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No Surprise, Congress Focuses on Surprise Billing

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As political pressure to address health care costs continues to rise, Congress has increased its focus and attention on unexpected charges from out-of-network (OON) providers, or what has become known as "surprise" medical bills. This issue arises, for example, when patients visit a hospital or facility in their insurer's or health plan's network but are seen by a provider practicing at the facility (e.g., a physician) who is not contracted with the insurer or plan (i.e., is OON). The hospital may bill at the in-network rate the patient expects to see, but the OON physician may separately bill an amount that well exceeds what the patient would have been charged by an in-network provider.

According to a Brookings Institution report, one in five emergency department visits to an in-network facility involve an OON physician, and nearly 10 percent of scheduled hospital stays at an in-network facility lead to a surprise bill. *The New York Times* has reported that patients subject to surprise bills often face out-of-pocket (OOP) costs in the hundreds of thousands of dollars. State legislatures have been active in addressing surprise billing, with several states adding comprehensive patient protections in recent years even while debate heats up at the federal level.

As a result of growing patient OOP costs and financial liability, surprise billing has been subject to considerable criticism from stakeholders and on a bipartisan basis from members of Congress. For example, on February 5, 2019, a group of bipartisan senators sent a letter to insurers and providers asking questions about balance billing. The White House has also voiced support for dealing with surprise medical bills. Despite widespread agreement among policymakers that surprise billing must be addressed, consensus has yet to emerge on the best approach. Legislators have introduced various bills with differing mechanisms to protect patients and shift responsibility to providers and payers.

Key distinctions among current proposals indicate potential challenges in reaching consensus on a bill that can get to the President's desk. For example, some proposals call for the use of arbitration to determine how much insurers and plans must pay OON providers, while others use a predetermined reimbursement rate or method.

In light of the significant focus on surprise billing and the impact on patients, Congress will likely take action in 2019, but a clear policy solution has not yet emerged. This leaves open the question of how any final legislative action may impact payers (insurers and health plans), providers, and patients.

White House Position on Surprise Billing

On May 9, 2019, the White House issued principles for any effort to address the issue of surprise billing. The principles include:

- Patients receiving emergency care should not be forced to shoulder extra costs billed by a care provider but not covered by their insurer.
- Patients receiving scheduled care should have information about whether providers are in or out of their network and what costs they may face.
- Patients should not receive surprise bills from OON providers they did not choose.
- Federal health care expenditure should not increase.

The White House has expressed its preference that surprise billing issues not be resolved through arbitration. On a call with reporters, a senior White House official stated that the White House does "not have a lot of enthusiasm for arbitration. We believe that that would be disruptive."

Legislative Activity in the 116th Congress

Multiple bills have been introduced or released in draft form, all of which generally adhere to the principle that patients should not be subject to surprise bills resulting from emergency care or OON providers they have not chosen to see. Most legislation also includes provisions related to improving transparency for network status and possible OON charges. The variety of legislative proposals highlight the myriad ways the surprise billing issue could be addressed. The proposals tend to include the following major categories:

- Prohibit balance billing in certain situations (e.g., emergency care, services provided at an in-network facility by an OON provider).
- Limit patient cost-sharing liability to a predetermined rate (e.g., in-network rate).
- Limit provider reimbursement to a predetermined rate (e.g., in-network rate, geographic median in-network rate for the geographic area, or a percentage of the Medicare rate) or a rate resulting from a specified process.
- Apply penalties to providers (in some cases the insurer or health plan) for surprise billing.

Primary differences across the legislative proposals include:

- The situations in which a patient would be protected from surprise billing, including the transparency and notice requirements to educate patients about a provider's network status.
- The methodology for establishing the appropriate reimbursement rate for OON services.
- The dispute resolution process between insurers/health plans and providers, including whether arbitration is available.
- The plans surprise billing policies would apply to.
- Interaction of federal and state law.

Comparison of Legislative Proposals Addressing Surprise Medical Billing

The following table provides a high-level summary of three bipartisan proposals addressing the issue of surprise medical bills:

- A discussion draft of the No Surprises Act, released on May 13, 2019, by House Energy and Commerce Committee Chairman Frank Pallone (D-NJ) and Ranking Member Greg Walden (R-OR).
- The Stopping the Outrageous Practice (STOP) of Surprise Medical Bills Act of 2019 (S. 1531), introduced on May 16, 2019, by Senators Bill Cassidy (R-LA), Michael Bennet (D-CO), Todd Young (R-IN), Maggie Hassan (D-NH), Lisa Murkowski (R-AK), and Tom Carper (D-DE).
- A discussion draft of the Lower Health Care Costs Act of 2019, released on May 23, 2019, by Senate Health, Education, Labor & Pensions (HELP) Committee Chairman Lamar Alexander (R-TN) and Ranking Member Patty Murray (D-WA).

Please note that the table is a summary only and does not include full details of the various provisions. Some provisions may be further clarified as the legislative process progresses. These bills may serve as the foundation for further congressional action to address surprise billing. Note that there are additional proposals are also being developed.

	No Surprises Act (House E&C Discussion Draft)	STOP Surprise Medical Bills Act (S. 1531)	Lower Health Care Costs Act (Senate HELP Discussion Draft)
Applicability[1]	Generally intended to apply to group health plans and health insurance issuers in connection with group or individual coverage. Generally would not apply to short-term, limited duration insurance or excepted benefits.	Same as the No Surprises Act.	Same as the No Surprises Act.
Emergency Services	• *Enrollees* are responsible for in-network cost-sharing in the form of a copayment or coinsurance. • *Providers* may not balance bill the enrollee. Providers may be subject to a civil penalty if they balance bill. • *Health plan/insurer* must count cost-sharing paid by the enrollee toward any deductible or OOP max. • *Health plan/insurer* must pay the OON provider the "recognized amount" for the services (see below).	Similar approach as the No Surprises Act, but the amount the *health plan/insurer* has to pay the provider is determined differently (see below). The normal Public Health Service Act (PHSA) civil penalties apply (i.e., $100 per violation per day) to a provider or health plan/insurer that balance bills.	Similar approach as the No Surprises Act, except that health plans/insurers can only impose the in-network *deductible*, copayment, and/or coinsurance on enrollees, and the amount that the health plan/insurer has to pay the provider is determined differently. The bill summary indicates that the intent is that the deductible paid by the enrollee counts toward the OOP max. Providers that balance bill are subject to a fine of $10,000.

[1] Note that technical changes may be needed in some cases to incorporate provisions into ERISA and the Internal Revenue Code, as appears to be the intent.

	No Surprises Act (House E&C Discussion Draft)	STOP Surprise Medical Bills Act (S. 1531)	Lower Health Care Costs Act (Senate HELP Discussion Draft)
Non-Emergency Services Provided by OON Provider	• Similar to emergency services approach **except** that *providers* may balance bill patients if the individual consents to the OON services. In order for a consent to be valid, the provider must comply with detailed notice requirements, including providing both written and oral notices that state the provider is OON and include an estimate of charges. • The consent exception does not apply to "facility-based providers," meaning emergency medicine providers, anesthesiologists, pathologists, neonatologists, assistant surgeons, hospitalists, intensivists, and other providers as determined by the Sec. of HHS. • Civil penalties may be imposed on providers that improperly balance bill.	Same as treatment of OON emergency services, including prohibition on balance billing and calculation of the amount the *health plan/insurer* has to pay.	• *Enrollees* are responsible for in-network copayments, coinsurance, and deductible. • *Providers* may not balance bill the enrollees, subject to a $10,000 fine. • *Health plan/insurer* must count amounts paid by the enrollee toward the in-network deductible and OOP max. • *Health plan/insurer* must pay the provider the amount as determined under the proposal.
Additional OON Provider Services Following Emergency Care	No special rule. The provisions for general non-emergency services could potentially apply (see above).	• In general, if the patient enters a hospital for emergency services and then receives required nonemergency services after the enrollee has been stabilized, the same emergency services rules apply. • However, the protections of the bill do not apply if the enrollee has been stabilized and is able to travel in a nonmedical transport, has been provided notice of OON charges, and assumed in writing full responsibility for OOP expenses for the OON care.	Generally similar to S. 1351. If the patient is stabilized following the emergency services and consents after receiving specified notice, then the patient is responsible for OON co-payments for the non-emergency services and can be balance billed by the provider.
Ambulances/ Air Ambulances	No provision.	No provision.	Requires emergency air ambulance providers to separately state the amount of charges for medical care and air travel.

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Health Plan/ Insurer Payment Amount	Health plan/insurer must pay the provider the "recognized amount," which is either: • The amount provided under applicable state law (which generally would not apply to self-funded plans under ERISA); or • The "median contracted rate"; in general, this is the median in-network rate recognized by the plan for the service in the same geographic area. Further detail on calculating the median contracted rate is to be provided in regulations. Note, there is no arbitration available under this legislation.	The amount the health plan/insurer has to pay the OON provider is subject to a binding independent dispute resolution (IDR) process between the provider and plan/insurer. • The plan/insurer must automatically pay the provider the median in-network rate under the plan. • The provider has 30 days to initiate the IDR process, which is "baseball style": the parties submit one final offer and the IDR reviewer picks one, and the losing party pays the prevailing party's costs. • When making its determination, the IDR reviewer is to consider commercially reasonable rates (based on in-network rates) for the geographic area and other factors submitted by the parties. • The cost of the IDR process is treated as a claims cost for medical loss ratio (MLR) purposes in the group market.	The draft includes three different options for payment resolution between the provider and health plan/insurer. The HELP Committee is expected to choose one of these three options when the bill is introduced. **Option 1: In-Network Guarantee** In-network guarantee for OON professionals at in-network facilities: • Health plans/insurers may not contract with a health care facility unless (1) each health care practitioner at the facility is also an in-network provider; and (2) all lab/diagnostic services provided in the facility are in-network and all referrals for such services by the facility are to in-network providers. • Providers may elect to be considered in-network for purposes of this provision if they agree to be paid through the facility and agree not to balance bill the enrollee. **OON emergency services:** • The plan/insurer and the provider have 30 days to reach agreement on the amount to be paid for the services. If no agreement is reached, the plan/insurer must pay the median contracted rate for the same geographic area. Note, in the case of OON non-emergency services provided after emergency care and after the patient has been stabilized, the amount the plan/insurer must pay appears to be determined under either Option 2 or Option 3 (unless the patient has consented to pay the OON charges, in which case the provider may balance bill). **Option 2: IDR** • The IDR process would apply to claims exceeding $750 (indexed). For claims of $750 or less, the plan/insurer would be required to pay the provider the median contracted rate. • If the parties do not settle the claim through the IDR process, the dispute is settled through arbitration similar to S. 1531. **Option 3: Benchmark Payment** • Plan/insurer must pay the "median contracted rate" developed pursuant to HHS regulations.
Interaction with State Law	States may set their own payment standards for plans regulated by the state (which would generally not include self-funded plans subject to ERISA).	The ability of states to enact greater patient protections is specifically preserved. In the case of fully insured plans, a state may establish its own methodology for resolution of provider compensation for surprise medical bills as long as the patient protections of the bill apply.	Notwithstanding ERISA preemption, a state may adopt its own method for determining the appropriate compensation for services addressed in the bill. In the absence of a state method, the provisions of the bill apply. The provisions of the bill apply to self-insured group health plans that are not subject to state regulation.

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Transparency and Reporting	No provision.	Includes a number of provisions relating to transparency, including: • Plans/insurers must notify in-network providers of new products the provider would be eligible for. • Plans/insurers must include information on deductibles and OOP maximums on the plan or insurance identification card. • Plans/insurers cannot contract with a provider unless the provider agrees to provide enrollees with certain information about cost-sharing for a particular health care service. • Certain requirements for hospitals. • Annual reporting for plans/insurers of detailed information about claims.	Includes a number of provisions relating to transparency, including: **Price and quality transparency:** • Bans gag clauses in contracts between providers and health plans that prevent enrollees, plan sponsors, or referring providers from seeing cost and quality data on providers. • Bans gag clauses in contracts between providers and health insurance plans that prevent plan sponsors from accessing de-identified claims data that could be shared, under HIPAA business associate agreements, with third parties for plan administration and quality-improvement purposes. **Anticompetitive provider contract terms:** Prohibits health plans/insurers from entering into contracts with providers that: • Restrict the plan/insurer from directing or incentivizing patients to use specific providers and facilities with higher quality and lower prices. • Require the plan/insurer to contract with all providers in a particular system or none of them. • Contain "most-favored-nation" clauses that restrict other plans/insurers not a party to the contract from paying a lower rate for items or services than the contracting plan/insurer. Prohibits self-funded plans from entering into an agreement with a provider or provider network if the agreement, directly or indirectly, requires the plan to agree to terms of contracts that the plan is not a party to and cannot review. This provision is aimed at agreements that may conceal anticompetitive contracting terms. **Provider directories:** Plans/insurers are required to have up-to-date network provider directories, which are to be available online or within 24 hours of an inquiry. The enrollee is required to pay only the in-network amount if they demonstrate they received incorrect information from the plan/insurer. **Pharmacy benefit management (PBM) oversight:** • Requires that plan sponsors receive a quarterly report on the costs, fees, and rebate information associated with their PBM contracts. • Prohibits plans/insurers and PBMs from charging the plan/insurer or enrollee more for a drug than the actual price paid to the pharmacy to provide the drug to the enrollee. (Intended to limit spread pricing.) • Requires the PBM to pass on 100% of any rebates or discounts to the plan sponsor. **Disclosure of direct/indirect compensation:** Amends the prohibited transaction provisions of ERISA to require health benefit brokers and consultants to disclose to group health plans any direct or indirect compensation the brokers or consultants may receive for referral of services, using a format similar to rules proposed in 2007 for health and pension plan brokers. Disclosure rules would also apply in the individual market. **Cost-sharing disclosure:** • Plans/insurers cannot contract with a provider unless the provider agrees to provide enrollees with an estimate of expected cost-sharing at the time of scheduling or not later than 48 hours after a request. • Plans/insurers must provide enrollees with an estimate of expected cost-sharing for specific services not later than 48 hours after a request.

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All-Payer Claims Database	Provides federal grants to states to provide for an all-payer claims database.	No provision.	Amends ERISA to provide for the establishment of an all-payer claims database by a nongovernmental, nonprofit entity chosen by the Sec. of Labor in consultation with the Sec. of HHS. The nonprofit entity, in compliance with current privacy and security protections, will use de-identified health care claims data from self-insured plans, Medicare, and participating states to help patients, providers, academic researchers, and plan sponsors better understand the cost and quality of care, and facilitate state-led initiatives to lower the cost of care, while prohibiting the disclosure of identifying health data or proprietary financial information. Self-funded group health plans are required to submit data if the plan is self-administered or is administered by an insurer or third-party administrator (TPA) that (1) administers benefits for more than 50,000 enrollees; and/or (2) is one of the five largest TPAs or insurer/administrators in the state as measured by the number of enrollees. Allows the creation of custom reports for employers and employee organizations seeking to utilize the database to lower health care costs. Authorizes grants to states for similar initiatives.
Other			Includes provisions related to: • Reducing the price of prescription drugs (Title II). • Improving public health (Title IV). • Improving the exchange of health information (Title V), which includes a provision that requires plans/insurers to provide certain information about claims, networks, and costs.

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