Relief from Surprise Medical Billing Becomes Law

Legislation could help control unplanned out-of-network costs

By Stephen Miller, CEBS
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When President Donald Trump signed into law the Continuing Appropriations Act, 2021 (https://rules.house.gov/sites/democrats.rules.house.gov/files/BILLS-116HR133SA-RCP-116-68.pdf), shortly before the end of 2020, it included a revised version of the bipartisan No Surprises Act (https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/No%20Surprise%20Act%20Section-by-Section%2012-11-20.pdf), with long-sought curbs on unscheduled "surprise" out-of-network health care charges. These expenses often result when care is received at an out-of-network emergency room, or for ancillary services, such as when, without the patient's knowledge, an out-of-network anesthesiologist assists in a surgery performed by an in-network surgeon at an in-network hospital.

The limits on surprise billing by doctors and hospitals, and so-called balance billing in which health care providers charge plan enrollees for the balance of an out-of-network bill when an insurance company won't pay the full amount, should reduce unplanned costs for plan enrollees and help self-insured employers, especially, to manage their health care spending. Fully insured employees could see some moderation in premium increases. A study published last September in the *American Journal of Managed Care* found that a comprehensive federal law to rein in surprise medical billing could reduce overall health insurance premiums by 1 percent to 5 percent (https://www.ajmc.com/view/policies-to-address-surprise-billing-can-affect-health-insurance-premiums).

The new law "holds patients harmless from surprise bills, including from air ambulance providers, and prohibits out-of-network providers from balance billing unless they give patients 72-hour notice of their network status and an estimate of the charges," said Chatrane Birbal, vice president for public policy at the Society for Human Resource Management.

Consumers and employers, however, did not get everything they had sought in the final legislation, which could lessen the expected cost savings they had hoped to see.

What the Law Changes

Most of the new requirements take effect with plan years beginning Jan. 1, 2022. Among the provisions affecting employer-sponsored group plans, including self-insured plans, are the following:

AMBULANCES

The legislation covers high-cost air ambulance services (https://surprisemedicalbills.chir.georgetown.edu/the-challenge/air-ambulances/) but excludes ground ambulances. Ambulances have a higher rate of surprise billing than any other medical specialties—by one estimate 71 percent of their bills are out of network (https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.01484) with

median potential surprise bills of $450 for ground transportation and $21,698 for air transportation.

The New York Times reported that "lawmakers have been reluctant to regulate surprise billing among [ground] ambulances (https://www.nytimes.com/2020/12/22/upshot/ground-ambulances-left-off-surprise-medical-bill-law.html), citing the diversity of providers, complex layers of state and local regulation, and a dearth of information about precisely what it costs to keep an ambulance stocked and running. Amid the bruising surprise-billing debate, many lawmakers saw it as one tricky issue too many."

ANCILLARY SERVICES

According to health policy specialists at the Health Affairs Blog (https://www.healthaffairs.org/do/10.1377/hblog20201217.247010/full/), patients often receive surprise bills from a nonemergency out-of-network provider's ancillary services (such as those delivered by a radiologist, anesthesiologist or pathologist) or specialty services for unexpected complications (such as those provided by a neonatologist or cardiologist). The No Surprises Act "allows for some voluntary exceptions to surprise medical bill protections but only if a patient knowingly and voluntarily agrees to use an out-of-network provider," the blog post noted.

While the law allows certain providers to request that a patient sign a consent waiver to be billed at out-of-network rates, this exception is only allowed in nonemergency situations.

ARBITRATION

The law provides for independent arbitration and dispute resolution between insurers and health care providers that otherwise cannot settle their claims, without requiring patients to become involved in the process.

Unless the state has a specified law that determines the price for an item or service that a health plan or issuer must pay, the plan will send either an initial payment at an amount determined by the plan, or a notice of denial to the provider, and the parties have 30 days to initiate negotiations.

DISCLOSURES

On a public website and in explanations of benefits, plans must disclose the requirements and prohibitions against surprise billing, any state law requirements regarding surprise billing, and contact information for the appropriate state and federal agencies when a provider or facility has violated those prohibitions.

A Federal Approach

Kim Buckey, vice president of client services at DirectPath, a benefits education, enrollment and health care transparency firm, welcomed the legislation. "Previously, there was a patchwork of 32 state-based programs (https://www.commonwealthfund.org/publications/maps-and-interactives/2020/nov/state-balance-billing-protections) that had attempted to address this issue, with some states taking a more comprehensive approach than others. And, these programs only affected fully insured plans in that state," she pointed out, as a state's authority to regulate self-insured employer-sponsored plans is constrained by the Employee Retirement Income Security Act.

"The new federal legislation will apply a consistent approach to all plans—both self- and fully insured—and extend relief to states that have not yet offered consumer protections against surprise bills," Buckey said.

Hold Negotiators Accountable

Randy King, president of Healthcare Horizons Consulting Group, advised self-insured employers to "hold their third-party administrator accountable for meaningful negotiation" with out-of-network providers, and suggested that carriers acting as negotiators "are going to have to establish a patient advocacy program and actively support their insureds. The balance billing mindset may not go away immediately."

He recommends conducting audits to ensure that patients' cost share is based on comparable in-network rates.

Negotiations are especially important regarding air ambulance rates (https://healthcarehorizons.com/wp-content/uploads/2020/07/Why_Self-Insured_Employers_Need_To_Negotiate_Air_Ambulance_Rates_by_Randy_King.pdf), King explained, noting there are two parts to most air ambulance bills: the lift-off fee and a per-mile charge. "Do not accept a 5 percent discount when more substantial savings can be negotiated," he advised. "Strive for an agreed upon amount for the base rate (lift charge) and per-mile rate versus a percent discount from billed charges."

Outlook for Arbitration

According to Birbal, "Most significant to employer-sponsored health plans, the bill allows for an independent dispute resolution [IDR] process to address surprise medical billing. Under an IDR process, the self-insured employer, not the contracted insurance carrier operating as a third-party administrator, would be responsible for settling claims disputes."

Binding arbitration, however, remains controversial, and was favored by some hospital corporations and physician staffing firms, for instance, but opposed by many self-insured employers and insurance companies.

"Arbitration is the method favored by doctors and hospital groups (https://www.mercer.us/our-thinking/healthcare/congress-nears-covid-aid-deal-that-may-include-surprise-billing-fix.html), but employers and insurers have pushed for settling disputes with payment of a median in-network rate for a particular service or procedure," according to Mercer, an HR consultancy. Some consumer advocates had sought for out-of-network charges to be limited to a multiple of Medicare and Medicaid reimbursement rates.

Under the new law, however, a health care provider's previously billed charges and government-payer rates cannot be considered during arbitration, and it disallows government rate-setting. The legislation does, however, include some provisions intended to encourage in-network agreements and prevent abuse and overuse of the arbitration process. It also does not require a threshold billing amount for arbitration.

According to *Politico* (https://www.politico.com/news/2020/12/20/congress-surprise-billing-fix-spending-449416), binding arbitration "is a loss for insurers, employers who [self-fund] a major chunk of private coverage, and patient advocates who thought including ... public rates as a barometer could help curb health care prices."

In addition, "for health insurers, lawmakers appear to have watered down a measure that would have required them to disclose detailed information to employers about their drug costs and rebates through their contracts with ... pharmacy benefit managers, whose business practices have come under scrutiny in recent years for their role in high drug costs," *Politico* reported.

As the law is implemented, the Coalition Against Surprise Medical Billing, which includes employer groups such as the American Benefits Council and industry groups such as America's Health Insurance Plans, urged regulators (https://stopsurprisebillingnow.com/coalition-statement-on-the-no-surprises-act/) to "prioritize lowering consumers' health care costs" and to prevent out-of-network

providers and their lawyers "from exploiting the new arbitration system."

Buckey said that while "it remains to be seen how well the arbitration system will work, this is an important step in the right direction for protecting consumers, including those who did all the right things to ensure their care was in-network but received surprise—and balance—bills through no fault of their own."

John Barkett, senior director of policy affairs at consultancy Willis Towers Watson, called the legislation "very good news for employees who in the past may have been caught off guard with unexpected bills despite receiving in-network care." However, he also had caveats, noting, for instance, that "It's unclear whether the law will lower or raise employer costs, and it will likely take a couple years before we know."

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Fiscal 2021 Omnibus and COVID-19 Relief (https://advocacy.shrm.org/issue/fiscal-2021-omnibus-and-covid-19-relief/), SHRM Government Affairs, December 2020

Employers Can Help with 'Surprise' Out-of-Network Medical Bills (www.shrm.org/ResourcesAndTools/hr-topics/benefits/pages/trump-urges-congress-to-end-surprise-medical-billing.aspx), *SHRM Online*, May 2019

Employers Cut Health Plan Costs with Reference-Based Pricing (www.shrm.org/ResourcesAndTools/hr-topics/benefits/pages/reference-based-pricing-lowers-health-plan-costs.aspx), *SHRM Online*, May 2019