cost reporting by air ambulance services and health plans. Requires a comprehensive federal report summarizing the cost information.
Nonemergency Services Settings in In-Network Facilities				
Nonemergency setting: health care professionals	Yes. Anesthesiologists, pathologists, emergency medicine providers, intensivists,	Yes. Anesthesiologists, pathologists, emergency medicine providers, intensivists,	Yes. Anesthesiology, pathology, emergency medicine, radiology, and neonatology, whether a	Yes. Anesthesiologists, pathologists, emergency medicine providers, intensivists,

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	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.	radiologists, neonatologists, hospitalists, assistant surgeons, or other providers determined by the Secretary; and includes an OON provider if there is no in-network provider at the facility who can furnish the needed service.	physician or nonphysician practitioner, and items and services provided by assistant surgeons, hospitalists, and intensivists. Includes an OON provider if there is no in-network provider at the facility who can furnish the needed service.	radiologists, neonatologists, hospitalists, assistant surgeons, or other providers determined by the Secretary and includes, an OON provider if there is no in-network provider at the facility who can furnish the needed service.
Nonemergency setting: labs, imaging, etc.	Yes. Diagnostic services, including radiology and lab services and those provided by other specialty practitioners not typically selected by the patients receiving the care, which the Secretary may add periodically through rulemaking.	Yes. Equipment and devices, telemedicine services, imaging services, laboratory services, and such other items and services as the Secretary may specify, regardless of whether the provider is at the facility.	Yes. Equipment and devices, telemedicine services, imaging services, laboratory services, and such other items and services the Secretary may specify, regardless of whether the provider is at the facility.	Yes. Equipment and devices, telemedicine services, imaging services, laboratory services, preoperative and postoperative services, and such other items and services as the Secretary may specify, regardless of whether the provider is at the facility.
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 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 is based on the median in-network amount determined by the rates for the same or similar services in 2019 offered by the health plan in the same line of business and geographic area. Increases the median contracted amount by the percentage increase in the CPI-U over the previous year.	There is no provision for a federal payment standard to be established (i.e., no benchmark) to determine the payment amount to a nonparticipating provider or nonparticipating facility covered by the surprise billing prohibitions. Requires instead an "open negotiation" process between the nonparticipating provider or facility and the relevant health plan to establish a payment (or reimbursement) amount. If the parties are unable to resolve their payment dispute, they can appeal to an independent dispute resolution entity, called in this bill a Mediated Dispute Process entity.

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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.	Health plans 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. Criteria for an acceptable database would be established through regulations.	Although no payment standard is used to determine payment to the provider, a standard is used for purposes of cost sharing. Health plans without sufficient data are to use a database or other source of information, as determined by the Secretary, to determine median contracted rates. If a substitute rate cannot be calculated because of the lack of appropriate data, the Secretary is required to develop a methodology for determining a substitute rate based on a similarly situated health plan that is not a federal health care program.
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 OON provider, OON 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.	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 OON provider, OON emergency facility, or health plan. The IDR entity's determination is final. The losing party pays fees for the cost of the arbitration.	Baseball style of arbitration whereby each party submits a final payment offer to an independent Dispute Mediation process entity, and the entity determines which offer is most reasonable. IDR can be initiated by the OON provider, OON emergency facility, or health plan. 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 the same geographic area as the disputed claim; level of training,	Median contracted rates that are comparable to those in the request and that are furnished in the same geographic area	Median contracted rate for the item or service; the information submitted by the parties; and may not take into account usual

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		education, experience, and quality and outcomes measurements of provider or facility; any other extenuating circumstances relating to acuity of the patient or complexity of furnishing the patient's services. The IDR entity may not consider billed charges.	(not including any facility rates). Also requires consideration of the level of training, education, experience, and quality and outcomes measurements of the provider or facility; its market share or that of the plan or issuer, in the relevant geographic area; any other extenuating circumstances relating to the acuity of the individual or the complexity of furnishing the patient's services; and a demonstration of good faith efforts (or lack of good faith efforts) made by the provider or facility or plan or issuer. The IDR entity may not take into account usual and customary charges or charges billed by the provider or facility for the item or service.	and customary nor charges billed by the provider or facility for the item or service.
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).	Limited to disputed claims for which the median contracted rate is at least $750 (in 2022), indexed for inflation (CPI-U).	There is no threshold for dispute mediation.
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. 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. 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. Limits cost sharing to the in-network amount if the enrollee received incorrect provider information from the health plan as to the provider's participation status.

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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.	No provision.	Prohibits a provider or facility 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.	No provision.	No provision.

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Interaction with State Laws				
Interaction with state laws: hold harmless protections	No provision. The 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."	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.	No provision. The 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."	No provision. The 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."
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.	Preserves a state's ability to determine its own payment standard for state-regulated issuers of group and individual insurance.	Preserves a state's ability to determine its own payment standards for state-regulated issuers of group and individual coverage. In states with certain All Payer Model Agreements, the state payment standard applies to health plans more generally in lieu of the federal payment standard.	Preserves a state's ability to determine its own payment standards for health plans regulated by the state. In states with certain All Payer Model Agreements, and in states with voluntary agreements in place (as of enactment) with self-insured group health plans, the state payment standards applies in lieu of the federal payment standard.
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	Federal enforcement if the Secretary determines that a State has failed to substantially enforce these provisions. Authorizes the Secretary to impose a CMP of not	Federal enforcement if the Secretary determines that a State has failed to substantially enforce these provisions. Authorizes the Secretary to	Authorizes a federal civil money penalty (CMP) of not more than $10,000 for each violation of the consumer hold harmless provisions.

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	enrollee notice or consent be subject to a federal civil money penalty (CMP) of not more than $10,000 for each violation. Requires the Secretary to waive such penalties if enforcement has already occurred under state law.	more than $10,000 per violation.	impose a CMP of not more than $10,000 per violation. Requires the Secretary of HHS, in consultation with the Secretary of Labor, to establish a process to receive consumer complaints of violations and resolve those complaints within 60 days of their receipt. Permits the Secretary of Labor to assist States, the Secretary of HHS, plans or issuers to ensure that appropriate measures have been taken to correct the violations. Authorizes a federal CMP of not more than $10,000 for each violation by a provider or facility of the IDR process for determining OON rates to be paid by health plans for covered surprise billing situations.	Authorizes a federal CMP of not more than $10,000 for each violation by a provider or facility of the “Open Negotiation” or IDR (Mediated Dispute) process for determining OON rates to be paid by health plans for covered surprise billing situations.
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.	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. Authorizes a CMP of up to $10,000 per violation on any group health plan or issuer	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.

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			offering group or individual coverage that violates a provision of the IDR process for determining OON rates to be paid by health plans for covered surprise billing situations.	
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.	For most provisions: on or after January 1, 2022.	For most provisions: on or after January 1, 2022.
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.	Requires health plans to include deductible and OOP limits on the plan or insurance identification card and to furnish expected cost-sharing information for specific health care services. Includes transparency requirements for brokers and consultants to employer-sponsored health plans and enrollees in the individual market. Requires GAO, to conduct a study and submit to Congress a report on the IDR process.	Requires health plans to include deductible and OOP limits on the plan or insurance identification card and to furnish expected cost-sharing information for specific health care services. Requires heath plans to maintain a price comparison tool of certain covered services. Establishes a new transitional tax deduction for taxpayers for their surprise billing expenses. Requires by July 1, 2021 that the Secretary establish a mediation process to determine an uninsured person's final payment to a provider if that provider charged significantly more than the provider's good faith estimate given to the individual before furnishing the service. Requires a Secretarial report on dispute mediation.

GLOSSARY OF KEY TERMS AND ACRONYMS

Ancillary services — The meaning of this term varies by bill and may also vary when used in the context of emergency services versus nonemergency services.

In **S. 1895,** the term includes nonemergency care that is provided by anesthesiologists, pathologists, emergency medicine providers, intensivists, radiologists, neonatologists, hospitalists, and assistant surgeons, whether the care is provided by a physician or nonphysician practitioner; a diagnostic service (including radiology and lab services); or provided by such other specialty practitioner not typically selected by the patients receiving the care, which the Secretary may add periodically to such definition through rulemaking.

In **H.R. 5800,** the term is used in the context of nonemergency care in an in-network facility, those services related to emergency medicine, anesthesiology, pathology, radiology and neonatology, whether or not provided by a physician or nonphysician practitioner, and those provided by assistant surgeons, hospitalists and intensivists. Includes radiology and laboratory services under diagnostic services unless the Health and Human Services Secretary, through rulemaking, establishes a list (and updates it) of advanced diagnostic laboratory tests not to be included as an ancillary service; items and services provided by such other specialty practitioners as the Secretary specifies through rulemaking; and items and services provided by a nonparticipating provider if there is no participating provider who can furnish the item or service at the facility.

In **H.R. 5826,** the term is used in the context of nonemergency care to include services provided by emergency medicine providers or suppliers, anesthesiologists, pathologists, radiologists, neonatologists, assistant surgeons, hospitalists, intensivists, or other providers determined by the Secretary.

ERISA — Employee Retirement Income Security Act of 1974.

FEHBP — Federal Employees Health Benefits Program. Authorized under Sec. 8902 of Title 5 of the United States Code.

Health plan — For purposes of this document as it relates to all four proposals, health plan includes a group health plan and health insurance coverage offered by issuers in the group or individual market and includes grandfathered health plans. Health insurance coverage "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 to all four proposals.

Independent freestanding emergency departments (EDs) — Defined in all four bills as a health care facility that is geographically separate and distinct and licensed separately from a hospital under State law and provides emergency services.

In-network — Used throughout this document to mean participating facilities, participating providers, contracting providers and contracting facilities.

IRC — Internal Revenue Code.

Out-of-network (OON) — Used throughout this document to mean nonparticipating facilities, nonparticipating providers, noncontracting providers, and noncontracting facilities.

Participating/nonparticipating facility and Participating/nonparticipating provider — H.R. 2328, H.R. 5800, and H.R. 5826 generally refer to "participating" and "nonparticipating" facilities and health care providers instead of "in-network" and "out-of-network" facilities and providers. In all three cases, the terms employed 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).

"Specified providers" — In **H.R. 2328** and **H.R. 5826**, means a facility-based provider, including emergency medicine providers, anesthesiologists, pathologists, radiologists, neonatologists, assistant surgeons, hospitalists, intensivists, or other providers as determined by the Secretary; and includes, with respect to an item or service, a nonparticipating provider if there is no participating provider at such facility who can furnish such item or service.