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Recent State and Federal Legislation Regarding "Surprise Billing"

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One of the most-covered news items in the health care industry over the past several years has been balance billing or "surprise billing" as it is often referred to. This news coverage has received lawmakers' bipartisan attention. It is one of the few issues in health care on which Democrats and Republicans agree: patients need a remedy to protect them from receiving surprise medical bills that can lead to financial ruin. This past year has seen dozens of proposals to limit surprise billing in some form in several states, as well as a renewed push at the federal level to enact federal surprise billing legislation.

This briefing summarizes the current status of proposed federal legislation and the more noteworthy state statutes that address surprise billing.[4]

What Is "Surprise Billing?"

At the outset, it is important to address what exactly constitutes "surprise billing." To understand "surprise billing," one must understand both balance billing and patient cost-sharing responsibility. Patient cost-sharing responsibility includes a patient's copayment, coinsurance, and deductible, and often applies whether the patient sees a participating (also referred to as in-network) or non-participating (also referred to as out-of-network) provider. A patient's copayment, coinsurance, and deductible are set by the patient's health insurance policy and are generally the portion of a provider's bill that a patient must pay (until the patient reaches the health plan's out-of-pocket maximum, after which the patient will no longer owe a copayment, coinsurance, or deductible). Health plans generally set patient cost-sharing at a level that they view as sufficient to incentivize the patient to both seek economical care and to receive treatment from a participating provider when available and feasible.[5]

Balance billing is patient cost-sharing responsibility in addition to the copayment, coinsurance, and deductible, and applies *only* when a patient receives treatment from a non-participating provider. (Provider agreements and state laws generally prohibit a participating provider from balance billing.[6]) "Surprise billing" is balance billing that occurs when the patient either does not expect it or is unable to control it. For example,

if a patient is suffering from an emergency medical condition and presents to the nearest emergency department, a balance bill from that emergency department would be a "surprise bill."[7] Another example of surprise billing is when a patient receives services (emergent or elective) at a participating hospital, but then receives a (surprise) balance bill from a non-participating physician or ancillary provider at that hospital (such as an emergency department physician, anesthesiologist, radiologist, pathologist, or lab).[8]

It is important to note that not all balance billing constitutes surprise billing. For example, when a patient opts to receive an elective surgery at a non-participating hospital, a balance bill from that hospital would not qualify as a surprise bill. Indeed, health insurers have argued that in that instance, the patient's health plan *requires* that he or she be balance billed.[9]

Federal Attempts to Limit Surprise Billing

Several recent legislative proposals have been making their way through Congress this year. If and when Congress is able to pass federal legislation addressing balance billing, it will be an important milestone given that, as it stands, most state balance billing legislation is unlikely to apply to employer based self-funded health plans, because these are governed by the Employee Retirement Income Security Act (ERISA), which generally preempts state law.[10]

At the time of this publication, there are many bills proposed in the House of Representatives that address surprise billing, and while it appears that lawmakers from both political parties are committed to passing legislation to limit or eliminate surprise billing, disagreements remain on the best means to do so.

The current leading proposal, the *No Surprises Act*,[11] is a bipartisan bill supported by the House Energy and Commerce Committee leadership, Frank Pallone (D-NJ) and Greg Walden (R-OR). The Senate Committee on Health, Education, Labor and Pensions, which passed a similar bill earlier this year, supports this bill,[12] as does the White House.[13] The bill provides that, for emergency services, insurers must reimburse a non-participating provider the median in-network rate for a particular emergency service, and the provider may not balance bill the patient.[14] The bill also institutes a baseball-style arbitration process in which a health insurer and non-participating provider may resolve disputes regarding the sufficiency of the insurer's reimbursement in certain circumstances.[15]

"Baseball-style arbitration" is a process that is present in a number of state and federal bills regarding surprise billing, based on New York's institution of such a process in 2015. It refers to a process where a non-participating provider and health insurer each submits their proposed reimbursement rate for the service at issue to an arbitrator, and the arbitrator, based on the evidence submitted, picks one of the two rates, rather than entering judgment on a third rate that neither party proposed.[16] The Act also would

impose certain surprise billing limitations on air ambulance providers.[17]

Shortly after the House Energy and Commerce Committee leadership announced a compromise to support the No Surprises Act, the House Ways and Means Committee leadership entered the fray and announced its own plan to tackle surprise billing.[18] The Committee's proposal does not include specific legislative language, but it appears to differ from the *No Surprises Act*. The proposal only addresses surprise billing by non-participating physicians at participating facilities, and while it would include a third-party dispute resolution process, that process would be materially different from the *No Surprises Act*'s proposed baseball-style arbitration process.[19] The proposal is silent regarding air ambulance bills.[20] This competing proposal delayed enactment of legislation regarding surprise billing until 2020.[21]

In addition to these committee-supported proposals, three other bills pending in Congress would also address surprise billing and institute a process for providers and health insurers to resolve disputes over balance bills:

- *Stopping the Outrageous Practice of Surprise Medical Bills Act of 2019*, sponsored by Senator Bill Cassidy (R-LA)[22]:

This bill would require insurers to cover median in-network charges for services not covered by the patient's insurance policy.[23] The Act defines "surprise medical bill" as a balance bill for emergency services provided by a non-participating professional or at a non-participating facility, as well as a balance bill for services provided at a participating facility and by a non-participating professional.[24] Nonparticipating providers would be paid the difference between the patient's in-network cost-sharing amount and the median in-network rate for the services in their geographic area.[25]

The bill also provides for a baseball-style arbitration process, by which the plan or insurer and provider would submit their final offers for reimbursement, and the arbitrator would determine which of the two offers is more reasonable.[26] In making this determination, the arbitrator must consider the following factors: commercially reasonable rates for comparable services in the same geographic area; the level of training, education, experience, and quality of the provider; the circumstances and complexity of the case; the market-share held by the non-participating provider; demonstration of good faith efforts made by the parties; and other relevant economic aspects of provider reimbursement.[27]

- The *Lower Health Care Costs Act*, sponsored by Senator Lamar Alexander (R-TN)[28]:

Another proposal working its way through the Senate is the Lower Health Care Costs Act, which has already been approved by the Senate Health, Education, Labor and Pensions Committee.[29] Under this bill, the suggested reimbursement standard would require health plans to pay out-of-network emergency and facility-based providers their plan-specific median contracted rate for the relevant service in that geographic area.[30]

This proposed Act does not provide for dispute resolution, instead opting to statutorily set the reimbursement rate for out-of-network providers at the median in-network rate.[31] Like the *No Surprises Act* in the House, this bill would also apply a balance billing prohibition to air ambulance bills.[32]

- The *Protecting People From Surprise Medical Bills Act*., sponsored by Representative Raul Ruiz (D-CA)[33]:

The *Protecting People From Surprise Medical Bills Act* would apply in-network cost-sharing requirements to applicable emergency and related nonemergency services that are provided out-of-network.[34] This bill also includes a modified baseball-style arbitration process, where disputes are first required to be negotiated for 30 days, and then proceed to independent dispute resolution if negotiations are unsuccessful.[35] In determining the reasonable reimbursement rate, the arbitrator will choose between the provider's charge for the service, or the rate paid by the plan for the services, unless the arbitrator determines both the charge and the rate paid were unreasonable.[36] If both are considered unreasonable, both parties would submit their final offers to the arbitrator, and the arbitrator will choose between these two offers.[37] In choosing between the final offers, the arbitrator will consider: the commercially reasonable rates for comparable services in the same geographic area, and the usual and customary cost of the service, which is the 80th percentile of charges for comparable services in the same geographic area, as determined by the medical claims database.[38] The arbitrator will also consider the provider's qualifications; the circumstances and complexity of the case; the provider's usual charges for comparable services; the patient's characteristics; and other relevant economic and clinical factors.[39]

Various State Attempts to Limit Surprise Billing.

In addition to the pending federal legislation summarized above, many states have enacted or revised already-existing laws prohibiting or limiting surprise billing during the past year. Summarizing each of these dozens of bills is beyond the scope of this briefing, so we have provided details regarding the largest states below, with a list of citations for states not covered at the end.

1. *New York*

New York was one of the first states to implement comprehensive balance billing protections. At the outset, the New York law does not apply to any health care services where "physician fees are subject to schedulers or other monetary limitations under any other law."[40] Additionally, some emergency services are exempt from the dispute resolution process under certain circumstances.[41] The New York law establishes a baseball-style dispute resolution process to resolve disputes for surprise bills and bills for emergency services.[42]

New York defines a "surprise bill" as a bill for health care services, other than emergency services, received by: (1) an insured for services rendered by a non-

participating physician at a participating hospital or ambulatory surgical center, where a participating physician is unavailable or a non-participating physician renders services without the insured's knowledge, or unforeseen medical services arise at the time the services are rendered; (2) an insured for services rendered by a non-participating provider, where services were referred by a participating physician to a non-participating provider without the consent of the insured; or (3) a patient who is not insured for services received by a physician at a hospital or ambulatory surgical center, when the patient did not receive required disclosures.[43] The law provides that when an insured assigns their health insurance benefits to the non-participating physician, the physician cannot bill the insured except for any applicable "copayment, coinsurance or deductible that would be owed if the insured utilized a participating physician."[44]

Where a dispute arises for the payment of a surprise bill or a bill for emergency services, the provider and the insurer must proceed to binding arbitration. When the dispute is over a bill for emergency services, the plan must pay an amount that is "reasonable for the emergency services rendered by the non-participating physician . . . except for the insured's co-payment, coinsurance or deductible . . . and shall ensure that the insured shall incur no greater out-of-pocket costs . . . than the insured would have incurred with a participating physician."[45] Either the physician or plan may submit a dispute regarding a fee or payment for review to an independent dispute resolution entity.[46] The independent dispute resolution entity selects either the plan's payment or the physician's fee as the reasonable fee for the services rendered.[47]

Where the dispute is over a surprise bill, and the insured who receives the surprise bill assigns their benefits to the non-participating physician, the physician may bill the plan for the services rendered and the plan must pay "the billed amount or attempt to negotiate reimbursement."[48] If negotiation does not result in a settlement, the plan must pay the physician "an amount the health care plan determines is reasonable" for the rendered services, except for any applicable copayment, coinsurance, or deductible.[49] Either the plan or the physician may initiate arbitration to dispute the payment or fee, and the independent dispute resolution chooses either the plan's payment or the physician's fee.[50]

In arbitration proceedings under both the emergency services bill and the surprise bill provisions, the independent dispute resolution entity considers a number of factors as they choose from either the plan's payment or the physician's fee. These factors include: whether there is a gross disparity between the physician's fee as compared to (1) the fees paid to the physician for the same services rendered to other patients in plans in which the physician does not participate, and (2) fees by the plan to reimburse similarly qualified physicians for the same services in the same region who do not participate in the plan; the level of training, education, and experience of the physician; the physician's usual charge for comparable services with regard to patients in plans in which the physician does not participate; the circumstances and complexity of the case; the individual patient's characteristics; and the usual and customary charge of the services.[51] The New York law defines "usual and customary cost" as the 80th percentile

of all charges for the particular service performed by a provider in the same or similar specialty and in the same geographical area.[52]

When the independent dispute entity determines that the plan's payment is reasonable, the non-participating physician pays for the dispute resolution process, and vice versa.[53] If the parties settle the dispute while the dispute resolution process is pending, the plan and physician shall evenly divide the prorated cost for dispute resolution.[54]

Interestingly, a third-party analysis recently published by the Brookings Institute shows that this process is actually making health care more expensive in New York, rather than keeping costs down.[55] It is unclear whether this study has had any impact on other similar proposals that include baseball-style arbitration, including the federal proposals summarized above.

2. California

California's first "balance billing" law was a matter of common law. In *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, the California Supreme Court held that billing disputes over emergency care must be resolved solely between emergency department physicians and health maintenance organizations (HMOs), and that the physician's may not bill the HMO enrollee.[56]

California has since enacted surprise billing legislation that became effective on July 1, 2017. In California, health care service plans, or HMOs, are governed by the California Health and Safety Code, as enforced by the California Department of Managed Healthcare (DMHC).[57] Other insurance policies, such as preferred provider organizations (PPOs) and indemnity products, are governed by the California Insurance Code, as enforced by the California Insurance Commissioner.[58]

For nonemergency care in the HMO context, California provides that all health care service plan contracts issued, amended, or renewed on or after July 1, 2017, must state that if enrollees receive covered services at a contracting facility from a noncontracting health professional, "the enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from a contracting individual health professional."[59] Enrollees do not owe the noncontracting professionals anything more than this amount, and noncontracting professionals cannot bill or collect any amount from an enrollee aside from the in-network cost-sharing amount.[60] If the enrollee's plan includes coverage for out-of-network benefits, the noncontracting professional can bill the enrollee for the out-of-network cost sharing "only when the enrollee consents in writing."[61] The same requirements apply for nonemergency care in the PPO and indemnity contexts.[62]

The reimbursement to noncontracting health professionals is the greater of: (1) the average contracted rate; or (2) 125% of the Medicare fee-for-service reimbursement rate for the same or similar services in the general geographic region where the services were rendered.[63] The "average contracted rate" is the average of the

“contracted commercial rates paid by the health plan or delegated entity for the same or similar services in the geographic region.”[64] The same reimbursement calculations are used in the PPO and indemnity contexts.[65]

In both the HMO and PPO contexts, the law required the DMHC and the Insurance Commissioner, respectively, to adopt dispute resolution processes when an out-of-network health professional disputes the payment made by the carrier or insurer.[66] The respective processes are similar in a number of respects. Both processes only apply to disputes over nonemergency services provided.

In the broader, non-HMO insurance context, when a noncontracting health professional wishes to dispute a payment made from the insurer, the professional must have completed “the insurer’s payment dispute resolution process,” which is satisfied “after completing one level of the insurer’s internal payment dispute resolution process.”[67] Once this happens, the professional can request an independent dispute resolution process (IDRP), and the party requesting the IDRP must submit its final offer for resolution.[68] Then, the responding party submits its final offer for resolution.[69] The parties can settle the claim at any time before a decision is made by the independent dispute resolution organization.[70] If the claim is not settled, the organization will decide the claims based on submissions from both parties and will not conduct any hearings.[71] The organization will ultimately pick between the two parties’ final offers for resolution.[72] In making the determination as to the appropriate rate of reimbursement, the organization may consider several factors, including: the provider’s training, qualifications, and length of time in practice; the nature of the services provided; the fees usually charged by the provider for the type of service; the fees usually charged by similar providers for the service in the geographic area in which the services were rendered; any unusual circumstances in the case; and any other relevant factors.[73] The Insurance Department has discretion to re-review the decision prior to adopting the decision.[74]

In the HMO context, the DMHC has released guidance explaining the dispute resolution process that occurs when a noncontracting health professional and an HMO are in a dispute over reimbursement.[75] To be eligible to use the DMHC’s dispute resolution process, the noncontracting provider must have completed the health plan’s Provider Dispute Resolution Process within the last year, although the guidance is silent as to whether that just means one level of the process, as the Department of Insurance’s guidance explains.[76] Unlike the Insurance Department’s dispute resolution process, the DMHC’s process does not restrict the dispute resolution organization from selecting between the parties’ final offers; the organization can choose a reasonable reimbursement rate that it sees fit.[77] The DMHC’s process is guided by the same set of factors laid out in the Insurance Department’s process.[78]

As explained above, California’s currently codified balance billing laws only apply to nonemergency services. However, the California legislature has proposed a bill, AB 1611, that would further address balance billing in the emergency context. The proposed bill states that in situations where a hospital provides emergency services to a

patient, “the patient shall pay no more than the same cost sharing that the patient would pay for the same covered emergency services received from a contracting hospital.”[79] The patient will owe no more than this amount, and the hospital cannot bill or collect an amount from the patient that is greater than the in-network cost sharing amount.[80] These requirements apply to both contracting and noncontracting hospitals.[81]

The noncontracting facilities must be reimbursed either “the reasonable and customary value of the hospital services . . . or the average contracted rate for the same or similar services in the general geographic region in which the services were rendered.”[82] The “reasonable and customary value of the hospital services” means the payment of the reasonable value of the services rendered “based upon statistically credible information that is updated at least annually,” and considers the following factors: the provider’s training, qualifications, and length of time in practice; the nature of the services provided; the fees usually charged by or paid to the provider; the prevailing provider rates; and any unusual circumstances.[83] The “average contracted rate” is the average of the “contracted commercial rates paid by the health plan or delegated entity for the same or similar services in the geographic region.”[84] The noncontracting facility may use the DMHC’s dispute resolution process described above.[85]

3. Texas

Texas enacted a comprehensive surprise billing prohibition that applies to certain health care services provided on or after January 1, 2020.[86] The new legislation does three things: first, it bans balance billing for certain services, including emergency care,[87] facility-based physician services (unless certain prerequisites are complied with),[88] and diagnostic imaging or laboratory service providers.[89] Second, it requires a health insurer to reimburse these services at the usual and customary rate in circumstances in which the provider is prohibited from balance billing.[90] Third, the legislation implements a dispute resolution process by which a non-participating provider and health insurer can resolve a dispute over the sufficiency of the insurer’s payment.[91]

The dispute resolution process builds on a pre-existing “balance billing mediation” process that was previously available only to patients after they received a balance bill for a particular health care service.[92] Under that process, the Texas Department of Insurance would, after receiving the patient’s complaint regarding balance billing, appoint a mediator to mediate the appropriate level of payment between the non-participating provider and the health insurer and resolve the dispute in a way that eliminated the patient’s balance bill.[93]

The new dispute resolution process has two different dispute resolution processes depending on the non-participating provider’s provider type. If the non-participating provider is a facility (such as a hospital), then it may submit a claim to a mandatory mediation process.[94] Similar to the prior practice, the mediation would be presided over by a mediator appointed by the Texas Department of Insurance who would attempt to resolve the dispute between the provider and health insurer over the appropriate level of reimbursement.[95] The mediation process is mandatory: only after completing this

process may a non-participating provider file a lawsuit against the health insurer to attempt to recover additional reimbursement.[96]

If the non-participating provider is not a facility, then a different dispute resolution process applies: a mandatory baseball-style arbitration process (similar to the models discussed above).[97] In this baseball arbitration process, the Texas Department of Insurance will appoint an arbitrator who will decide, by reference to a number of enumerated factors, what amount should be allowed on the non-participating provider's claim: the insurer's allowed amount (or a reformed allowed amount offered during the proceeding) or the non-participating provider's billed charge (or a reformed charge offered during the proceeding).[98] One factor that an arbitrator may consult is a benchmarking database; the Texas Department of Insurance recently announced that FAIR Health had been selected as the benchmarking database.[99]

The Texas Department of Insurance is still finalizing regulations that will govern these dispute resolution processes.

4. Florida

Florida law had already barred HMO networks from balance billing, and in 2016, Florida extended that protection to PPO and EPO customers.[100] Under the new law, "doctors and hospitals are prohibited from sending patients out-of-network medical bills for visits to the emergency room and other healthcare facilities if they don't have the ability or opportunity to be treated by a participating provider."[101]

Under this new Florida law, insurers maintain sole liability to pay non-participating providers of covered emergency services in accordance with the coverage terms of the insurance policy.[102] For covered emergency services, insureds are only liable for "applicable copayments, coinsurance, and deductibles."[103] The Florida law requires insurers to provide coverage for emergency services that (1) may not require pre-authorization, (2) must be provided regardless of whether the services are rendered by a participating or non-participating provider, and (3) may impose coinsurance amounts, copayments, or limitation of benefits requirements for non-participating providers only if the same requirements apply to participating providers.[104]

Also, insurers maintain sole liability for payments to non-participating providers in accordance with the terms of the insurance policy, and the insured is only liable for applicable copayments, coinsurance and deductibles, for covered nonemergency services that are: (1) provided at a facility with a contract for nonemergency services with the insurer, and (2) a participating provider is not available to treat the insured.[105]

In both scenarios, insurers must reimburse non-participating providers in the following way: the provider shall be reimbursed the lesser of (1) the provider's charges, (2) the usual and customary provider charges for similar services in the community where the services were provided, or (3) a charge mutually agreed to by the insurer and provider within 60 days after the claim is submitted.[106]

In the event of a dispute regarding the reimbursement rate, Florida provides that such dispute "shall be resolved in a court of competent jurisdiction or through the voluntary dispute resolution process."[107] Florida's arbitration process heavily encourages settlement before the arbitration process is completed.[108] If either party offers to settle, the offer must state its total amount, and the opposing party has 15 days to accept.[109] If the opposing party does not accept, and the final order amount is "more than 90 percent or less than 110 percent of the offer amount, the party receiving the offer must pay the final order amount to the offering party, and is deemed a nonprevailing party."[110]

During the arbitration, the resolution organization must review and consider all documentation submitted by both parties, and either party may request an evidentiary hearing.[111] The party who does not prevail in the final order must pay a "review cost" to the review organization.[112]

5. Other States

Other recent state statutes limiting, prohibiting, or otherwise addressing surprise billing include the following:

- Colorado: Colorado House Bill 1194 (effective Jan. 1, 2020);
- Connecticut: CONN. GEN. STAT. § 38a-477aa (amended effective Jan. 1, 2020);
- Illinois: 215 ILL. CONSOL. STAT. 5/356z.3a;
- Maryland: MD. CODE INS. §§ 14-205.2, 19-710;
- Missouri: MO. REV. STAT. § 376.690;
- New Mexico: Surprise Billing Protection Act, SB 337 (2019) (signed April 3, 2019);
- New Hampshire: Prohibition on Balance Billing; Payment for Reasonable Value of Services, N.H. REV. STAT. ANN. §§ 329:31-b, 420-J:8 (amended July 1, 2018);
- New Jersey: Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act, N.J.S.A. 26:2SS-7 (et seq. (effective Aug. 1, 2018);
- Oregon: ORE. REV. STATUTES § 743B.287 (enacted);
- Pennsylvania: Surprise Balance Billing Protection Act, HB 1862 (currently pending passage); and
- Washington: Balance Billing Protection Act, HB 1065, 66th Legis. §§ 4-9 (2019) (signed May 21, 2019; effective Jan. 1, 2020).

Conclusion

Despite the variety of state laws on the issue of surprise billing, there is a strong consensus on both sides of the political aisle that surprise billing should be prohibited in certain circumstances in which the patient has limited or no control over whether she is treated by a participating provider (such as emergency care, or non-participating physicians at a participating facility). Most state laws and proposed state and federal statutes on the issue also include a specified reimbursement rate mechanism and a

dispute resolution process where the non-participating provider does not accept the health insurer's payment, though the details vary widely from state to state (and from federal proposal to federal proposal). It looks likely that surprise billing legislation will pass at a federal level in 2020, and providers are advised to monitor developments at the federal level and in their specific states closely.

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[3] Ms. Miller is a Senior Associate in the Trial practice group at Thompson & Knight.
[4] Unfortunately, as is often the case in articles such as this, the information may soon be outdated as federal legislators move towards enacting legislation and as new states pass surprise billing laws, and other states make legislative fixes to their own statutes. Readers are encouraged to check for updates to the statutes and bills discussed in this briefing.
[5] This is why certain states have enacted laws requiring health plans to apply a patient's in-network cost-sharing when they receive emergency care from an out-of-network provider: these incentives do not apply then. *See* TEX. INS. CODE § 1301.155 (pre-2019 amendment by SB 1264 discussed below).
[6] *E.g.*, TEX. INS. CODE §§ 843.361, 1301.060.
[7] Stopping The Outrageous Practice of Surprise Medical Bills Act of 2019, S.1531, § 3, 116th Cong. (2019).
[8] *Id.*; *see also* Tex. S.B. 1264, 86th Leg., R.S.
[9] *Conn. Gen. Life Ins. Co. v. Humble Surgical Hosp.*, 878 F.3d 478, 483-86 (5th Cir. 2017).
[10] Ellee Cochran, Spencer Smith, *Proposed Federal Legislation Mirrors State's Attempts to End Surprise Billing*, JDSUPRA, Nov. 6, 2019, https://www.jdsupra.com/legalnews/proposed-federal-legislation-mirrors-15087/.
[11] No Surprises Act, H.R.3630, 116th Cong. (2019). Representative Pallone initially proposed the bill.
[12] Robert King, *Providers get win in surprise billing compromise*, *but they're not happy*, FIERCE HEALTHCARE, Dec. 9, 2019, https://www.fiercehealthcare.com/payer/providers-get-win-surprise-billing-compromise-but-not-happy.
[13] Stephanie Armour, *White House Applauds Bipartisan Congressional Deal to Curb Surprise Medical Bills*, WALL ST. J., Dec. 9, 2019, https://www.wsj.com/articles/white-house-applauds-bipartisan-congressional-deal-to-curb-surprise-medical-bills-11575920261. The White House has made ending surprise medical bills a priority, and the President has repeatedly pressed Congress to pass a bill doing so in 2019. *Id.*
[14] No Surprises Act, at § 2.
[15] *Id.*
[16] NPR, *To End Surprise Medical Bills, New York Tried Arbitration. Health Care Costs Went Up*, Nov. 5, 2019.
[17] No Surprises Act, at §§ 4-5.
[18] *Top House Tax Writes Unveil Rival Surprise Medical Billing Deal*, BLOOMBERG LAW, Dec. 11, 2019.
[19] House Committee on Ways & Means, *Ways and Means Committee Surprise Medical Billing Plan*, Dec. 11, 2019, https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/WM%20Surprise%20Billing%20Summary.pdf.
[20] *Id.*
[21] Robert King, *Congress likely to punt on drug prices, surprise billing as year-end deadline nears,* FIERCE HEALTHCARE, Dec. 16, 2019, https://www.fiercehealthcare.com/payer/congress-likely-to-punt-drug-prices-surprise-billing-as-end-year-deadline-nears?mkt_tok=eyJpIjoiWVdOaE9UVXdZMll3TVRaayIsInQiOiJDRjhFZlIGcEgxOFwvY1gwQTVkcUtwWE5kVyszWnBjcWRvZHEya1NkTlhcL04rT0FDeHdMMEY2T1lSTnk2a1FGR1JWMlpjTkcrdXVRcnduS3RkVXhqckp4eU5OU3ZCajhhYWJLNkk1R1JBQkpQMnRyOHhXMzhkMjJQdmtza2NLSTN4In0%3D&mrkid=59344411.
[22] Stopping The Outrageous Practice of Surprise Medical Bills Act of 2019, S.1531, 116th Cong. (2019).
[23] *Id.* at § 3.
[24] *Id.*
[25] *Id.*

[26] *Id.*
[27] *Id.*
[28] Lower Health Care Costs Act, S.1895, 116th Cong. (2019).
[29] Ellee Cochran, Spencer Smith, *Proposed Federal Legislation Mirrors State's Attempts to End Surprise Billing*, JDSUPRA, Nov. 6, 2019, https://www.jdsupra.com/legalnews/proposed-federal-legislation-mirrors-15087/.
[30] Lower Health Care Costs Act, at § 103.
[31] *See id.*
[32] *Id.*
[33] Protecting People From Surprise Medical Bills Act, H.R.3502, 116th Cong. (2019).
[34] *Id.* at § 2(b).
[35] *Id.* at § 2(c).
[36] *Id.*
[37] *Id.*
[38] *Id.*
[39] *Id.*
[40] N.Y. FIN. SERV. LAW § 602(a).
[41] *Id.* at § 602(b)(1)(A)-(B).
[42] *Id.* at § 601.
[43] *Id.* at § 603(h).
[44] *Id.* at § 606.
[45] *Id.* at § 605(a)(1).
[46] *Id.* at § 605(a)(2).
[47] *Id.* at § 605(a)(4).
[48] *Id.* at § 607(a)(2).
[49] *Id.* at § 607(a)(3).
[50] *Id.* at § 607(a)(4), (6).
[51] *Id.* at § 604(a)-(f).
[52] *Id.* at § 603(i).
[53] *Id.* at § 608(a).
[54] *Id.*
[55] Loren Adler, *Experience with New York's arbitration process for surprise out-of-network bills*, BROOKINGS, Oct. 24, 2019, https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/10/24/experience-with-new-yorks-arbitration-process-for-surprise-out-of-network-bills/; *see also* NPR, *To End Surprise Medical Bills, New York Tried Arbitration. Health Care Costs Went Up,* Nov. 5, 2019.
[56] 198 P.3d 86, 92-93 (Cal. 2009).
[57] Marcia Augsburger, *Surprise! California's "No Surprise" Health-Care Billing Law Poses Unexpected Challenges*, BLOOMBERG LAW NEWS, Nov. 29, 2017.
[58] *Id.*
[59] CAL. HEALTH & SAFETY CODE § 1371.9(a)(1).
[60] *Id.* at § 1371.9(a)(2)-(3).
[61] *Id.* at § 1371.9(c).
[62] CAL. INS. CODE § 10112.8(a)(1)-(3), (c).
[63] CAL. HEALTH & SAFETY CODE § 1371.31(a)(1).
[64] *Id.*
[65] CAL. INS. CODE § 10112.82(a)(1).
[66] CAL. HEALTH & SAFETY CODE § 1371.30; Cal. Ins. Code § 10112.81.
[67] CAL. DEP'T OF INS., Implementation Guidance AB72:2 § 2239.2(c).
[68] *Id.* at § 2239.3(b).
[69] *Id.* at § 2239.4(b).
[70] *Id.* at § 2239.6(a).
[71] *Id.* at § 2239.6(c).
[72] *Id.* at § 2239.6(g).
[73] *Id.* at § 2239.6(e).

[74] *Id.* at § 2239.8.
[75] DEP'T OF MANAGED HEALTHCARE, *Non-Emergency Services Independent Dispute Resolution Process (AB 72 IDRP)*, https://www.dmhc.ca.gov/FileaComplaint/ProviderComplaintAgainstaPlan/NonEmergencyServicesIndependentDisputeResolutionProcess.aspx.
[76] *Id.*
[77] *Id.*
[78] *Id.*
[79] CA AB-1611, § 2.
[80] *Id.*
[81] *Id.* at § 4.
[82] *Id.* at § 5.
[83] *Id.*
[84] *See id; see also* CAL. HEALTH & SAFETY CODE § 1371.31(a)(3).
[85] CA AB-1611, § 5.
[86] Tex. S.B. 1264, § 5.01, 86th Leg., R.S.
[87] *Id.* §§ 1.06 [amending TEX. INS. CODE § 1301.0053(b)], 1.08 [amending Tex. INS. CODE § 1301.155(d)]. With respect to HMOs, Texas regulations already require an HMO to make sure that an enrollee is held harmless from surprise billing for emergency care. 28 TEX. ADMIN. CODE § 11.1611(c).
[88] *Id*. §§ 1.04 [amending TEX. INS. CODE § 1271.157(c)], 1.09 [amending TEX. INS. CODE § 1301.164(c)].
[89] *Id*. §§ 1.04 [amending TEX. INS. CODE § 1271.158(c)], 1.09 [amending TEX. INS. CODE § 301.165(c)].
[90] *Id*. §§ 1.04 [amending TEX. INS. CODE §§ 1271.157(a), 1271.1588(b)], 1.06 [amending TEX. INS. CODE § 1301.0053(a)], 1.08 [amending TEX. INS. CODE § 1301.155(a)], 1.09 [amending TEX. INS. CODE §§ 1301.164(b), 1301.165(b)].
[91] *Id*. Art. 2.
[92] *See generally* TEX. INS. CODE ch. 1467.
[93] *Id*.
[94] Tex. S.B. 1264, §§ 2.04-2.14 [amending TEX. INS. CODE ch. 1467 subch. B].
[95] *Id*.
[96] *Id*. § 2.13 [amending TEX. INS. CODE § 1467.0575].
[97] *Id*. § 2.15 [enacting TEX. INS. CODE ch. 1467 subch. B-1].
[98] *Id*.
[99] TEXAS DEP'T OF INS., *FAIR selected as arbitration benchmarking database*, Nov. 26, 2019, https://www.tdi.texas.gov/news/2019/tdi11262019.html.
[100] Ashlee Kieler, *Florida Implements Law Protecting Consumers From Surprise Medical Bills*, CONSUMERIST, Apr. 14, 2016, https://consumerist.com/2016/04/14/florida-implements-law-protecting-consumers-from-surprise-medical-bills/; *see also* FLA. STAT. § 641.513.
[101] Ashlee Kieler, *Florida Implements Law Protecting Consumers From Surprise Medical Bills*, CONSUMERIST, Apr. 14, 2016, https://consumerist.com/2016/04/14/florida-implements-law-protecting-consumers-from-surprise-medical-bills/.
[102] Fla. Stat. § 627.64194(2).
[103] *Id.*
[104] *Id.*
[105] *Id.* at § 627.64194(3)(a)-(b).
[106] *Id.* at § 627.64194(4); FLA. STAT. § 641.513(5).
[107] FLA. STAT. § 627.64194(6).
[108] FLA. STAT. § 408.7057(2)(h).
[109] *Id.*
[110] *Id.*
[111] *Id.* at § 408.7057(3)(a), (c).
[112] *Id.* at § 408.7057(6).