POLICY BRIEF
Congressional Action on Surprise Medical Bills

COMMUNITY CATALYST

Recently, federal lawmakers have begun tackling an important issue for consumers — surprise medical bills. Over the past three months congressional committees have convened meetings, collected input from stakeholders and introduced several bills:

- On the Senate side, we have seen two pieces of legislation. In May, Senator Bill Cassidy and Senator Maggie Hassan lead a bipartisan effort to tackle the issue by introducing the Stopping The Outrageous Practice of Surprise Medical Bills Act of 2019 (S.1531). A month later, the Senate Health, Education, Labor and Pensions (HELP) Committee marked up the Lower Health Care Costs Act (S.1895) (also known as the Alexander-Murray bill) that includes many provisions to address surprise medical bills.

- Similarly, there are two pieces of legislation on the House side. In June, Representative Raul Ruiz and Representative Phil Roe introduced the Protecting People From Surprise Medical Bills Act (H.R.3502). And recently, the House Energy and Commerce Committee approved the No Surprises Act (also known as the Pallone-Walden bill), as part of the Reauthorizing and Extending America's Community Health Act (H.R. 2328) (House E&C bill). During the panel's markup, an amendment (the Ruiz-Bucshon amendment) was added to create a backstop to out-of-network payment resolution.

Below is a deeper dive analysis of key measures in these pieces of legislation.

A step in the right direction on consumer protections against surprise medical bills

- ***Surprise scenarios*** - As described in our policy report, there are many scenarios where consumers are unable to secure in-network care. Among the three bills introduced so far, the Alexander-Murray bill is the strongest on consumer protections. In this bill, providers are prohibited from balance billing patients in the following situations: (1) emergency services; (2) out-of-network, ancillary or non-emergency services (including any referrals for diagnostic services) delivered at an in-network facility; (3) air ambulance transportation; and (4) out-of-network services inadvertently provided due to inaccurate provider directories. Notably, there are no protections for ground and water emergency ambulance services. The omission of ground and water emergency services will continue to be a challenge for some consumers, particularly people living in remote areas.

Surprise scenario	**Stopping The Outrageous Practice of Surprise Medical Bills Act of 2019 (Cassidy-Hassan bill)**	**Lower Health Care Costs Act (Alexander-Murray bill)**	**Protecting People From Surprise Medical Bills Act (Ruiz-Roe bill)**	**Reauthorizing and Extending America's Community Health Act (The House E&C bill)**
Emergency services	YES	YES	YES	YES
Ambulance services	NO	Protections only applied to air ambulance services.	NO	NO
Out-of-network services delivered at an in-network facility	YES	YES	YES	YES

Surprise scenario	Stopping The Outrageous Practice of Surprise Medical Bills Act of 2019 (Cassidy-Hassan bill)	Lower Health Care Costs Act (Alexander-Murray bill)	Protecting People From Surprise Medical Bills Act (Ruiz-Roe bill)	Reauthorizing and Extending America's Community Health Act (The House E&C bill)
Out-of-network services inadvertently provided due to inaccurate provider directories	NO	YES	NO	Providers and insurers are required to coordinate to keep provider directories accurate, but the bill does not explicitly state that patients are not responsible for out-of-network bills if they unknowingly rely on an inaccurate provider directory.

- ***Consumer notices*** - To limit the incidents of surprise out-of-network billing for non-emergency services, all four pieces of legislation require providers to inform patients in advance (ranging from 48 to 72 hours) of their network status and estimated cost-sharing amount. This provision is promising. However, transparency alone is not enough to protect patients from getting hit by surprise medical bills. In many cases of post-stabilization care and scheduled procedures, despite having advanced notices, a patient might not have sufficient time to make the right decision. They may also not have a way to safely travel to an in-network facility that is available within a reasonable travel time and distance.

- ***Consumer cost-sharing*** - All four legislative approaches ensure that in surprise scenarios, consumers will only be responsible for the cost-sharing amounts they would pay if they received in-network care, and that these payments count toward in-network deductibles and out-of-pocket maximums.

These consumer protections represent a robust step forward in shielding individuals and families from medical debt.

Resolution approach to out-of-network payment — a sticking point for enacting protections

To actually get consumer protections enacted, it is critical to address how out-of-network payment disputes between insurers and providers will be resolved. Currently, the situations that most often are associated with surprise balance billing stem from broken markets — both lack of effective consumer choice and provider monopoly over pricing. This results in both higher out-of-pocket costs for patients and higher health care spending overall. However, resolving payment disputes between health plans and out-of-network providers, who are prohibited from balance billing patients, is challenging.

A number of approaches have been proposed, including arbitration (or independent dispute resolution) and benchmark setting at median contracted rates.

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This chart summarizes the different approaches introduced in legislation.

Stopping The Outrageous Practice of Surprise Medical Bills Act of 2019 (Cassidy-Hassan bill)	Lower Health Care Costs Act (Alexander-Murray bill)	Protecting People From Surprise Medical Bills Act (Ruiz-Roe bill)	Reauthorizing and Extending America's Community Health Act (House E&C bill)	
			(Pallone-Walden bill)	(Ruiz-Bucshon amendment)
Automatic payment at median contracted rates. Baseball arbitration if a payment dispute is not resolved within 30 days. The arbitrator can determine a final payment based on a number of criteria including commercially reasonable rates for comparable services in the same geographic area and prior contracted rates between the two parties.	Benchmark setting at median contracted rates.	Baseball arbitration. The arbitrator can determine a final payment based on a number of criteria including the provider's usual OON charge for comparable services and usual and customary cost of service – 80th percentile of charges for comparable services in that geographic region.	Benchmark setting at median contracted rates.	For surprise medical bills that are more than $1250, out-of-network providers are paid at median contracted rates, but can appeal to an arbitrator if they are unhappy with the median contracted rate. The arbitrator can only consider the complexity of the case and the quality of care to determine the final payment rate.

Since Congress took interest in solving the problem of surprise medical bills, groups representing employers and insurance plans and medical specialty providers groups have ramped up their lobbying activities. While the former favors benchmark setting, the latter advocates for arbitration. Each approach has advantages and disadvantages. But, according to health economists, the Alexander-Murray bill that sets a benchmark at median contracted rates for surprise out-of-network services appears to be the favorable approach to partially curb provider monopoly power, thus lowering health care costs overall. According to the Congressional Budget Office (CBO), this policy would reduce commercial insurance premiums by one percent on average nationwide and decrease deficits by $25 billion over ten years.

In contrast, the arbitration approach proposed under the Cassidy-Hassan bill, the Ruiz-Roe bill and the House E&C bill would lead to much higher costs. Among the three bills that include arbitration, the Ruiz-Roe bill is the most troublesome as it uses providers' billed charges as the criteria for the arbitrator to determine the final out-of-network payment rate. Evidence show providers' billed charges are extremely high, and even median contracted rates are very high because of providers' negotiating clout. Specialists such as anesthesiologists, radiologists and pathologists, whose services most often result in surprise bills, charge four times more for their services than what Medicare pays for similar services. In addition, these billed charges are subject to arbitrary increases.

In addition, the arbitration approach typically gives too much discretion to arbitrators, which could make the process less transparent and might lead to excessively high settlements. For instance, the House E&C bill does not include a rate cap or a numerical point of reference which could open the door for manipulation if providers request arbitration. Similarly, the Cassidy-Hassan bill would direct arbitrators to the direction of selecting out-of-network payment rate in line with average contracted rates. However, the arbitrator might side with providers who historically get paid at contracted payment rates that are excessively higher than median contracted rates. Finally, there would be administrative costs added to the system — about one billion dollars according to CBO's preliminary estimation — if arbitration was used.

All the bills introduced so far meet our number one priority — some bills better than others — to keep patients unharmed by surprise medical bills. Still, there are remaining questions on how to resolve out-of-network payment disputes between insurers and providers.

Prepared by
Quynh Chi Nguyen
Policy Analyst, Community Catalyst