Insight

The Deal to End Surprise Medical Bills: Federal Policymakers Finally Get to Yes

CHRISTOPHER HOLT | DECEMBER 15, 2020

Executive Summary

- Late last week, after years of deadlock, lawmakers announced an agreement on draft legislation to end surprise medical bills (SMBs). The legislative language could be included in the government funding package Congress is expected to pass later this week, although discussions are ongoing.
- The No Surprises Act addresses the most crucial objective of lawmakers: protecting patients from unexpected, out-of-network medical bills. On this point the proposal is in line with most previous congressional proposals as well as state laws addressing SMBs. Under this proposal patients would no longer have to worry about SMBs.
- On the three major points of dispute between lawmakers prior to reaching agreement on the No Surprises Act—whether to require an interim payment prior to entering an independent dispute resolution process (IDRP), the criteria for deciding payment as part of IDRP, and whether to include a dollar threshold for claims to be eligible for IDRP—the legislation moves toward the positions favored by provider groups.

Introduction

Late last week, the House Committees on Ways and Means (W&M), Energy and Commerce (E&C), and Education and Labor (Ed & Labor), along with the Senate Health, Education, Labor and Pensions (HELP) Committee, collectively announced an agreement on draft legislative text to end surprise medical bills (SMBs).

The issue of SMBs has been on federal policymakers' radar for several years. Now, after years of deadlock and negotiation, a compromise on SMBs could be included in a legislative package providing government funding and additional COVID-19 relief later this week.

In recent years, as Congress has struggled to reach consensus, 31 states—most recently Michigan—have enacted some level of SMB protections for patients, and a number of states including Ohio and Pennsylvania are debating new legislation. As detailed in recent American Action Forum research, broad consensus has emerged in the various state approaches.[1] States have widely agreed that patients should be protected from SMBs, and three-fifths of states have undertaken measures to do so. Additionally, over two-thirds of states that regulate SMBs mediate payment disputes between payers and providers for out-of-network (OON) services. Finally, more than half of the states regulating SMBs have included an independent dispute resolution process (IDRP) as part of their approach, including most states that enacted SMB laws within the last year.

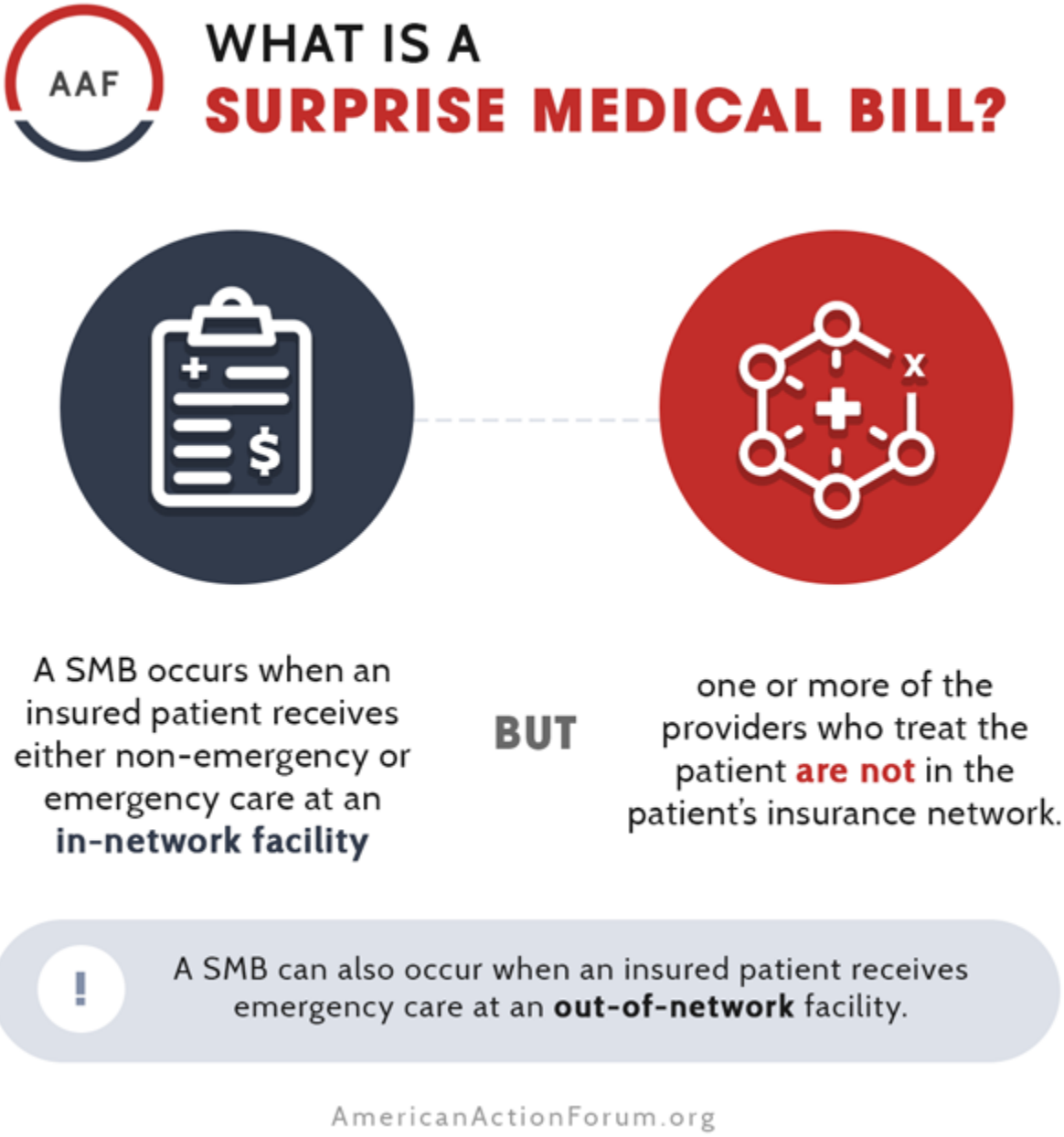
Unsurprisingly, federal policymakers have settled on an approach that mirrors those of most states. Under the agreement—the "No Surprises Act"—patients will be removed from payment disputes between providers and insurers, balance billing will be prohibited, and there will be an IDRP to resolve disputes. Federal action is

necessary because existing federal law means that state laws cannot protect patients in employer-sponsored insurance (ESI) plans from SMBs.

Background

What Is a Surprise Medical Bill?

A SMB occurs when an insured patient receives either non-emergency or emergency care at an in-network facility, but one or more of the providers who treat the patient are not in the patient's insurance network. Alternatively, a SMB can occur when an insured patient receives emergency care at an OON facility. In these instances, providers can and often do bill the patient for the difference between their charged rate and what the insurer agrees to pay. This is what is known as "balance billing." While in-network providers agree to accept a negotiated rate from the insurer for their services, OON providers are not similarly limited.



The Employee Retirement Income Security Act of 1974

While states have stepped into the gap and sought to provide patients with protections from SMBs, states cannot apply those protections to all their residents. The Employee Retirement Income Security Act of 1974 (ERISA) preempts state regulation of the self-insured health plans typically run by large employers, and as a result only the federal government can regulate SMBs in the context of self-insured plans. Thus, notwithstanding any state actions, the problem of SMBs cannot be fully addressed without federal action.

The Surprise Medical Bills Debate in the 116th Congress

The debate over SMB legislation has occurred largely out of public view as members and staff have sought to reach consensus between the various proposals introduced during the 116th Congress.

In December 2019, HELP and E&C Chairmen Alexander and Pallone, along with E&C Ranking Member Walden, announced a bipartisan, bicameral agreement on SMBs.[2] Legislative text of the agreement, however, was never released and the effort fell short amid opposition from hospitals and some provider groups as well as an announcement by W&M Chairman Neal and Ranking Member Brady that they would be releasing their own proposal. Their legislation, the Consumer Protections Against Surprise Medical Bills Act of 2020 (H.R. 5826), was ultimately released the following February.[3]

Also in February 2020, Ed & Labor Chairman Scott and Ranking Member Foxx introduced their own SMB legislation.[4] Though Scott and Foxx did not endorse the compromise package the previous December, they were involved in those discussions, and both E&C and HELP Committee leadership signaled support for the Ed & Labor bill when it was released.[5]

Since that time members and staff have been busy behind the scenes working toward a deal. Over the summer HELP, Ed & Labor, and E&C leaders engaged with Senator Bill Cassidy—a long-time proponent of SMB legislation—who ultimately endorsed a revised version of Ed & Labor's Ban Surprise Billing Act (H.R. 5800) in an October op-ed with HELP Chairman Alexander.[6] While text of that agreement was never made public, it is widely understood to have been a version of the Ed & Labor bill with additions and alterations drawn from Senator Cassidy's STOP Surprise Medical Bills Act (S. 1531). Until the agreement on the No Surprises Act was struck last week, supporters of the compromise package and W&M's leadership had been unable to reconcile their proposals.

The congressional debate over SMBs is a rarity in this day of ultra-partisanship, in that the disagreement is neither partisan in nature nor a matter of cross-chamber differences. In general, insurers have supported the tri-committee/Cassidy package, while hospitals and physicians have leaned toward the W&M bill. While it is unlikely that either side will be happy with every aspect of the No Surprises Act, the proposal appears to be a good-faith effort on the part of lawmakers to bridge the gap, although it moves toward providers' positions on several issues.

Summary of the No Surprises Act[7]

Balance Billing and Out-of-Network Charges

As with H.R. 5800, S. 1531, and H.R. 5826, the draft text of the No Surprises Act prohibits physicians and facilities from balance billing patients for the difference between in-network cost-sharing and the billed charges. The legislation would limit patient liability for emergency medical services at OON facilities to their in-network deductible and cost-sharing. Similarly, patients who receive medical care from an OON provider at an in-network facility would also have their costs limited to in-network rates. The legislation would also clarify that OON services rendered in accordance with the above provisions must be counted toward the patient's in-network deductible.

OON providers would only be allowed to balance bill patients in cases where the provider gave notice at least 72 hours in advance of delivering care that it would be considered OON, gave the patient an estimate of the

charges that they would incur, and the patient consented to receive OON treatment.

Insurer Requirements

Under the agreement, insurers would be required to print information about deductibles, cost-sharing, and maximum out-of-pocket limits on insurance cards. Health plans would have to keep their provider directories up to date regarding the current network status of physicians, and if patients seek care from an OON provider based on information that has not been properly updated, the care is treated as in-network for the patient. Plans would also be expected to give patients an Advanced Explanation of Benefits for scheduled procedures at least three days prior to the service being rendered, detailing which specific providers are scheduled, their network status, and expected costs to the patient.

Patients with ongoing medical treatments receive a 90-day transition period if their providers leave their insurance network, during which time they can continue to receive care from their existing providers as if still in-network.

Last, insurers would have to offer online price comparison tools so that patients can compare costs between in-network providers, and insurers must resolve bills from providers within 30 days of receiving them.

Provider Requirements

Like insurers, providers and facilities would be expected to verify the patient's insurance coverage three days in advance of a scheduled service and to provide a good-faith estimate of the patient's expected cost. Providers are required to deliver patients a list of all services rendered within 15 days of the visit or of discharge from a facility. Facilities and physicians are required to submit bills to insurers within 30 days of rendering service and must submit any bills to the patients for their share of the resolved bill within 30 days of receiving payment from the insurer. Patients will not be responsible for bills received more than 90 days after receipt of care, and patients have 45 days from the postmark of a bill to make their payment—something the American Hospital Association (AHA) objected to in a letter over the weekend, arguing that delayed payments from insurers could result in providers missing this deadline through no fault of their own.[8] All of these timelines are extended, however, if there is an ongoing payment dispute still being resolved between the provider and insurer.

Last, the Secretary of the Department of Health and Human Services (HHS) is also directed to establish a dispute resolution process for payment disputes between providers and patients without insurance coverage.

Interim Payments

One of the more significant areas of disagreement between policymakers as well as insurers and providers has been over whether the government should establish a mandated interim payment prior to the parties appealing to arbitration, and if so, how that payment should be set. In what appears to be an attempt at compromise, the No Surprises Act does require that insurers make an initial payment within 30 days, but it does not establish any minimum amount for that payment.

Payment Dispute Resolution

The primary feature of the No Surprises Act is its IDRP. Under the legislation, if a provider and insurer disagree over an OON payment either party can initiate IDRP. There is no minimum threshold for the dollar amount of

the disputed charges, and the legislation would allow claims between the same provider[9] and insurer for similar services to be batched together for a single IDRP. Both parties would, however, be required to first engage in a 30-day negotiation period to try to resolve their dispute prior to the beginning of the IDRP.

The IDRP would be final offer, or baseball-style, arbitration, where both parties propose what they believe to be an appropriate payment and the mediator selects between the two offers. The legislation requires the IDRP mediator to consider the median in-network rate for similar services in the same geographic region, the provider's education and experience, patient acuity and case complexity, a facility's status as a teaching hospital as well as its case mix and scope of service, previous good-faith efforts by either party to contract with the other, and any previously contracted rates between the parties in the previous four years. The mediator would be allowed to request additional information it deems necessary, and either party may submit additional justification for their offers as it sees fit.

The party that initiates the IDRP would be prohibited from initiating additional IDRPs for the same service against the same party for 90 days. Claims occurring within that 90-day period would still be eligible for IDRP when the 90-day moratorium lapses, however. There is some confusion over what would happen to claims for services provided after IDRP had been triggered but before the 90-day cooling off period under the current legislative text. It is possible some claims could be barred from IDRP as currently drafted, though that does not seem to be the authors' intent.

Air and Ground Ambulance Services

The No Surprises Act would apply all of the above patient protections to instances where air ambulance services are rendered—protecting patients from one form of especially expensive SMBs—and would establish a parallel IDRP to resolve disputes between providers and insurers over appropriate payments. It would also establish an advisory committee on air ambulance quality and safety and require providers to submit two years of cost data to the Secretaries of HHS and the Department of Transportation. Insurers would provide two years of claims data to HHS, and both departments would publish a report on the data.

The legislation would also establish an advisory committee to report on options for protecting patients from surprise ground ambulance charges and improving disclosure of charges and fees for ground ambulance services.

Reports and Other Provisions

The No Surprises Act would direct federal agencies to produce a number of reports. HHS would, in consultation with the Federal Trade Commission and the Department of Justice, provide annual reports beginning no later than January 2023, and continuing for four years, on the impacts of the Act's provisions. The Government Accountability Office would also produce two reports to Congress, one on the impact of the Act's SMB provisions and another on its impact on provider network adequacy.

The Affordable Care Act amended the Public Health Services Act to prohibit health insurers from discriminating against providers "with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law."[10] The provision explicitly does not require insurers to contract with any willing provider, nor does it prohibit plans from "establishing varying reimbursement rates." HHS has indicated previously that it does not intend to issue rulemaking regarding this provision, calling it "self-implementing." The No Surprises Act would require HHS to issue rulemaking with regard to this provision within six months of enactment.

The legislation also includes extensions of mandatory funding for community health centers, the National Health Service Corps, graduate medical education, and the Special Diabetes Programs for Indians and for Type I Diabetes, all at current levels for fiscal years 2021 through 2024.

The Congressional Budget Office Analysis

In an estimate of the budgetary effects of H.R. 5826, the Congressional Budget Office (CBO) found that legislation would reduce the federal deficit by $17.8 billion over 10 years, while an analysis of H.R. 5800 projected deficit reduction of $23.9 billion.[11], [12] According to CBO, the reduction in outlays would derive primarily from reduced provider payments as payments to both in-network and OON providers would be expected to move toward the median-in network rate under the legislation and away from the average overall payment, which is higher generally. CBO further anticipates a potential reduction in insurance premiums of .5 to 1 percent for H.R. 5826 and of 1 percent for H.R. 5800 due to lower provider reimbursement. The bulk of the deficit reduction, however, results from increased revenue. CBO does not describe these savings in either analyses, but its earlier score of the HELP Committee's S. 1895 explains the source of revenue as coming from reductions in private health insurance premiums as well as fewer people claiming itemized medical tax deductions.[13] In other words, lower employer-sponsored health insurance premiums would lead to higher taxable employee compensation.

There is no publicly available score of the No Surprises Act at this time, but based on the provisions of the legislation—especially the way the interim payment is structured—it is likely this proposal will result in deficit reduction closer to that of H.R. 5826's $17.8 billion figure.

How the No Surprises Act Reconciles Differences Between Previous Proposals

The No Surprises Act is a compromise proposal seeking to bridge the differences between the revised, but unreleased, H.R. 5800 proposal, seen as more friendly to insurers, and the provider-backed H.R. 5826. Many of the provisions are similar if not identical between the bills, and reconciling the various reporting requirements, patient protections, and assorted other provisions of H.R. 5800, H.R 5826, and S. 1531 does not seem particularly controversial. The protections for patients are largely the same across the various proposals, reflecting widespread agreement on that point.

The most significant points of disagreement between the revised H.R. 5800 proposal and W&M's H.R. 5826 were around the requirement of an interim payment, whether to have a dollar threshold below which claims would not be eligible for IDRP, and the criteria to be used by the mediator during IDRP. In each of these areas, the No Surprises Act moves in the direction of H.R. 5826 and providers.

Interim Payment

The inclusion of an interim payment has been a consistent source of tension at both the federal and state levels when attempting to address SMBs. Having the government establish the payment rate for OON care is generally seen as the preferred solution of insurers. If OON providers are required to accept a payment that is less than what the insurer would pay to an in-network provider or below what the provider would have negotiated with the insurer, the insurer comes out ahead. Under such an arrangement the metric for setting the payment is crucially important. In cases where provider payments decrease because of the payment standard, providers will be incentivized to join networks while insurers will have more leverage in negotiating in-network rates. The opponents of this sort of rate-setting argue that insurers might be less inclined to include providers in their network if the rate is tied to the median in-network rate. By shrinking networks, insurers could drive down the median in-network rate, reducing overall physician payments further. Because of this potential to drive down in-network reimbursement, many in the provider community are opposed to using the median in-network rate as a benchmark either for interim payments or criteria for IDRP.

Some conservatives have also opposed interim payments as part of opposition to government rate setting. At the same time, supporters argue that tying payments to an existing, geographically adjusted standard is not the same as rate setting. It should be noted that not all providers see the two as necessarily synonymous. For example, in a September 2019 letter to the relevant committee chairman, the American Medical Association (AMA) opposed rate setting while at the same time calling for upfront payments to providers that were structured so as not to disincentivize provider participation in insurance networks.[14] The AMA use the language of "commercially reasonable" rates as opposed to median in-network rates, though commercially reasonable rates are not clearly defined.

Specific to H.R. 5800 and S. 1531, critics argue the inclusion of an interim payment weighted the IDRP toward the interim payment standard, in that case median in-network rates. Supporters of the interim payment in turn argue that while some large facilities and physician practices may prefer to go directly to IDRP without an interim payment, many providers, especially smaller physician practices, operate on smaller margins and may not be able to afford going without a cash payment while the dispute is litigated.

The No Surprises Act resolves this difference by requiring insurers to make an upfront payment to providers but does not set a minimum standard for that payment. Insurers can make a payment of any amount they deem appropriate, but under the proposal the provider will be able to take the claim to an IDRP if they feel the payment is inappropriate. The AHA has responded to this provision, asking that Congress require that an insurance company's offer in arbitration be the same as its interim payment, amid stated concerns that insurers could make below-market interim payments.[15] Including an interim payment without a payment standard does, however, minimize the impact of the payment requirement. It is less likely to drive down median in-network rates. A less dramatic shift toward median in-network payments is the primary reason why the No Surprises Act's savings will likely be less than that of H.R. 5800.

IDRP Threshold

An IDRP without an interim payment is often presented as the preferred solution of providers, although as previously mentioned this will vary to a degree based on provider type and size. Providers are unified, however, around the importance of making any IDRP accessible. Impediments to bringing claims are seen as neutralizing the benefits of IDRP. As a result provider groups—such as the AMA[16]—and hospitals have strongly opposed inclusion of a dollar threshold for accessing IDRP. Supporters of thresholds argue they are necessary to prevent frivolous and potentially costly abuse of IDRPs. Unlike H.R. 5800, the No Surprises Act takes the H.R. 5826 approach and does not include any threshold for accessing the IDRP. This is a clear win for providers. Over the weekend, America's Health Insurance Plans expressed strong concern the absence of a threshold would lead to

excessive utilization of IDRP.[17]

IDRP Criteria

Once the parties make it to the IDRP, the criteria for choosing between the two final offers is of critical importance. On this point the battle lines have been murkier. Some provider groups have advocated for parties to be able to bring any evidence into the IDRP for consideration while others have focused on specific criteria. In the previously mentioned September 2019 letter, the AMA lists a number of criteria that it argues should be considered as part of IDRP. Those criteria are as follows: physician training, experience and specialization, as well as quality and outcome metrics; case complexity and circumstances; commercially reasonable amounts for comparable services in the same geographic area; good-faith efforts by the provider to contract with the insurer and any previously negotiated rates between the plan and provider; the market share of both parties; and relevant economic aspects of provider reimbursement for the same specialty within the same geographic area.[18] It is worth noting that these criteria match up closely with the combined criteria of H.R. 5800 and S. 1531. Alternatively, H.R. 5826 only specifies that median-in-network rates be considered while leaving the door open to virtually any other criteria either party wants to submit—though commercially reasonable rates are explicitly prohibited from consideration.

The No Surprises Act merges the two approaches, detailing a number of specific criteria for consideration in deciding the IDRP, but also leaving both parties to the dispute free to bring in additional justification for their position. The AHA has argued for an additional prohibition on the arbiter considering rates paid by Medicare and Medicaid—which are often well below those of private payers—in the finalized text.[19]

Conclusion

The draft text of the No Surprises Act addresses the most crucial objective of congressional policymakers, protecting patients from the harm of SMBs. On this point the proposal is in line with virtually all the previous congressional proposals and state laws addressing SMBs. Under the legislation patients will no longer have to worry about SMBs. Additionally, many of the reforms around transparency and reporting included in the No Surprises Act are noncontroversial and have broad support.

A number of issues are still being litigated among lawmakers, providers, and insurers as the authors work to finalize legislative text. On the three major points of dispute between lawmakers prior to the No Surprises Act, however, the legislation moves toward W&M's position and is more favorable to provider group priorities, while insurers are likely to be unhappy that an IDRP will play the primary role in resolving payment disputes and have stated their concerns about the lack of a threshold.

As all parties continue to raise last-minute concerns with the agreement, and work on a final draft is completed, it is important to recognize that Congress has not come to this deal easily. If the No Surprises Act is not enacted, negotiations over resolving SMBs could look very different in the next Congress. Both HELP Chairman Alexander and E&C Ranking Member Walden will be leaving Congress at the end of the year, and there will be a new administration in the White House. New parties to the negotiations may not be inclined to continue negotiations from the same starting point next year.

[1] https://www.americanactionforum.org/research/state-policies-for-addressing-surprise-medical-bills/

[2] https://energycommerce.house.gov/newsroom/press-releases/bipartisan-house-and-senate-committee-leaders-announce-agreement-on

[3] https://www.politico.com/news/2020/01/16/medical-bills-congress-fix-100141

[4] https://edlabor.house.gov/media/press-releases/committee-advances-bipartisan-solution-to-ban-surprise-billing

[5] https://thehill.com/policy/healthcare/482593-house-panel-advances-bipartisan-surprise-billing-legislation-despite

[6] https://www.tennessean.com/story/opinion/2020/10/05/congressional-compromise-would-end-surprise-medical-billing/3593461001/

[7] https://republicans-waysandmeansforms.house.gov/uploadedfiles/surprisebill_text.pdf?utm_campaign=203573-211

[8] https://www.aha.org/2020-12-13-aha-letter-no-surprises-act

[9] It is not clear from the draft legislative text if only claims from a specific health provider could be batched, or if claims from multiple providers in a single physician group or practice could be batched.

[10] https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15#:~:text=PHS%20Act%20section%202706(a,who%20is%20acting%20within%20the

[11] https://www.cbo.gov/system/files/2020-02/hr5826table.pdf

[12] https://www.cbo.gov/system/files/2020-02/hr5800.pdf

[13] https://www.cbo.gov/system/files/2019-07/s1895_0.pdf

[14] https://www.acep.org/globalassets/new-pdfs/advocacy/specialty-letter-to-waysmeansedlabor—09.04.2019.pdf

[15] https://www.aha.org/2020-12-13-aha-letter-no-surprises-act

[16] https://www.acep.org/globalassets/new-pdfs/advocacy/specialty-letter-to-waysmeansedlabor—09.04.2019.pdf

[17] https://www.washingtonpost.com/politics/2020/12/14/health-202-health-insurers-balk-last-minute-deal-congress-surprise-medical-bills/

[18] https://www.acep.org/globalassets/new-pdfs/advocacy/specialty-letter-to-waysmeansedlabor—09.04.2019.pdf

[19] https://www.aha.org/2020-12-13-aha-letter-no-surprises-act