

Surprise Medical Billing – A Primer

Surprise medical billing 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. Recent studies indicate that surprise billing is concentrated in specific specialties like pathology.¹ 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, but rather, promote reasonable solutions that appease payers, providers, and patients.

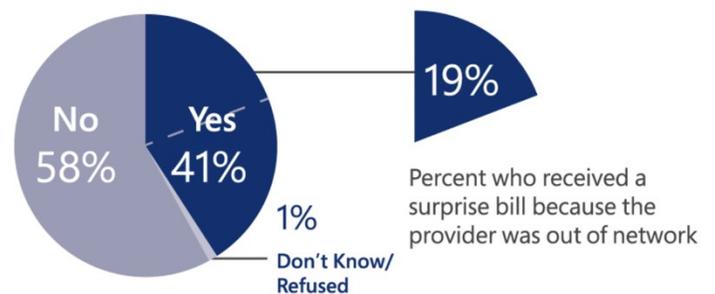
Surprise medical bills are burdensome

- **Approximately 1 in 5 insured adults** had a surprised medical bill in the past 2 years.
- **67% of U.S. adults** are worried about being able to afford unexpected medical bills.
- **18% of emergency department visits** result in a surprise medical bill.²

Defining the problem correctly to avoid unintended consequences

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 (ED) visits, surgical procedures, and laboratory services are where such surprise billing happens most frequently.³

One in 5 Insured Adults Had a Surprise Medical Bill in the Past 2 Years



¹ <https://healthcostinstitute.org/out-of-network-billing/how-often-do-providers-bill-out-of-network>

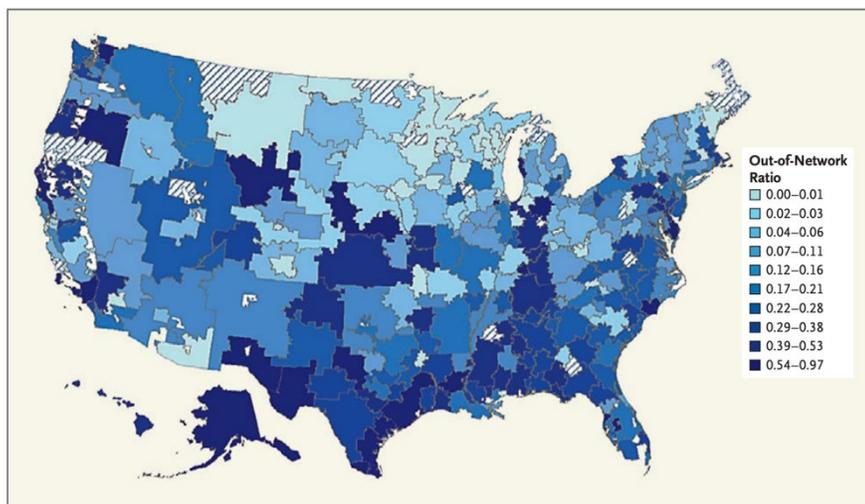
² <https://jamanetwork.com/journals/jama/fullarticle/2760721>

³ <https://jamanetwork.com/journals/jama/article-abstract/2762312>

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. A recent study by the Health Care Cost Institute shows that pathology is also of particular concern.⁵ Any legislation may want to address these specific situations.

Any legislation should address a range of contexts 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, especially when these services are conducted in emergencies or "behind-the-scenes".



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

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.⁶ 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.

⁴ https://zackcooper.com/sites/default/files/paper-files/NEJM_surprise_billing.pdf

⁵ <https://healthcostinstitute.org/out-of-network-billing/how-often-do-providers-bill-out-of-network>

⁶ <https://www.dol.gov/general/topic/health-plans/erisa>

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?

Colorado

Colorado passed [legislation](#) that protects patients from surprise bills from out-of-network emergency care providers. The legislation also prohibits surprise bills from care visits in an in-network facility where the patient unknowingly receives out-of-network care. The law prohibits all balance billing, sets payment rates for specific services, and utilizes an arbitration process to settle payment disputes. Providers also must notify patients about when they can and cannot receive a balance bill. Colorado's legislation is comprehensive and protect patients from balance bills, while also appeasing providers and payers.⁷

New Mexico

New Mexico passed [legislation](#) removes prior authorization requirements for emergency care services and also mandates that insurers pay for out-of-network emergency care required to stabilize the patient. Insurers also must reimburse providers for out-of-network care at in-patient facilities. If a patient seeks nonemergency care from an out-of-network provider, the provider must tell the patient that they will be liable for the cost of the services. Health care facilities must also communicate information about patient rights.⁸

Texas

In Texas, [legislation](#) passed protect individuals with state-sponsored plans; these patients cannot receive any balance bill from both emergency and nonemergency care services. Like Colorado, the legislation uses an arbitration process for providers and insurers to negotiate fair reimbursement rates while removing the patient from the equation. Providers must notify patients when they can and cannot receive a balance bill, depending on the provider's network status. Insurers must pay out-of-network providers reimbursement rates based on

Colorado



- Prohibits surprise bills from in-network facility where patient receives out-of-network care
- Uses arbitration for providers and insurers to determine payment

New Mexico



- Removes prior authorization for emergency services
- Insurers must pay for out-of-network emergency care
- Facilities must notify patients of out-of-network care

Texas



- Prohibits surprise bills for individuals with state-sponsored plans
- Uses arbitration for providers and insurers to determine payment

⁷ <https://essentialhospitals.org/policy/four-states-start-2020-new-surprise-billing-laws/>

⁸ <https://essentialhospitals.org/policy/four-states-start-2020-new-surprise-billing-laws/>

similar services in a defined geographic location. Texas' legislation protects patients, while also allowing for reasonable negotiation between insurers and providers.⁹

Determining a fair and reasonable out-of-network rate

Some proposals to address surprise billing do so by proposing a pre-determined rate formula to apply in specific situations. Doing so should keep the patient in mind first, while also preventing additional system costs.

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?

There is little to no consensus on this question. 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.

Current federal legislation

The House and Senate have drafted varying forms of surprise medical bill legislation. In December 2019, the Senate collaborated on a compromise proposal focused on surprise medical bills. In February 2020, the House Education and Labor Committee approved the [Ban Surprise Billing Act](#). Also, the House Ways and Means Committee passed the [Consumer Protects Against Surprise Medical Bills Act](#). Congress agrees that surprise

⁹ <https://essentialhospitals.org/policy/four-states-start-2020-new-surprise-billing-laws/>

medical bills must be addressed. Different proposals address payment standards, dispute resolution, and ambulance services. The Ways Mand Means Committee proposal opts for voluntary negotiations between insurers and providers, while the Education and Labor Committee proposal favors a median in-network rate for reimbursement. The proposals also vary in arbitration requirements and regulations.¹⁰

The Trump Administration has been [vocal](#) on surprise medical bills. As Congress [grapples](#) with policy solutions to address surprise billing, the COVID-19 pandemic has pushed current legislation aside.

	E&C / HELP / E&L	W&M
PROHIBITS SURPRISE MEDICAL BILLS & BALANCE BILLING FOR OON SERVICES	YES	YES
ESTABLISHES A BENCHMARK FOR REIMBURSEMENT OF OON SERVICES	YES – MEDIAN IN-NETWORK RATE	NO
ALLOWS AN ARBITRATION PROCESS TO SETTLE OON SERVICE REIMBURSEMENT	YES – IF SERVICES MEET A \$750 THRESHOLD	YES – NO THRESHOLD

*For predominantly EMS, as well as certain non-EMS post-stabilization.



COVID-19’s impact on surprise billing

Given the current COVID-19 crisis, patients worry over surprise medical bills for both testing and treatment of the disease. The [Families First Coronavirus Response Act](#) mandates insurers to cover coronavirus treatment and testing. However, the Act does not explicitly ban surprise billing, so patients may still receive a balance bill.¹¹ Patients may receive balance bills either directly, or indirectly, related to a coronavirus diagnosis. For example, a patient may have pneumonia in addition to coronavirus. This patient will not be responsible for cost-sharing related to COVID-19 treatment; however, this patient would be responsible for cost-sharing related to pneumonia specialty treatment. Further, the [Coronavirus Aid, Relief, and Economic Security \(CARES\) Act](#) appropriated and authorized HHS to send aid directly to providers (“Provider Relief Fund”). [The terms and conditions](#) of this funding include [a prohibition](#) on balance billing for COVID-19 testing and treatment, although it remains unclear [how well](#) this will work to protect patients. NCHC released a [letter](#) urging Congress to unequivocally ban surprise billing for testing and treatment of COVID-19 – to mitigate public health concerns that people would avoid testing or treatment.

¹⁰ <https://www.commonwealthfund.org/blog/2020/update-surprise-billing-legislation-new-bills-contain-key-differences>

¹¹ <https://www.healthaffairs.org/doi/10.1377/hblog20200330.353921/full/>