PUBLICATION

Surprise Medical Billing Gains Momentum in Washington

Authors: Sheila P. Burke
May 28, 2019

Over the last few weeks, President Trump and lawmakers in both the House and Senate have taken several steps to protect patients from surprise medical bills, the latest signs of bipartisan momentum to address the issue this year. On May 9, the White House held a summit on surprise medical bills and released principles for a solution. On May 14, House Energy & Commerce (E&C) Committee Chairman Frank Pallone (D-NJ) and Ranking Member Greg Walden (R-OR) released the *No Surprises Act*. On May 16, a bipartisan working group led by Senators Bill Cassidy (R-LA) and Maggie Hassan (D-NH) released the *STOP Surprise Medical Bills Act*, building off their work last fall. Last week, the Senate Health, Education, Labor and Pensions (HELP) Committee released the *Lower Health Care Costs Act*, including approaches to end surprise medical bills. In addition, the House Ways and Means Health Subcommittee held a hearing on surprise medical bills featuring testimony from industry experts.

Background

Surprise medical bills describe charges that arise when an insured patient unintentionally receives care from an out-of-network provider, usually in situations that they cannot reasonably avoid. Studies suggest that roughly one in seven insured patients receive a surprise medical bill per year. These instances typically involve emergency care, when the patient is unable to select the emergency room, treating physicians, or ambulance providers. Surprise medical bills can also occur when patients seek elective care at an in-network facility if the patient receives care from treating physicians (e.g., anesthesiologists, radiologists, pathologists, surgical assistants, etc.) who are not in the same network. In these cases, surprise medical bills can include both the difference in patient cost sharing between in-network and out-of-network providers and "balance billing" from providers for the remaining charges not paid by the patient's insurer.

Surprise medical billing is not new, but in recent years, the problem has become more widespread as patient cost sharing, balanced billing practices, and narrow provider networks have all increased. While at least 25 states now have laws offering some protections against surprise medical billing, state laws vary significantly and can only govern about half of the privately insured market, which may create need for a consistent federal policy solution.

House and Senate Bipartisan Proposals

The bipartisan draft proposals generally ensure that patients only pay in-network cost sharing and deductibles for surprise medical bills by requiring health insurers to treat out-of-network providers in these instances as in-network and by prohibiting balanced billing from providers to patients. However, the proposals take different approaches on the more contentious issue of how to resolve payment between the insurer and the out-of-network provider.

- **House E&C Committee:** Chairman Pallone and Ranking Member Walden's proposal establishes a **benchmark payment rate**. The proposal would require insurers to make a minimum payment to out-of-network providers based on the median in-network negotiated rate for the service in the local geographic area.

- For scheduled (non-emergency) care, the proposal requires providers to give patients both written and oral notice about whether their treating physicians will be out-of-network and what charges they may face. Patients must sign a consent form in order to be billed the balance for out-of-network provider charges. The legislation also prohibits balance billing from providers that a patient could not reasonably choose, such as anesthesiologists, radiologists, and pathologists.

- The House E&C Committee proposal would not override state laws on surprise medical billing for settling payments between insurers and out-of-network providers for state-regulated insurance plans.

- **Senate Working Group:** The Bipartisan Senate Working Group, which includes Senators Cassidy, Hassan, Todd Young (R-IN), Lisa Murkowski (R-AK), Michael Bennet (D-CO), and Tom Carper (D-DE), released a proposal that would also require insurers to automatically pay providers the median in-network rate for the service in the local geographic market. However, insurers or providers would have 30 days to dispute that payment amount, initiating a **"baseball-style" arbitration process**, where each party would submit their proposal for a fair price for the medical service. The Department of Health and Human Services (HHS), with input from the Department of Labor, would certify an "impartial mediator" to select one of the two price offers submitted. The losing party would pay the costs of the arbitration process for the prevailing party to help ensure that parties submit reasonable offers and do not frivolously pursue arbitration. Patients would not be involved in the arbitration process.

  - Mediators would base their decisions on the "commercially reasonable rates" in a local market (e.g., the in-network negotiated rates for that area), rather than the higher billed charges.

  - The Senate Working Group proposal includes similar transparency requirements as the House E&C draft. The legislation requires insurers and providers to notify patients of the expected cost of a service within 48 hours of requesting it and requires insurers to provide price information online.

  - The Senate Working Group proposal would preempt state laws on surprise medical billing to require all states to accept its protections for patient cost sharing, while allowing states the option of choosing between its baseball-style arbitration process or their own plans for resolving payment disputes between insurers and out-of-network providers.

- **Senate HELP Committee:** The Senate HELP Committee's draft proposal includes three options to resolve payment disputes for lawmakers to consider. The first approach would establish an **in-network guarantee**, under which in-network facilities would guarantee to patients and health plans that all practitioners at their facilities will be considered in-network. The second approach would implement a similar baseball-style arbitration process for all surprise medical bills costing more than $750; for bills below that amount, insurers would automatically pay providers the median in-network rate for the service in the local geographic area. The third option would skip the arbitration system and establish a benchmark payment rate for all surprise medical bills based on the median in-network rate for the service in the local market.

  - For all three options, the resolution of a surprise bill would apply to all self-insured employer health plans. States may choose to enact or continue in effect state laws or regulations on surprise medical billing for markets regulated by the state.

- The Senate HELP Committee proposal includes transparency requirements to ensure that providers give patients advance notice of out-of-network care and estimated costs for non-emergency care.

- The Senate HELP Committee is accepting comments on their draft proposal.

Neither the House E&C Committee nor the Senate Working Group proposals address ambulance services. Consumers frequently face high surprise medical bills from both ground and air ambulances. The Senate HELP Committee would require that bills for air ambulance trips separate the air and medical charges, so that patients and health plans can better understand the cost of emergency air transport. The House E&C Committee is currently soliciting feedback on how to address this problem.

Divided Reactions

While momentum is building in Washington to protect patients from surprise medical bills, stakeholders and policymakers remain divided on how to address payment disputes.

On one hand, doctor and hospital groups strongly prefer a dispute resolution process, such as the baseball-style arbitration process, but argue that the process should not be tied to median in-network or Medicare payment rates. After the House E&C Committee released their proposal based on a benchmark payment rate, the American Hospital Association issued a statement stating, "We strongly oppose approaches that would impose arbitrary rates on providers. Insurers should maintain comprehensive networks and this plan takes us in the opposite direction by removing incentives to contract with providers."

On the other hand, insurers and employers prefer setting benchmark payment rates compared to a dispute resolution or arbitration process. A coalition of America's Health Insurance Plans, large and small employers, and brokers issued a letter to congressional leaders asking to avoid the use of "complex, costly, and opaque arbitration processes" that can lead to higher premiums.

Of note, the Administration has indicated opposition to the use of arbitration in payment disputes and Senate HELP Committee Chairman Lamar Alexander (R-TN) has stated concerns with that approach, which may influence how Congress proceeds on the issue.

Next Steps

Lawmakers intend to move quickly on passing bipartisan surprise medical billing legislation and appear open to further negotiations. House E&C Ranking Member Walden has stated that "all the tools are still in the toolbox" and that he hopes the House and Senate can reach a compromise agreement soon. Senator Cassidy announced additional cosponsors for the STOP Surprise Medical Billing Act, including Senators Kevin Cramer (R-ND), Ben Cardin (D-MD), John Kennedy (R-LA), Bob Casey (D-PA), Joni Ernst (R-IA), and Sheldon Whitehouse (D-RI). Senate HELP Committee Chairman Alexander plans to markup legislation this summer and seeks to pass a bill in Congress by July.

We will continue to monitor and provide updates on surprise medical billing as lawmakers move forward in their considerations.