Recent Federal Legislation and Proposals on Surprise Billing

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Vizient Office of Public Policy and Government Relations

Overview

In recent years, concerns related to the practice of “surprise billing” have captured the attention of policy-makers at the state and federal level. Typically, surprise billing refers to when (privately insured) patients receive significant bills after receiving emergency care at a health care facility that was not in their insurance network or were treated at an in-network facility by an out-of-network physician. Additionally, a growing trend that is concerning policymakers is when patients receive surprise bills if their insurer deemed their emergency care unnecessary. Over the past year, both the Trump administration and bipartisan leaders in the House and Senate have begun to focus on this issue more intensely, drafting proposals and introducing policies to address surprise billing. At the time of this publication, there are currently two discussion drafts and three pieces of legislation that have been circulated and introduced, respectively.

All proposals prohibit balance billing – the practice of charging a patient the difference between the provider’s charge and what their health plan agrees to reimburse – for emergency services. All proposals also prohibit balance billing for certain non-emergency services, though which services are included vary by proposal. Most proposals (all but one) outline at least one type of reimbursement mechanism or rate for health plans and providers to follow in the event that a patient utilizes services that are covered under the balance billing prohibition. While substantially different in some ways, the goal of each proposal is to provide relief to patients who have received surprise bills by placing the responsibility for final payment between payors and providers, not the patient. An individual summary of each proposal is outlined in greater detail below.

The No Surprises Act, Rep. Frank Pallone (D-NJ) and Rep. Greg Walden (R-OR) – Discussion Draft

Released by Energy and Commerce Committee Chairman Frank Pallone (D-NJ) and Ranking Member Greg Walden (R-OR) on May 14, 2019, this discussion draft prohibits the balance billing of patients for emergency services, and requires that they only bear responsibility for paying their in-network cost sharing rate. Balance billing of patients would also be prohibited for services delivered at an in-network facility that were furnished by an out-of-network provider that a patient couldn’t reasonably be expected to choose themselves (such as an anesthesiologist, radiologist, etc.). Payments made by patients would be counted towards their deductible and out-of-pocket maximum. The prohibition of balance billing for these services would, at the start of 2021, be enforced by civil monetary penalties for providers. Providers would be able to charge patients more than their in-network rate only if they receive the patient’s consent to provide services after first alerting patients to the fact that they are out-of-network and providing them with the estimated charge for those services.

Where patients were required to only pay their in-network rate for out-of-network services, health plan payments to providers would be set at the benchmark of the in-network rate for services provided, in the geographic area in which they were furnished. The Secretary of Health and Human Services (HHS) would determine the methodology health plans would use to decide that rate. However, states that already have laws related to such payments would have the option to preserve such laws instead of using the Secretary’s

methodology. Lastly, this bill would also authorize $50 million for state grants, which would be used to establish or maintain an all payer claims database.

As a discussion draft, this proposal has not yet been formally introduced in Congress; it is expected that the Committee will continue to make changes both prior to and after introduction.

The Lower Health Care Costs Act – Sen. Lamar Alexander (R-TN) and Sen. Patty Murray (D-WA) – Discussion Draft

Released by Health, Education, Labor and Pensions (HELP) Committee Chairman Lamar Alexander (R-TN) and Ranking Member Patty Murray (D-WA) on May 23, 2019, this discussion draft would prohibit balance billing both for emergency services and for some out-of-network ancillary services, including diagnostic services, at in-network facilities.

This draft also outlines three potential payment resolution options for health plans and providers but, prior to formal introduction of the bill, the committee intends to select only one of the three options based on stakeholder feedback. These options include: 1) In-network facilities must guarantee that every practitioner will be considered in-network, and out-of-network emergency care payment will be privately determined by the provider and plan. If the amount cannot be agreed upon after 30 days, the median contracted rate for services in that geographic area will be used; 2) For surprise bills over $750, the health plan or provider can initiate a baseball-style arbitration process, wherein, once the process is started, the two parties will have either 10 days to reach a settlement or both submit final offers to the certified independent dispute resolution entity who will then choose which payment is to be used. Bills under $750 will be paid the median contracted rate for services in that geographic area; 3) The health plan will pay the provider based on the median contracted rate for services in that geographic area.

While this draft includes language on surprise billing, it also includes a number of other sections aimed at decreasing the cost of health care. These include sections related to decreasing the cost of prescription drugs, improving transparency of health care costs, and improving public health (specifically, maternal health) and health information technology. The Committee is currently accepting stakeholder feedback and preparing a draft for formal introduction. Given the bipartisan support of the Chair and the Ranking Member of this Committee, this is arguably the health care legislation most likely to advance this Congress.

S.1531, the Stopping the Outrageous Practice (STOP) of Surprise Medical Bills Act of 2019 – Sen. Bill Cassidy (R-LA)

Introduced by Sen. Bill Cassidy (R-LA) on May 16, 2019 along with a bipartisan group of senators, the STOP Surprise Medical Bills Act would prohibit balance billing for all emergency services, as well as for additional services after a patient has been stabilized after receiving emergency care. Balance billing of patients would also be prohibited for non-emergency services at an in-network facility that were furnished by an out-of-network provider, including laboratory and imaging services. Patients in these circumstances would only be required to pay the in-network rate for such services. The prohibition of balance billing in these cases would be enforced by civil monetary penalties for providers. There would be a safe harbor, however, for providers who mistakenly balanced billed a patient when they shouldn't have, as long as the provider reimburses the patient within 30 days of sending the payment.

Under this bill, health plans would be required to pay the median in-network rate for services provided for all surprise billing situations. However, if either the plan or provider disagrees with that amount, they would have 30 days to initiate an independent dispute resolution process whereby the plan and provider would submit a final offer, from which an independent arbitrator, certified by both the Secretary of HHS and the

Secretary of Labor, would choose which final offer to accept. The party whose offer was not accepted would pay the cost of the arbitration process. However, if the independent arbitrator feels that the two parties may be able to reach a settlement, they may direct them to attempt to negotiate a settlement before submitting final offers. The final decision of the independent arbitrator would be binding.

This bill also includes a number of transparency initiatives for health plans as well as providers. Health plans would be required to clearly list the in-network and out-of-network deductibles and the out-of-pocket maximum limitation on the enrollee's insurance card(s). Plans (as well as providers) would also be required to provide patients with the expected cost-sharing amounts for scheduled services when a patient schedules an appointment or within 48 hours of a patient requesting such information. Plans would further need to make the out-of-pocket costs and benefits information for services at different sites of care in their network available online. Finally, the bill would also require plans to notify its contracted providers about new insurance products that the provider would be eligible for within seven days of offering the product.

Hospitals would be required to disclose any profit-sharing relationships they have with physician groups. They would also need to include any ancillary services that were provided during the episode of care in hospital bills they send to patients.

The STOP Surprise Medical Bills Act has the support of more than 20 bipartisan Senators and has been referred to the Senate Health, Education, Labor and Pensions Committee for further consideration[1].

S.1266, the Protecting Patients from Surprise Medical Bills Act, Sen. Rick Scott (R-FL)

Introduced by Senator Rick Scott (R-FL) on May 1, 2019, this bill requires that self-insured group health plans not charge participants or beneficiaries more than the applicable copayment, coinsurance, or deductible amount for covered emergencies services. In the case of covered non-emergency services at in-network facilities where a patient did not have "the ability or opportunity" to receive services from an in-network provider, those providers are similarly not permitted to balance bill patients.

The self-insured health plan is responsible for reimbursing the health care provider for out-of-network emergency and non-emergency services based on one of the following payment methodologies: 1) the amount of the provider's claim; 2) the "usual and customary amount" the providers charges for similar services in the same community; or 3) the amount the health plan and the provider agree on – an amount that would be required to be agreed on within 60 days of the provider submitting their original claim. In cases where providers and insurers have not agreed within 60 days, the bill outlines a process of voluntary binding arbitration, whereby the provider or insurer will make an offer to the other, who will then have 15 days to respond. If the issue is still not settled, an eligible arbitrator from an eligible outside organization, as determined by the Secretary of Labor, would issue a final order to either the provider or insurer that would be more than 90 percent or less than 110 percent of the final offer amount. The party that would be required to pay this would also be required to pay the costs of arbitration.

This legislation does not currently[2] have any cosponsors but has been referred to the Senate HELP Committee for future consideration.

H.R.861, the End Surprise Billing Act, Rep. Lloyd Doggett (D-TX-35)

Introduced by Rep. Doggett (D-TX) on Jan. 30, 2019, and identical to his 2017 bill on surprise billing, this bill would require hospital providers to notify patients making a future appointment as to whether or not their

[1] As of June 12, 2019
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facility or individual providers are out-of-network. If a facility or a provider is out-of-network, providers will be required to provide written notice to patients, stating this information, at the time the appointment is made, and further obtain their signature of consent at least 24 hours before any services are furnished. This notification must state whether either the facility and/or provider the patient is seeking services from are out-of-network and, if so, the estimated amount that the provider will charge the patient in excess of their cost-sharing amount for in-network services. If the provider fails to provide the notice and obtain a signature of consent, the patient will not be balanced billed for any services provided. In the cases of same-day emergency services, the bill would similarly limit the amount patients pay to not more than their in-network cost-sharing amount (or such an amount determined by State law). As a condition of participation in Medicare, providers would need to adopt and enforce these rules.

This legislation currently[3] only has the support of Democrats in the House, but has been referred for consideration to both the House Committee on Energy and Commerce and the House Committee on Ways and Means.

Conclusion and Next Steps

Vizient is tracking the rapidly evolving legislative and regulatory efforts underway to address surprise billing. We continue to provide feedback to policymakers that while our members support the prohibition of balance billing, solutions must not pose additional regulatory burdens on providers nor should they include fixed payment rates that interfere with the ability for providers and payers to negotiate private contracts. Both of these suggested policies could have the unintended consequence of limiting access to care. Because of the broad bipartisan agreement that something must be done to protect consumers against these unexpected, often times large, bills, it is likely that Congress and the administration will reach agreement on this policy issue and that providers can expect changes ahead.

[3] As of June 12, 2019