What You Need to Know On Surprise Medical Billing

Myth:

A benchmark approach would impose a one-size-fits-all payment structure that would disproportionately harm rural providers and hospitals while exerting downward pressure on in-network rates.

Fact:

A benchmark based on local, in-network rates would ensure provider reimbursement accurately reflects the cost of providing care in each market without impairing patient access to care.

The vast majority of providers and doctors are not bad actors when it comes to surprise billing. While 50% of hospitals have out-of-network billing rates below two percent, a recent study found that 15% of hospitals have out-of-network billing rates above 80%.

Typical provider negotiations with health plans ensure patients have access to a wide range of clinical specialists, hospitals, and doctors and that these providers are well compensated for their work. A benchmark provision would ensure patients currently subject to exorbitant surprise bills benefit from these competitive rates by addressing cases where bad actors are exploiting patients at their most vulnerable.

Research shows that in many cases a median, in-network rate would still far exceed the Medicare rate provided for the same service. For example:

- Anesthesiologists are reimbursed a median amount of 344 percent of Medicare;
- Emergency physicians' average contracted rates are 306 percent of Medicare; and,
- Radiologists' average contracted rates are 200 percent of Medicare.

There is no evidence that a fair benchmark rate would have any negative impact on the vast majority of rural hospitals.

Sources:

- https://jamanetwork.com/journals/jama/fullarticle/2598253
- https://www.nber.org/papers/w23623

Myth:

Establishing a local benchmark for out-of-network charges would pave the way for government rate setting.

Fact:

Advancing a fair benchmark rate as part of comprehensive surprise billing reforms would replicate private sector processes for establishing a market-based rate for medical care in a geographic area without having to rely on government rate-setting.

Under the current benchmarking proposal, health plans would still be responsible for using their own data to calculate rates specific to local markets, specialties, and lines of business. Importantly, these rates would only apply to providers that remain out-of-network and only in emergency situations or when out-of-network providers see patients at in-network facilities. A benchmark rate does not preclude a provider from negotiating the terms or rate of care with a health plan before care is provided.

Myth:

A benchmark would discourage health plans from contracting with providers.

Fact:

A benchmark provision will not change network adequacy requirements or market dynamics that drive health plans to offer competitive provider networks for consumers.

Provider networks are regulated at both the state and federal levels to ensure patients have a wide range of providers available in their geographic area. Health insurance plans must offer competitive terms to providers in order to offer networks that provide a value-add as part of comprehensive coverage. Employers won't contract with plans that don't have sufficient networks. Further, network adequacy requirements at the state level clearly specify the number and type of provider, specialist, and hospital that must be considered in-network for enrollees.

A benchmark provision will not change these structural market dynamics. Further, there is no reason to assert that the local in-network rate will be less than a fair market price.

Myth:

Arbitration is working in New York. A federal solution should piggyback on the reform that New York implemented.

Fact:

The situation in New York was dire before the state enacted baseball-style arbitration.

Before the passage of the New York law, health insurance providers were required to pay full usual and customary rates, which were based on total billed charges. These charges have no oversight or accountability for actual costs to provide services. It makes sense that enacting an arbitration system lowered costs relative to the unsustainable trajectory they were on.

However, for the vast majority of states that do not currently require health insurance providers to pay full usual and customary rates, a massive expansion of arbitration – which is administratively costly, convoluted, and difficult to predict – would significantly increase health care costs and raise premiums for all beneficiaries. Additionally, arbitration would have an especially egregious impact on smaller businesses that should not be forced to spend their more limited resources on lawyers and legal fees. Taking money away from providing health care and redirecting it to lawyers is inefficient and the opposite of where policymakers should be headed.

Myth:

Congress could address surprise medical billing by enacting stringent network adequacy standards.

Fact:

The experience in several states show the need for federal legislation to protect patients from out-of-network providers who continue to exploit market loopholes.

Surprise billing is widespread in states with some of the strictest network adequacy laws, reinforcing the need for federal safeguards. Texas has some of the most stringent network adequacy laws in the country, but the state is regularly cited for ongoing issues with excessive surprise billing. For example:

- Texas requires annual reporting, has strict requirements on how far a patient would have to travel for care and ensures covered access to non-participating providers when participating providers are not available. Enforcement includes severe penalties, and enforcement is regularly exercised.
- However, Texas is also home to the most egregious examples of surprise billing. Surprise bills have increased in recent years due to provider-staffing firms moving certain doctors, such as emergency medicine physicians, out of network as a profit strategy, not because of a lack of strict network adequacy laws in the state.

Additionally, existing federal law already establishes network adequacy standards. The ACA requires health insurers that offer Qualified Health Plans to comply with network adequacy requirements, which are spelled out in regulations (45 CFR § 156.230). Further, the Brookings Institution also recently examined the relationship between network adequacy and surprise billing found that "a network adequacy standard for facility-based clinicians would not do anything to address the market failure that leads to surprise out-of-network billing."

Sources:

- https://www.modernhealthcare.com/article/20181011/NEWS/181019967/texas-fines-humana-for-out-of-network-anesthesiology-bills
- https://www.houstonchronicle.com/business/article/Surprise-Out-of-network-medical-bills-still-trap-13649786.php
- https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/05/10/the-relationship-between-network-adequacy-and-surprise-billing/

Myth:

Addressing surprise billing is a fight exclusively between the providers and the insurers.

Fact:

Cracking down on surprise billing protects patients, families, employers, and taxpayers. Employers provide health coverage to over 181 million Americans – including providing self-insured coverage to over 100 million Americans. For those 100 million Americans, their employer is the one paying the claims – and if the costs that employers are reimbursing providers increase significantly, it directly impacts employees in the form of higher premiums and deductibles.

Sources:

- https://www.siia.org/files/SIPA%20Dear%20Colleague%20%20-%20Dr_%20Roe%209_22_15.pdf
- https://www.ahip.org/wp-content/uploads/coverage@work_1_pager_IV.pdf

Myth:

Arbitration would only be used in a small number of cases.

Fact:

While state laws have been enacted too recently to assess the long-term impact of arbitration as a solution, we have already seen that the use of arbitration, and subsequently the burden, will increase over time.

The volume of cases going through independent dispute resolution in New York has been increasing since implementation. In 2015, there were 207 emergency service surprise bills and 36 non-emergency surprise bills that went through the process. As of 2017, the use of the process had increased 450 percent (645 and 451 cases, respectively). In addition, when Texas established an arbitration system for surprise medical bills, the number of cases increased significantly - from 43 requests preceding the law to more than 600 a year later. Four years later, there was a backlog of more than 4,000 cases waiting for resolution, and this backlog is expected to be even larger this year.

Myth:

Arbitration would not raise healthcare costs.

Fact:

Arbitration would be extremely costly and burdensome for many small and mid-sized businesses. Based on the way self-insured plans are structured, employers would often be the entity responsible for going to arbitration if a provider contests payment. This would mean that small companies could be forced to either accept provider pricing or hire external legal support, both of which could be extremely costly.

Additionally, arbitration requires expensive new infrastructure. At least one judge who represents a District Court in Massachusetts has raised concerns on the cost of arbitration, citing a $1,900 filing fee per case, a $750 care management fee and the arbiter's time. This would be in addition to the legal costs incurred by both entities to prepare for and be represented in these cases. In many cases, these costs could quickly exceed the cost of the bill itself and will ultimately be passed on to consumers through higher prices.