

Surprise Billing: Proposed Federal Solutions From Both Sides of the Aisle

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Paul DeWolfe needed back surgery. He knew the operation would be covered by his insurance and was careful to make sure the hospital he chose was in his insurer's network. DeWolfe sat down and did the math. He figured his portion of the bill would cost roughly \$3,000. When DeWolfe recovered from his procedure, he was shocked to receive a bill for \$18,590.83.[\[1\]](#) Despite all his attentive preparation, some of the physicians who treated him at his in-network hospital were, in fact, out-of-network. This story is far from fiction for nearly half of Americans. In fact, research shows that 18 percent of emergency room visits result in a surprise bill of some kind.[\[2\]](#)

Surprise bills can occur when patients are unexpectedly treated by an out-of-network provider at in-network facilities. They can also arise in an emergency when the patient is unable to choose their emergency care, facility, or ambulance provider. While insurers frequently cover part of the cost, the provider can also bill the patient for the difference between what the insurer paid and the provider's charge. Although slightly different, this form of billing, called balance billing, is often grouped with surprise billing. Surprise balance billing not only affects the patient, but also contributes to a price spiral for the privately insured, threatening the viability of private coverage as a whole.[\[3\]](#)

While all 50 states have some jurisdiction to protect the privately insured from surprise medical bills, the Employee Retirement Income Security Act of 1974 (ERISA) preempts state regulation of employer-provided health benefit plans. ERISA is not the only federal limitation on state regulatory powers concerning surprise billing. Federal aviation law prevents states from passing laws to regulate or set prices for air ambulances as well.[\[4\]](#) The limited ability of states to regulate self-insured plans necessitates federal action to effectively and comprehensively fix this

problem.

There is bipartisan and bi-cameral support in Congress to enact legislation, and in the last two years five bills have attempted to resolve the issue. The House introduced four of the five bills: (1) Protecting People From Surprise Medical Bills (H.R. 3502)^[5]; (2) The Consumer Protections Against Surprise Medical Bills Act (H.R. 5826)^[6]; (3) The Ban Surprise Billing Act (H.R. 5800)^[7]; and (4) The No Surprises act (H.R. 3630)^[8]. The Senate introduced the fifth bill (5) The Lower Health Care Costs Act^[9] (S. 1895)^[10] (See table below for details). While all are similar in the scope of coverage, the bills differ in important ways.

SCOPE OF COVERAGE

Most legislators in Congress agree on the general scope of coverage: they propose to protect and hold patients harmless from any costs beyond normal in-network cost-sharing associated with surprise out-of-network services, including services provided at in-network hospitals by out-of-network providers. In terms of the type of care, every proposed federal surprise billing legislation applies to out-of-network emergency claims and post-stabilization inpatient services provided to patients admitted to the hospital from the emergency room. While this coverage is important, the bills should also consider applying coverage to ancillary out-of-network providers assisting with non-emergency in-network care, additional procedures, and labs that are not pre-authorized. When things go wrong and additional care is required, individuals should not be held responsible for the surprise bills that appear as a result.

Under this same reasoning, extending the same protections for users of both ground and ambulance services is particularly important because of the sheer cost of ambulance rides and, particularly in relation to air ambulance services, the inability for states to regulate their costs. Additionally, patients are often unconscious or have just suffered a serious trauma, and it is unethical to expect them to make decisions under such conditions. However, the proposed federal bills diverge on this aspect of coverage. Senate bill 1895, for example, prohibits surprise air ambulance

bills from out-of-network providers, if such services are covered in-network. H.R. 5826, on the other hand, does not prohibit surprise billing for air ambulance services. The Ban Surprise Billing Act (H.R. 5800) strikes a balance by covering air ambulance services and creating an advisory committee to study ground ambulance services to determine coverage.

In terms of type of insurance coverage, all five proposed bills apply to both individual health insurance plans and group health plans, whether fully-insured or self-insured. This is a key aspect of coverage as federal protections would effectively reach the private plans that ERISA preempts states from regulating.

PAYMENT RATES

The major difference in Congressional opinion arises in the approach to paying for the cost of care. To hold patients harmless for surprise medical bills, or prevent them from occurring at all, requires setting up a new provider payment system. There are two primary theories when it comes to payment resolution, the first involves creating benchmark rates, and the second utilizes arbitration (also known as independent dispute resolution).

Benchmarks

In a benchmark approach, Congress determines the rate an insurer would be required to pay a provider regardless of whether they are in or out of network. Under this method, health care providers would receive a set, market-based payment, for their services. This benchmark limits their ability to charge patients egregious rates while ensuring patients still be responsible for their share of the payment. Benchmarks can be set in a variety of ways including in-network rates, median rates dependent on geographic region, and rates based on Medicare.

Depending on their design, benchmarks can create broad downward pressure on commercial health care prices and encourage providers to come in-network. Estimates from the Congressional Budget Office (CBO) illustrate that benchmarked payment standards based on median in-network rates, for example, could lead to lower provider payments.[\[11\]](#)

Hospital and physician groups generally oppose the use of a fixed payment standard, arguing that it may incentivize insurers to rely on default payments rather than contract with providers.[\[12\]](#) Discouraging payers from contracting with providers may lead to more narrow networks and therefore more out-of-network care. The American Hospital Association (AHA) also expressed concern that uniform benchmarks could create market failures and negatively impact, specifically, rural care.[\[13\]](#) Although the cost of health care varies widely across the country, the Health Care Cost Institute recently found that the median in-network rates for specialties most likely to be out-of-network (anesthesia, emergency room, and radiology services) are fairly similar for rural and urban areas within states.[\[14\]](#) Thus, implementing a local benchmark based on geographical averages could assuage these fears. Either way, it is important that these prices be set at a fair rate in order to justly compensate providers for their services while decelerating the current upward cost spiral.

Many of the proposed federal bills utilize, at least in part, a benchmark payment standard. S. 1985 relies solely on benchmarks, which are to be set for insurers for 2019 and will be inflated for future years. H.R. 5800 creates a similar default payment standard, setting rates based on costs in 2019 and adjusting for inflation. The No Surprises Act, H.R. 3630, bases its payment rates on median in-network costs for 2021, which are to be indexed to CPI-U[\[15\]](#) for subsequent years. Even H.R. 5826, which does not use benchmarks, still relies on median in-network rates (inflated for future years and rebased every five years) to determine ultimate cost-sharing.

Arbitration / Dispute Resolution

Arbitration, or independent dispute resolution, is a second way to resolve provider payment in the surprise billing context. An arbitrator considers a wide array of information, and then works with both providers and insurers to settle on a “fair” price. Groups representing physicians champion this system because both the insurer and provider get a say in the ultimate cost or payment. Under this theory, the independent third-party provides an amicable solution to a complex problem.

There are significant administrative costs, however, associated with arbitration,

including paying an arbitrator and other resources (such as lawyers) for both sides. Moreover, arbitrators confront the same fundamental challenges of any rate setters and can produce the same unintended consequences. Whether rates are set too high or too low, they can introduce large market distortions by propelling a degree of market uncertainty, meaning higher premiums for consumers.[\[16\]](#) Furthermore, when a third-party sets rates without transparency or oversight, physicians can use excessively high charges as a baseline for negotiation. If arbitrators award artificially high rates, it may incentive providers to opt for out-of-network contracts because of the increased price opportunity.[\[17\]](#) The opposite is true as well. If arbitrators start with Medicare rates as their baseline, it could be good for consumers and incentivize providers to go in network. Arbitration, when done correctly, can be diplomatic because it allows both providers and insurers to find a fair price. However, without proper guardrails, it can enable the rise of health care costs and insurance premiums.

Most of the bills Congress introduced in 2019 and 2020 include arbitration provisions. For example, H.R. 3502 allows for an arbitrator to determine final payments based on criteria including charges for comparable services, usual cost of service, and the 80th percentile of charges for comparable services in that geographic region. Rather than relying on benchmarks to determine reimbursement, the Consumer Protections Against Surprise Medical Bills Act (H.R. 5826) includes a period for providers and health plans to negotiate costs. There is also an independent mediated negotiation process for any non-voluntary agreement within a set 30-day period. The Ban Surprise Billing Act (H.R. 5800) establishes a process for providers and insurers to settle disputes for out-of-network bills greater than \$750 (or \$25,000 for air ambulance cases). Under this binding final-offer arbitration, the loser pays the cost. H.R. 3630 also establishes an independent dispute resolution where factors such as medial in-network payment by other plans, severity of case, and provider training are taken into consideration.

There are strong arguments for both arbitration and benchmarks. Health insurers and employer groups prefer a benchmarked federal payment standard as they argue it is less complex and more cost effective,[\[18\]](#) while hospital and physician groups lobby for reliance on mediation to resolve surprise bills,[\[19\]](#) because they believe the independent dispute resolutions could resolve the problem of providers leaving

networks over fears of rate setting. The solution, like many, maybe found in compromise. Setting benchmarks at the Medicare rate, or indexing it to the CPI-U, while establishing an arbitration process for particularly large bills, could be a viable arrangement. Many of the bills already do so, including H.R. 5800, H.R. 5826, and H.R. 2328, and it seems possible these types of compromises may gain traction on both sides of the aisle. It is unclear whether, or how, the committees will resolve their differences, but the movement forward does signal progress.

CONCLUSION

While ideally, we move in the direction of a universal healthcare system - the practicality of this goal is far from immediate, and in the time-being, it is important to protect people from crushing medical debt caused by surprise billing. Health care, as it stands today, is a complex and fragmented system, and working within it will be messy with no solution that is perfect. However, there are concrete policy initiatives which, if implemented correctly, can have positive impacts on millions of Americans. Policymakers have a myriad of tools at their disposal, from explicit price capping to healthcare contract reforms. At their core, every surprise billing legislation under consideration aims to protect consumers; however, the differences in approach could cause vastly different repercussions. Advocates for consumer protection against surprise medical bills hoped to include a fix in the federal relief package in response to the COVID-19 pandemic. This possibility is increasingly unlikely, however, as deadlines loom near and the Trump Administration has yet to take a decisive stand.[\[20\]](#) While today it looks as though legislation has stalled, the overwhelming support for a resolution to surprise medical bills could still mean a solution in the near future.

[\[1\]](#) The Editorial Board, *You think doctors at the hospital in your insurance network*

are in-network too? Surprise! USA Today (Sept. 23, 2019, 4:37 PM) <https://www.usatoday.com/story/opinion/2019/09/23/out-of-network-doctors-surprise-medical-bill-scam-editorials-debates/2378662001/>.

[2] Chris Lee, *About 1 in 6 Emergency Visits and Hospital Stays Had At Least One Out-of-Network Charge in 2017*, KFF (June 20, 2019) <https://www.kff.org/health-costs/press-release/about-1-in-6-emergency-visits-and-hospital-stays-had-at-least-one-out-of-network-charge-in-2017/>.

[3] Daniel P. O'Neill, *Surprise Bills, Benchmarks, And The Problem of Indexation*, Health Affairs (Nov. 25, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20191121.868286/full/>.

[4] Sammy Chang, *Can AB 652 Survive Possible Legal Difficulties as California Strives to Protect Both Air Ambulances and Patients?*, The Source on Healthcare Price & Competition: The Source Blog (Sept. 30, 2019), <https://sourceonhealthcare.org/can-ab-651-survive-possible-legal-difficulties-as-california-strives-to-protect-both-air-ambulances-and-patients/>.

[5] Protecting People From Surprise Medical Bills Act, H.R. 3502, 116th Cong. (2019).

[6] Consumer Protections Against Surprise Medical Bills Act of 2020, H.R. 5826, 116th Cong. (2020).

[7] Ban Surprise Billing Act, H.R. 5800, 116th Cong. (2020).

[8] No Surprises Act, H.R. 3630, 116th Cong. (2019).

[9] Katie Gudiksen, *The Lower Health Care Costs Act: A Bipartisan Federal Effort to Improve Competition in Healthcare Markets*, The Source on Healthcare Price & Competition: The Source Blog (June 21, 2019), <https://sourceonhealthcare.org/the-lower-health-care-costs-act-a-bipartisan-federal-effort-to-improve-competition-in-healthcare-markets/>.

[10] Lower Health Care Costs Act, S. 1895, 116th Cong. (2019).

[11] Karen Pollitz, Matthew Rae, Gary Claxton, Cynthia Cox & Larry Levitt, *An examination of surprise medical bills and proposals to protect consumers from them*, Peterson-KFF: Health System Tracker (Feb. 10, 2020), <https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them-3/>.

[12] *Statement of the American Hospital Association for the Committee on Education and Labor Subcommittee on Health, Employment, Labor and Pensions of the U.S. House of Representatives "Examining Surprise Billing: Protecting Patients from Financial Pain"*, American Hospital Association (Apr. 2, 2019), <https://www.aha.org/system/files/media/file/2019/04/040219-aha-statement-before-help-committee-examining-surprise-billing.pdf>.

[13] Tom Nickels, *AHA Statement on Revised Lower Health Care Costs*, American Hospital Association (June 19, 2019), <https://www.aha.org/press-releases/2019-06-19-aha-statement-revised-lower-health-care-costs-act>.

[14] John Hargraves & Jean Fuglesten Biniek, *Comparing Commercial and Medicare Rates for Select Anesthesia, Emergency Room, and Radiology Services by State*, Health Care Cost Institute (July 23, 2019), <https://healthcostinstitute.org/out-of-network-billing/median-allowed-amounts-esi-2017>.

[15] The Consumer Price index (CPI-U) is a measurement of the average prices paid by consumers for certain goods and services.

[16] Hunter Kellett, Alexandra Spratt & Mark E. Miller, *Surprise Billing: Choose Patients Over Profits*, Health Affairs (Aug. 12, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20190808.585050/full/>.

[17] Jack Hoadley & Maanasa Kona, *How States Are Using Independent Dispute Resolution to Resolve Out-of-Network Payments in Surprise Billing*, The Commonwealth Fund: To The Point (Feb. 27, 2020), <https://www.commonwealthfund.org/blog/2020/how-states-are-using-independent-dispute-resolution-resolve-out-network-payments-surprise>.

[18] *Hill Sign on Letter Surprise Medical Bills*, American Health Insurance Plans (Mar. 18, 2019), <https://www.ahip.org/wp-content/uploads/Hill-Sign-on-Letter-Surprise-Medical-Bills-031819-2.pdf>.

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[20] Rachael Cohrs, *Surprise billing fix faces major hurdles in last-minute push*, Modern Healthcare (July 30, 2020 4:34 PM), <https://www.modernhealthcare.com/politics-policy/surprise-billing-fix-faces-major-hurdles-last-minute-push>.