WSC Policy Brief: Senators Release Draft Legislation on Out-of-Network Billing

Overview

On September 18, 2018, a bipartisan group of six Senators introduced draft legislation that would limit health care providers' ability to send patients "surprise bills" – unexpected out-of-network charges that can leave patients with substantial medical bills not covered by insurance.

The draft bill, entitled the "Protecting Patients from Surprise Medial Bills Act" would: (1) limit patient cost-sharing to the amount they would owe to an in-network provider; (2) set a payment standard regarding what insurers owe providers in these situations; and (3) prohibit providers from balance billing patients. The bill is intended to cover self-insured plans that are exempted from state laws by ERISA, and would address the two main situations in which surprise out-of-network bills frequently arise: (1) out-of-network emergency care; and (2) out-of-network care, typically from ancillary physicians, delivered at an in-network facility (e.g., a hospital or ambulatory surgical center).

The bill's sponsors – Sens. Bill Cassidy (R-LA), Michael Bennet (D-CO), Chuck Grassley (R-IA), Tom Carper (D-DE), Todd Young (R-IN), and Claire McCaskill (D-MO) – are members of the two Senate committees with primary jurisdiction over health care: The Committee on Finance and the Committee on Health, Education, Labor and Pensions. The senators are expected to formally introduce the bill at the beginning of the next Congress in January.

While this is not the first bill that has been put forth – Rep. Michelle Lujan Grisham (D-NM) introduced the "Fair Billing Act of 2017" – this proposal represents one of their Congress's most serious efforts to date.

Background

Surprise Medical Bills and Balance Billing

"Surprise medical bill" is a term commonly used to describe charges arising when an insured individual inadvertently receives care from an out-of-network provider. This situation could arise in an emergency when the patient has no ability to select the emergency room, treating physicians, or ambulance providers; or when a patient receives planned care at an in-network facility, but at least part of the care is delivered by other providers who are not in the same network.

For insured patients, the surprise medical bill can involve two components. The first component reflects the difference in patient cost-sharing between in-network and out-of-network providers. For example, in a managed care plan that provides coverage in- and out-of-network (sometimes called a PPO plan), a patient might owe 20% of allowed charges for in-network services and 40% of allowed charges for out-of-network services.

A second component of surprise medical bills is due to "balance billing." Typically, health plans negotiate fee schedules, or allowed charges, with network providers that reflect a discount from providers' full charges. Network contracts also typically prohibit providers from billing patients the difference between the allowed charge and the full charge. However, because out-of-network providers have no such contractual obligation, patients can be liable for the balance bill in addition to any cost-sharing that might otherwise apply.

An August 2018 analysis by the Kaiser Family Foundation (KFF) found that 7.7% of outpatient service days—combined outpatient services from a single day—included a claim from an out-of-network provider. Outpatient service days that included a claim from a facility provider, such as an emergency department (ED) or an outpatient hospital, were slightly more likely (9.2%) to include an out-of-network claim. Those seeking inpatient treatment for psychological reasons or substance use are most likely to receive an out-of-network claim (33.5%), followed by those seeking surgical treatment (20.3%), medical treatment (18.9%), and childbirth or newborn care (11.1%).

State Action

Policymakers at the state level have expressed concern that surprise medical bills can pose significant financial burdens and are beyond the control of patients to prevent since, by definition, they cannot choose the treating provider. Many states have taken steps to address surprising medical billing, including a handful in just the last two years: Arizona, Missouri, New Hampshire, New Jersey, and Oregon.

State Approaches to Balance Billing: A Guide to Terminology

Insurer hold harmless requirement	A requirement that insurers pay providers their billed charges or some lower amount that is acceptable to the provider.
Prohibition on provider balance billing	A requirement that out-of-network providers cannot bill insured patients beyond any allowed cost-sharing amounts.
Payment standard	A law or rule setting payment rates for out-of-network providers, such as 125 percent of the rate set by Medicare.
Dispute resolution process	An independent mediation or other process through which providers and insurers can negotiate or settle on a fair rate of payment for a claim.

New Jersey's Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act (Assembly Bill 2039) restricts the amount a provider may charge in excess of a deductible, copayment, or coinsurance amount applicable to in-network services pursuant to the covered person's health benefits plan. The bill, which was signed into law by Governor Phil Murphy on June 1, 2018, also requires health care facilities and providers to provide additional information before a non-emergency patient receives services. The bill also requires that the providers supply each patient, upon request, an estimate of fees, and requires facilities to establish public postings regarding standard charges.

However, current state laws do not apply to the roughly half of privately-insured Americans enrolled in "self-funded" health plans that are common among large employers, because the Employee Retirement Income Security Act (ERISA) precludes states from regulating these plans. The "preemption" doctrine generally allows self-funded ERISA plans operating in multiple states

to be administered in a uniform manner, and employers are provided with great latitude to design their plans free from state mandates. Self-funded ERISA plans are generally not subject to state insurance mandates because of this preemption concept and its corollary (sometimes referred to as the "Deemer Clause") since self-funded plans are generally not "deemed" to be an insurance policy subject to state insurance mandates.

Under New Jersey's surprise medical bill law, self-funded health plans may voluntarily elect to be subject to its requirements. An employer that sponsors a self-funded health plan that wishes to be subject to Assembly Bill 2039 must make an election by providing notice, on an annual basis, to the NJ Department of Banking and Insurance (DOBI) attesting to the Electing Plan's intended participation and agreement to comply with the law. New Jersey's law is the first of its kind in the country to apply (even voluntarily) to ERISA-governed plans.

Previous Federal Action

The Affordable Care Act, signed into law in 2010, requires non-grandfathered health plans, in and outside of the Marketplace, to provide coverage for out-of-network emergency care services and apply in-network levels of cost sharing for emergency services, even if the plan otherwise provides no out-of-network coverage. However, final regulations issued in 2015 clarified that this provision does not prohibit out-of-network emergency doctors, hospitals and other providers (such as ambulance services) from balance billing consumers for the amounts their health plan didn't pay.

In a May 1, 2018 clarification to the final ACA regulations, the federal government reiterated that the out-of-network rule was intended "to establish a floor on the payment amount for out-of-network emergency services" and that states are free to enact rules that allow for payment of higher amounts by plans.

Rules governing the traditional Medicare program, in place since 1989, generally limit patient exposure to balance billing, including surprise medical bills. Medicare does not allow any type of balance billing for its Part A (hospital insurance) and Part B (medical insurance) enrollees including coinsurance, deductibles, or copayments. Providers that do not participate in Medicare are limited in the amount they can balance bill patients to no more than 15% of Medicare's established fee schedule amount for the service.

The rules are somewhat different for Part C (Medicare Advantage) plans, which typically have more limited provider networks compared to traditional Medicare and which may not provide any coverage out-of-network. For emergency services, Medicare Advantage plans must apply in-network cost sharing rates even for out-of-network providers. Balance billing limits similar to those under traditional Medicare also apply. For non-emergency services, enrollees in PPO plans in surprise medical bill situations would be liable for out-of-network cost sharing, but Medicare balance billing rules would still apply, while enrollees in HMO plans might not have any coverage for non-emergency out-of-network services.

Protecting Patients from Surprise Medial Bills Act

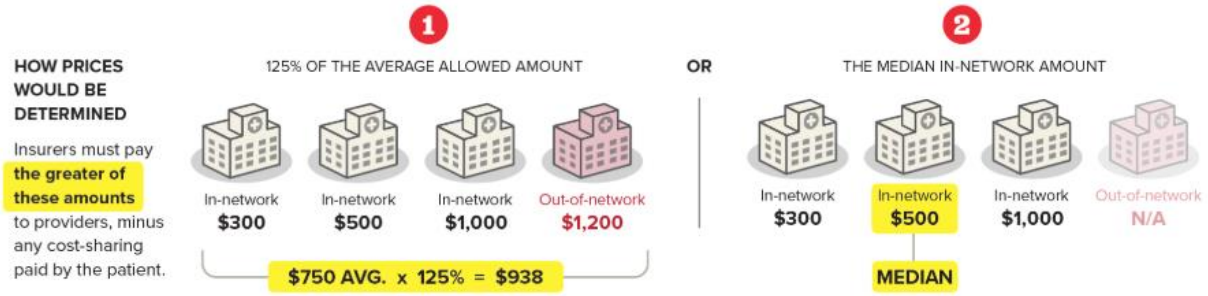
The discussion draft of the of the ***Protecting Patients from Surprise Medial Bills Act*** is intended to address three scenarios: emergency services provided by an out-of-network provider in an out-of-network facility; non-Emergency services following an emergency service from an out-of-network facility; and Non-Emergency services performed by an out-of-network provider at an in-network facility.

If enacted, the bill would: (1) limit patient cost-sharing to the amount they would owe to an in-network provider; (2) set a payment standard regarding what insurers owe providers in these situations; and (3) prohibit providers from balance billing patients. Additionally, once a patient is stabilized following emergency care at an out-of-network facility, the patient must be notified about the potential for higher cost-sharing if they remain at the current facility and provided the option to transfer to an in-network facility.

If a patient receives out-of-network emergency care or care from out-of-network providers at an in-network facility, the patient would only be required to pay the standard amount they would have owed if the service in question was performed by an in-network physician; balance billing would be prohibited. The patient's health plan would have to pay the provider an amount determined by the state (or locality) in which the service was performed. If a state does not elect a payment methodology, then the federal default would require the health plan to pay (less the patient cost-sharing) the greater of:

- 125 percent of the average allowed amount for the service in a specified geographic area, as determined by the most recent year of data available from a "statistically significant benchmarking database maintained by a nonprofit organization," such as FAIR Health, Health Care Cost Institute, or a state's all-payer claims database if administered by a nonprofit; or

- The median in-network contracted rate for the service in a specified geographic area (the draft legislation does not specify from which data this median rate would be calculated).



The out-of-network physician would have to accept this amount as payment in full. Because this current proposal would prohibit balance billing, it would effectively cap total payments to providers at a particular payment rate.

This approach is broadly similar in structure to the surprise billing laws in several states, such as Illinois, New Jersey, New Hampshire, and New York, but instead of directly prescribing a payment rate from health plan to provider, those states leave that determination up to a binding arbitration process. California and Connecticut have implemented laws that are similar to the current federal proposal, combining a regulation on the health plan to treat the "surprise" out-of-network service as in-network, a prescribed rate that the health plan must pay to the provider, and a prohibition on the provider from balance billing the patient above their standard in-network cost-sharing amounts.

The bill would also direct the HHS Secretary to conduct a study "on the prevalence of patient cost-sharing, patients' access to care and the quality of that care, the price of insurance premiums, any change in overall health care costs, the use of emergency rooms, access to new and improved drugs and technology, [and] the adequacy of insurance networks." The bill would also direct the secretary to release a public report with recommendations to Congress on how to address surprise bills.

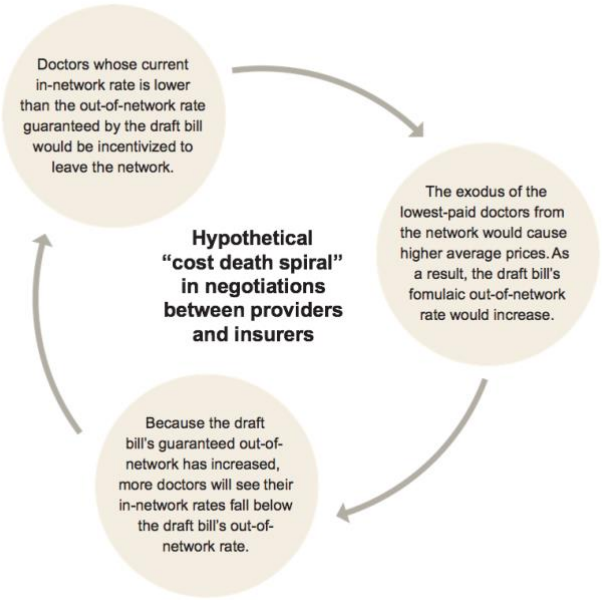
Analysis

Constructing policies to help consumers exposed to surprise medical bills is complex and involves several difficulties due to the multiple parties involved. For policies to effectively protect enrollees, they must both address what the insurer requires the enrollee to pay under the plan (e.g., the amount of cost sharing) and also would need to restrict the amount that the provider can assess as a balance bill. This can be politically controversial because it essentially sets private payment rates for the affected services.

Cost

Because the draft bill creates a guaranteed minimum rate for out-of-network providers, some analysts worry that the result could be higher prices and more doctors choosing to be out-of-network.

"I think the bill shifts negotiating power to the provider," said Loren Adler, associate director of the USC-Brookings Schaeffer Initiative for Health Policy. "In theory, you would expect some sort of very big unraveling of network negotiations."



A staffer involved in drafting the legislation said they were looking at concerns regarding how the draft bill could affect negotiation dynamics. One fix recommended by Adler would be to tie the formula to rates from a particular year, with a standard adjustment for medical cost inflation in future years. Insurers and hospitals could also possibly take matters into their own hands if out-of-network costs spiral out of control.

Insurers might refuse to contract with hospitals unless all providers in the facility are in-network. Hospitals might respond by offering doctors bonuses to stay in-network. States have different laws requiring insurers to maintain adequate providers networks, which could also affect negotiations.

"I think something would intervene," Adler said, "but I don't know exactly what that is."

Arbitration

In its comments on the proposed HHS Notice of Benefit and Payment Parameters for 2018 (CMS-9945-P), the American Hospital Association (AHA) recommended that CMS look to the National Association of Insurance Commissioners' (NAIC) Model Act #74, which offers the consumer greater financial protections from unexpected bills through a structured mediation process between the health plan and the out-of-network provider and apply a consistent policy both inside and outside of the marketplaces.

NAIC model acts do not have the force of law, but often encourage state legislative action. For example, at least twenty states had adopted the previous NAIC model act on network adequacy or similar laws for network-based health plans. In addition, federal health insurance laws and regulations sometimes cite NAIC model act standards.

Network Adequacy

Network adequacy is an evaluation of a health plan or insurer's ability to deliver the benefits it promises under its plan by providing reasonable access to a sufficient number of in-network primary care and specialty physicians. While network adequacy and balance billing are two separate issues, they are directly related because inadequate networks often result in an increase in balance billing.

The ACA requires that qualified health plans (generally sold through the health insurance marketplaces) must, "ensure a sufficient choice of providers [in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act], and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers." However, this requirement has not had an appreciable effect on balance billing; insurers have continued narrowing their networks in recent years in order to reduce costs and keep premiums downs. As networks narrow, the number of patients who inadvertently received out-of-network care has jumped at hospitals, particularly with regard to contracted physicians.

Prior to the enactment of the ACA provisions for network adequacy, the National Association of Insurance Commissioners (NAIC) offered its own Model Law #74 (see above) for network adequacy. The NAIC Model Law was considerably stricter than ACA provisions and even addressed issues such as contracting with health carriers, enforcement of network adequacy policies, and filing requirements and administration to be implemented by the states.

Other Issues

As currently drafted, the protections would apply to medical care but not to emergency transportation such as ambulances. A recent study of large employer health plan claims found that roughly half of all ambulance rides were billed out-of-network.

As written, the draft bill does not provide an exception for patients who wishes to opt in to such care and pay the extra out-of-pocket costs – a broad approach that ensures patients are financially protected in all situations, without needing to navigate complicated consent forms at in-network facilities. But some critics say this approach is overly broad, potentially preventing patients from seeing an out-of-network doctor that they're willing to pay extra for.