

Surprise Medical Billing Legislation *Issues for Congress to Consider*

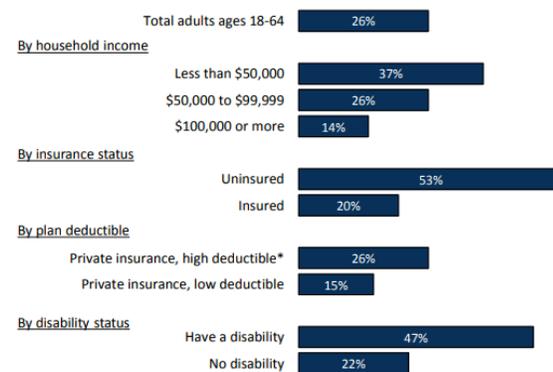
Legislative solutions are needed to combat the rising cost of health care in the United States, which accounted for almost 18% of the GDP in 2017.¹ One symptom of the problem, surprise medical bills, contributes to unpredictable, high out-of-pocket costs for consumers. Patients often encounter surprise medical bills when receiving emergency or ancillary health services from out-of-network practitioners. These providers “balance bill” patients for the difference between the full charge for services and the amount paid by the insurer, or bill for the entire amount of undiscounted charges. Payers, providers, facilities, and health consumers are all stakeholders to consider in legislation to address surprise medical bills. In protecting consumers, policymakers should not fuel health care inflation.

Surprise medical bills are common and burdensome

- Approximately 7 in 10 individuals with surprise medical bills did not know that they were receiving out-of-network health services.²
- 26% of U.S. adults said they or someone in their household had issues paying a medical bill in the past year.²
- Problems paying medical bills significantly vary depending on household income level, insurance status, plan deductibles, and disability status.²

Figure 1
Shares Reporting Problems Paying Medical Bills In Past Year

Percent who say they or someone in their household had problems paying medical bills in the past 12 months:



*High deductibles defined as \$1,500 and above for an individual or \$3,000 and above for a family.
SOURCE: Kaiser Family Foundation/New York Times Medical Bills Survey (conducted August 28-September 28, 2015)

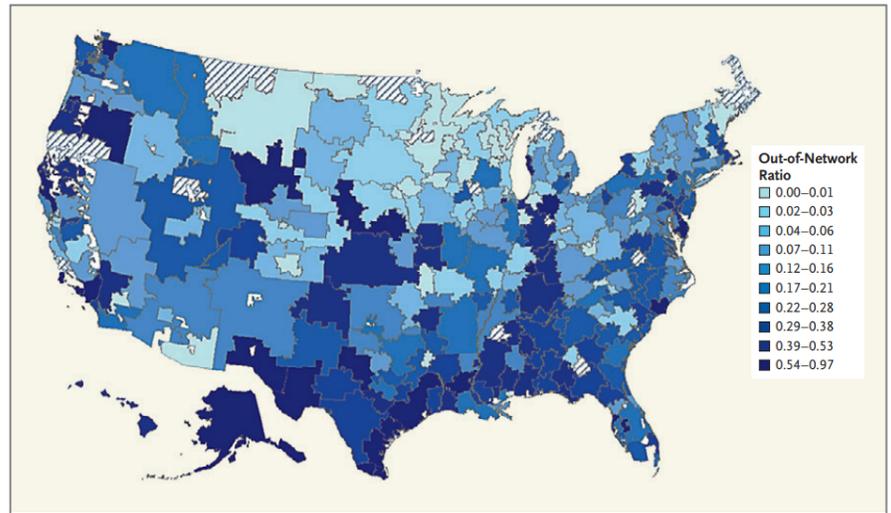
Defining the problem correctly to avoid unintended consequences

1. Which circumstances and providers should be covered by legislation to address surprise medical bills?

There is an apparent increase in frequency of patients receiving care in an in-network hospital where physicians practicing in the hospital, often under contract to the hospital, are not in-network. In those circumstances, the patient may receive a bill for the full charges of the out-of-network physician. [Media reports](#) suggest emergency department visits and surgical procedures are where such surprise billing happens most frequently.³

Some provider types in some geographies appear to have a business model of staying out-of-network.⁴ These include air ambulances and freestanding EDs, where it could be argued that patients don't have time to shop around or call their insurer in advance. Any legislation may want to address these situations.

Any legislation should address a range of situations in which it is unreasonable to expect patients to be able to identify in advance all of the possible providers who may bill for services and not be in network.



Proportion of ED Visits at In-Network Facilities Involving Out-of-Network Physicians, by Hospital Referral Region.

Source: Cooper, Z. & Scott Morton, F. (2016). Out-of-network emergency-physician bills—an unwelcome surprise. *The New England Journal of Medicine*, 375(20): 1915-1918.

Deciding how to coordinate with state authority and action

A key question federal lawmakers have to decide is whether to only address situations arising for patients covered by [ERISA plans](#), or whether they want to also pre-empt state law or set minimum standards for state laws.⁵ States are acting to protect consumers, but ERISA, the federal law which governs most self-insured employer plans, pre-empts them from enacting protections for ERISA plan participants. For employers, plans, and providers who operate across state lines, having streamlined and consistent practices governed by federal legislation may be preferable to a patchwork of state laws.

Goals of legislation: protect patients while preventing higher premiums

1. Protect patients

The goal of surprise billing legislation should be to protect patients in situations in which it is unreasonable to expect them to research and know all of the providers in their network, or when network information is not up to date. Hospitals should notify patients if physicians and services at that hospital may be out-of-network.

2. Prevent price and premium inflation

Just as important, any legislation to protect patients from surprise bills should not have unintended consequences of raising premiums and the total cost of care. Providers may stay out-of-network because the reimbursement rate paid in out-of-network situations is likely to be significantly higher than the in-network rate in the local market.

3. Encourage network simplicity

Any legislation should encourage hospitals and physicians to be joining and staying in common networks, and coordinating their network participation in order to lower complexity for patients.

What are states doing?

Evaluation criteria

1. Is the consumer taken out of the middle of the dispute?
2. How is the dispute resolved between the payer and the provider?
3. How are payers determining reimbursement rates for providers?

California

Out-of-network providers can bill full amounts for out-of-network services at in-network facilities; however, patients must provide written consent to receiving these services 24 hours in advance of receiving services. Patients must also receive cost estimates for these services.⁶ Furthermore, health plans must pay out-of-network providers either their average contracted rate or 125% of Medicare rates.⁶ Patients can only be billed for rates identical to in-network cost-sharing rates when they use an in-network facility for non-emergency care.⁷

New York

New York utilizes mandatory and binding dispute arbitration for surprise medical bills, known as “final offer” arbitration.⁶ Both payers and providers submit their requested rate; then, an independent reviewer under contract with the state selects the price that best aligns with “usual and customary rates” (UCR).⁶ Because the arbiter’s price decision is binding, payers and providers are encouraged to negotiate the best price before the dispute goes to arbitration.⁶ Patients do not have to pay more than in-network cost-sharing rates for out-of-network service charges.⁸

New Jersey

New Jersey has prioritized transparency, and mandates that facilities, individual health care professions, carriers, and self-funded health plans disclose health service fees, payment schedules, and in-network vs. out-of-network status.⁹ New Jersey mandates that unresolved disputes are settled through arbitration. New Jersey’s arbitration process is based on an arbitration process between payers and providers.⁹

California	New York	New Jersey
		
Patient only liable for in-network cost sharing in in-network facilities	Patient only liable for in-network cost sharing	Patient only liable for in-network cost sharing
Out-of-network service rates are comparable to in-network OR 125% of Medicare	Uses binding arbitration based on UCR rates	Uses negotiation through arbitration
Patients must consent to out-of-network care		Transparency in pricing for out-of-network rates

Determining a fair and reasonable out-of-network rate

1. What is the patient's responsibility?

There is general agreement that out-of-network disputes should protect the patient from balance billing, which could include 100% of the billed charges. This can be done by requiring the provider to accept the in-network cost-sharing amount required by the patient's plan as payment in full from the patient.

2. What is the hospital's responsibility?

At minimum, hospitals should be required to notify patients in writing of the insurance networks in which they and the providers practicing within their facilities participate. This could be required through Medicare Conditions of Participation, or a condition of licensure at state level.

3. What's the best dispute mechanism process to get a reasonable rate and quick action?

States are setting up dispute settlement mechanisms to determine a fair and reasonable rate in out-of-network billing situations. As federal lawmakers look at the experience from the state level, it is difficult to determine which dispute mechanism process will produce reasonable, fair rates.

Plans and providers generally don't like their in-network rates to be made public, so some kind of geographic average or median must be determined using a process that plans and providers believe is credible. Usual and customary rates are favored by providers, but they are likely to fuel higher rates and could encourage out-of-network behavior. Pegging the rate to a multiple of Medicare's fee schedule is more transparent and more likely to be lower than usual and customary, so that reference price is not favored by providers.

To resolve rate disputes, should an impartial umpire in dispute mechanism be required to take higher of, lower of, or split the difference between two or more possible rates? There is disagreement here as well. How much discretion to give the umpire(s)? Proponents of final offer arbitration believe it should force the two parties to propose reasonable rates, but others disagree.

Recommendation

Give arbitrator or umpire the ability to use Medicare rates as a factor to drive reasonable behavior from provider community and promote transparency. Use "final offer" arbitration and give the arbiter the ability to use Medicare rates to settle disputes.

Future state proposals to watch

Washington

There is currently proposed legislation in the Washington legislature that bans surprise medical bills when individuals receive out-of-network services at in-network facilities. If payers and providers cannot compromise on a price, they go to binding arbitration. Washington's proposed binding arbitration process is similar to New York's process. The bill passed in the House on March 4, 2019 and is currently being debated in the Senate.¹⁰

Texas

Currently, the Texas legislature is debating a bill that protects patients from surprise medical bills from emergency rooms and in-network facilities. The legislation bans surprise bills from out-of-network providers and in-network facilities that provide out-of-network care. The bill maintains that the insurer pays fair reimbursement rates for out-of-network services and facility-based providers. If the provider disagrees with the reimbursement rate, they can request mandatory mediation. Moreover, patients will still be responsible limited to their in-network cost-sharing rates.¹¹

Resources

1. Historical. (2018). *Centers for Medicare & Medicaid Services*. Retrieved from <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccounts/historical.html> on 5 April 2019.
2. Hamel, L., Norton, M., Pollitz, K., Levitt, L., Claxton, G., & Brodie, M. (2016). The burden of medical debt: results from the Kaiser Family Foundation/New York Times Medical Bills Survey. *The Henry Kaiser Family Foundation*, 1-29. Retrieved from <https://kaiserfamilyfoundation.files.wordpress.com/2016/01/8806-the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey.pdf> on 5 April 2019.
3. Sanger-Katz, M. & Abelson, R. (2016). Surprise! Insurance paid the E.R. but not the doctor. *The New York Times*. Retrieved from <https://www.nytimes.com/2016/11/17/upshot/first-comes-the-emergency-then-comes-the-surprise-out-of-network-bill.html> on 5 April 2019.
4. Cooper, Z. & Scott Morton, F. (2016). Out-of-network emergency-physician bills—an unwelcome surprise. *The New England Journal of Medicine*, 375(20): 1915-1918. Retrieved from http://zackcooper.com/sites/default/files/paper-files/NEJM_surprise_billing.pdf on 5 April 2019.
5. Health Plans & Benefits: ERISA. (2019). *U.S. Department of Labor*. Retrieved from <https://www.dol.gov/general/topic/health-plans/erisa> on 5 April 2019.
6. Hall, M., Ginsburg, P.B., Lieberman, S.M., Adler, L., Brandt, C., & Darling, M. (2016). Solving surprise medical bills. *The Schaeffer Initiative in Health Policy, A Brookings Institution—USC Schaeffer Center Partnership*. Retrieved from <https://cqrcengage.com/acradiology/file/LRBoQt7ZMK0/Brookings%20Surprise%20Billing%20White%20Paper%2010.13.16.pdf> on 9 April 2019.
7. What is a surprise bill? (2017). *California Department of Insurance*. Retrieved from <https://www.insurance.ca.gov/01-consumers/110-health/60-resources/NoSurpriseBills.cfm> on 9 April 2019.
8. Surprise medical bills and emergency services. (2015). New York State Department of Financial Services. Retrieved from https://www.dfs.ny.gov/consumers/health_insurance/surprise_medical_bills on 9 April 2019.
9. Selby, J., Farruggia, L.A., & Malone, K. (2018). New Jersey's surprise medical bill law: implications and national trends. EBG Advisors. Retrieved from <https://www.ebglaw.com/news/new-jerseys-surprise-medical-bill-law-implications-and-national-trends/> on 9 April 2019.
10. Surprise medical billing (2019). *Office of the Insurance Commissioner for Washington State*. Retrieved from <https://www.insurance.wa.gov/surprise-medical-billing> on 9 April 2019.
11. Deam, J. (2019). Surprise billing protection for Texans moves forward to Senate vote. *Houston Chronicle*. Retrieved from <https://www.houstonchronicle.com/business/article/Surprise-billing-protection-for-Texans-moves-13736600.php> on 12 April 2019.