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Assessing the Legislative Responses to Surprise Billing and Other Transparency Issues

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Executive Summary

- Surprise medical bills often arise from out-of-network ancillary services provided at an in-network facility, and both the House and Senate are considering legislation to limit the occurrence of the situation.

- S. 1895 attempts to curb surprise medical bills by allowing patients to pay in-network rates unless they are given advance notice about a non-ancillary service being out of network; ancillary services are automatically charged at the in-network rate.

- While shifting costs to insurers and providers in this way would be expected to raise premiums, a study indicates that it could instead lower them by reducing the incentive for doctors to jump between networks in an effort to bargain for higher rates.

Introduction

One of the more unpleasant features of America's health care system is the existence of "surprise billing"—the unexpected cost of paying for care from a provider who is not in the network of a patient's insurance company. There are three main situations where the phenomenon of surprise billing takes place:

1. Visits to the emergency room, where a patient usually does not have a choice in providers;
2. Ancillary care services (e.g. care from an anesthesiologist) that are performed as a supplement to the primary care received during a procedure or test;
3. Ambulance services, where a transport shows up and a patient typically has no say in which hospital they go to or which provider or services they receive.

In the last few months, lawmakers have introduced various pieces of legislation seeking to reduce the existence of surprise billing. The Senate Committee on Health, Education, Labor, and Pensions (HELP) produced legislation in recent weeks to reduce the existence of surprise billing: S. 1895 or the "Lower Health Care Costs Act."[1] The House Energy and Commerce Committee is also considering similar legislation as the text for H.R. 3630—or the "No Surprises Act"—is scheduled for markup this week.[2] While S. 1895 seeks to restrain surprise billing, it goes beyond that issue, aiming to reduce the cost of drugs, increase transparency and the exchange of information in health care, and improve public health. This paper will outline and analyze how S. 1895 would seek to restrain surprise billing and increase price transparency and information exchange between providers, insurers, and patients.

Surprise Billing

As noted, surprise billing frequently occurs when ancillary care is administered to patients. Surprise bills are most troubling when patients are receiving care from an in-network facility, and are thus safe from

out-of-network charges. Therefore, S. 1895 gives particular attention to out-of-network care provided at in-network facilities.

Under S. 1895, patients receiving care at in-network hospitals would be held harmless for any ancillary care provided to them by an out-of-network provider. As a result, for any out-of-network ancillary care that patients may receive, they would only be subject to the in-network cost-sharing amount they agreed to when they purchased their insurance plan.

In the case that patients receive non-ancillary, out-of-network services at in-network facilities, the facilities must provide patients notice at least 48 hours prior to the patients receiving the service. Otherwise, the patients will only be subject to the in-network cost-sharing requirements of their insurance provider. The table below summarizes how cost-sharing works in each of the situations described above.

In-Network Facility?	In-Network Service?	Ancillary Service?	Notice?	Cost-Sharing
Yes	No	Yes	N/A	In-Network
Yes	No	No	No	In-Network
Yes	No	No	Yes	Out-of-Network

S. 1895 also provides for patients stabilized but in need of additional care after receiving emergency care at an out-of-network facility. For such patients, the facility must give them an advanced notice of any additional out-of-network care, complete with the estimated costs for patients, before that care is administered to them. The facility must also give patients alternative options for in-network care.

Finally, S. 1895 stipulates that patients receiving air ambulance services from an out-of-network provider are also only subject to the in-network cost sharing requirements of such services. The bill, however, does not address surprise bills that result from ground ambulance services.

For the cases above, when out-of-network services are performed, insurers would pay providers a median in-network rate. The median in-network rate for a particular service would be determined by the median rate that an insurer has contracted with providers for the same (or similar) service in a given geographical area. The bill gives authority to the Secretary of Health and Human Services to determine these geographical areas. An insurer may not be able to produce their own median in-network rate for a given geographical area, however, because they simply lack enough claims or have been unable to contract with any provider for such a service. In such a scenario, the insurer must use a database (i.e. a state's all-payer claims database) with sufficient information in order to produce a suitable median in-network rate.

It is at this point that the Energy and Commerce Committee's bill, H.R. 3630, deviates from S. 1895 on the issue of surprise billing. While S. 1895 uses the median in-network rates for the given year, H.R. 3630 would use median in-network rates from the year prior to the bill's enactment as a benchmark and then inflate that benchmark in subsequent years by CPI-U.

WOULD THIS LAW INCREASE PREMIUMS?

The purpose of this bill is to protect patients from expensive, surprise bills, and any bill attempting to move this risk from patients to insurers would shift costs from patients to insurers, providers, or both. S. 1895 would mandate that insurers reduce beneficiary cost-sharing for many scenarios where insurers currently provide little or no coverage. It would also soften the blow for insurers by requiring providers in such scenarios to charge rates that an insurer has already negotiated with others. Nevertheless, this bill would likely raise costs for insurers, or lower revenue for providers, or some combination of the two. Following this line of reasoning, it seems likely that the passage of this bill would put pressure on both providers and insurers to increase rates, and that consumers would see this upward pressure in the form of increased premiums or cost-sharing.

There is, however, evidence to the contrary. One study shows that a similar surprise billing law instituted in the state of New York produced in-network payment rates that were 9 percent lower than before the law was instituted.[3] The study suggested that, under the current system, physicians will often jump in and out of insurance networks in order to renegotiate higher rates with insurers. Over time, this dynamic leads to inflated in-network rates. These findings suggest that laws reducing the incentives for providers to leave networks, such as S. 1895, lead to lower in-network rates over time, thus leading to reduced premiums and cost-sharing for patients.

This bill's potential impact on the cost of health care is complicated as a result. On the one hand, there is a cost shift from patients to insurers and providers that would seem to put upward pressure on prices and premiums that patients face. On the other hand, there is a reduced incentive for providers to jump in and out of networks for the purpose of negotiating higher rates, which would put downward pressure on patient costs. The interplay of these two forces would determine how a bill such as S. 1895 would impact patients' pocketbooks. But if the interplay is similar to that in New York, then patients can be hopeful that the reduction of surprise billing could also lead to reduced premiums.

PRICE TRANSPARENCY

S. 1895 seeks to provide consumers more knowledge of the prices of health care and their in-network provider options by removing gag clauses and banning anticompetitive terms in contracts between providers and insurers, among other things.

Hospitals with large portions of market share have been known to introduce gag clauses and anticompetitive terms to contracts with insurers in order to steer patients into their facilities.[4] The bill would seek to avoid such things by prohibiting contractual agreements that would prevent patients, insurers, or providers from seeing cost and quality data on providers. S. 1895 also explicitly prohibits any hospitals from inserting anti-steering clauses in contracts with insurers; such clauses prevent insurers from encouraging their patients to seek care at facilities with better care or lower prices. The bill would exempt certain kinds of health plans from having to comply with these rules. Plans such as Health Maintenance Organizations (HMOs) and Accountable Care Organizations (ACOs) are explicitly mentioned

as being exempt. When a consumer enrolls in such plans, they know up front that they are purchasing a plan with a restrictive network.

In addition to the transparency and information exchange provisions above, S. 1895 also includes a requirement that facilities and providers send patients bills within 45 days of the service, and a requirement that insurers provide accurate and up-to-date network information to their beneficiaries.

As AAF has stated elsewhere, mandating transparency for the price of every service that insurers negotiate with providers could be counterproductive. The transparency requirements outlined by S. 1895, however, do not go that far and are much more reasonable: It makes sense that consumers purchasing a health plan would have access to all the benefits that they are purchasing, especially when it comes to the providers in their network, and what those providers charge.

CONCLUSION

Surprise medical bills require substantial resources from the recipient. Normally insurance is purchased for such events, but the problem is that surprise billing takes place in the context of an insurance contract, leaving the beneficiary exposed to something the insurance otherwise would cover. A reasonable legislative solution will move the burden of cost from the beneficiary to the insurer and provider without creating undue premium burdens or otherwise. The specifics of S. 1895 and other forthcoming proposals will no doubt be debated in the months ahead.

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[1] https://www.congress.gov/116/bills/s1895/BILLS-116s1895is.pdf
[2] https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/BILLS-116hr3630_Surpise%20Billing.pdf
[3] https://www.nber.org/papers/w23623.pdf
[4] https://www.modernhealthcare.com/government/senators-tackle-hospital-gag-clauses