INSIDE THE BELTWAY

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The battle lines have been drawn in the legislative battle to address surprise medical billing, with payers on one side and providers on the other.

Payers and providers agree on several key tenants of surprise billing, including protecting patients from receiving such bills. However, the difference comes down to how much of that payment providers will receive in emergency situations, and those in which a patient receives service in an in-network facility, though by an out-of-network provider. In those cases, payers, which include both the insured and self-insured employer community, support establishing a reimbursement benchmark for certain medical services—whether it be based on in-network rates or a percentage of Medicare reimbursement rates--and requiring all providers to accept that amount as final payment, regardless of whether they are in network or not.

Meanwhile, providers--including both hospitals and doctors--want the ability to negotiate their compensation with 'baseball-style' arbitration in which each party—both the provider and the payer—submits their best financial offers, and a neutral arbitrator determines which one is the most reasonable compensation for the provider. However, any reimbursement mechanism would only take effect if and when the payer and provider cannot agree on a set rate.

The term "surprise medical bill" describes fees charged when a patient receives care from non-network providers or services not covered by their health benefits. Surprise medical bills occur in 18% of emergency room visits and 15% of in-network hospital stays, according to an analysis of 2017 claims data from large employer plans conducted by the Kaiser Family Foundation.

Surprise medical bills typically arise out of three scenarios: When a patient receives care at an in-network facility but is treated by an out-of-network provider; when a patient receives emergency care from providers, at a facility or by an ambulance service that is outside of their insurance network; or when a patient is transferred to a non-network provider or facility, but not informed that this care is out-of-network, and is not offered an in-network alternative.

While several states have taken action to address the issue, for the more than 100 million Americans covered by a self-funded health plan, these state laws provide no protection and underscore the need for Congressional action. Therefore, the Self-Insurance Institute of America, Inc., has joined forces with a diverse group of payers including employers, health insurance providers and brokers, who support legislation that will protect patients from surprise medical bills and rein in out-of-control health care costs.

Legislation to end surprise medical bills also has bipartisan support in Congress and is backed by the Trump Administration. In fact, SIIA and several of its members sat down earlier this year with White House staff to help develop principles that the president has said he would like to see included in a final bill, which he has promised to sign.

In particular, SIIA members support using a federal reimbursement benchmark set at a median contracted rate, based on geography, rather than a percentage of Medicare, because the latter has the potential to "lead us down the rabbit hole to Medicare for All," a single-payer, government-run health care program advocated by several Democratic presidential candidates, explained Ryan Work, vice president for federal government relations at SIIA.

Such a program would replace almost all other existing public and private plans with a more generous version of Medicare.

"SIIA believes that the in-network facility offering services of an out-of-network provider should adhere to the terms and conditions set forth in their network agreement," according to Work, whose team of lobbyists has met with hundreds of lawmakers to present the payers' position. Work also has authored two letters to lawmakers specifically outlining SIIA's stance.

SIIA has long favored an approach to surprise medical billing that protects patients from providers charging excessive amounts for services rendered after their health plan has already made an objectively reasonable payment. In other words, the network contract should apply to any and all services provided by the in-network facility, regardless of whether they are administered by an in-network or non-network provider.

But SIIA opposes arbitration, which is a complex and inefficient process that will ultimately increase patient costs rather than reduce them, according to Work. Moreover, even arbitration would need some sort of benchmark mechanism in place to prevent out-of-network providers from maximizing costs and payments through a binding arbitration process, Work pointed out.

Congress is currently reviewing four proposals to tackle surprise medical bills:

- S. 1895, the "Lower Health Care Costs Act" introduced in June by Health, Education, Labor & Pensions Committee Chairman Sen. Lamar Alexander (R-TN) and Ranking Member Sen. Patty Murray (D-WA), is an omnibus bill that, along with surprise billing, also addresses prescription drug prices, transparency and numerous public health issues such as improving mental health parity, maternity care and obesity and disease prevention programs.

  The proposal also addresses air ambulance service providers, an issue of concern to SIIA members. Air ambulances charged private payers between about 4 and 9.5 times more than what Medicare actually paid for those services in 2016, according to a Health Affairs study by researchers at Johns Hopkins School of

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Medicine and Johns Hopkins Carey Business School. The Alexander-Murray bill would levy a $10,000 fine on air ambulance service providers each time they charge more than the median in-network rate for a particular geographic region set by HHS.

- S. 1531, titled "STOP Surprise Bills Act of 2019", introduced in May by Sens. Maggie Hassan (D-NH) and Bill Cassidy (R-LA), largely centers around baseball-style arbitration. Under the proposal, providers would automatically be paid the difference between the patient's in-network cost-sharing amount and the median in-network rate for these services, but providers and plans would have the opportunity to appeal this payment amount through an independent dispute resolution process. This measure has gained the support of 24 cosponsors as well as Physicians for Fair Coverage, a group backed by physician-owned businesses that oppose any measure that places caps on their fees.
- In the House, lawmakers are considering the "No Surprises Act" introduced in May by Energy and Commerce Committee Chairman Frank Pallone (D-NJ) and Ranking Member Greg Walden (R-OR), which takes an approach similar to the Alexander & Murray proposal, implementing some sort of benchmark for determining non-network provider compensation.
- Another arbitration bill mirroring the Hassan & Cassidy measure was introduced in the House just prior to the July 4th recess by Reps. Raul Ruiz (D-CA) and Phil Roe (R-TN).

As these bills go through the committee markup process, it is highly likely that some sort of compromise could be worked out that establishes a benchmark based on in-network reimbursement rates and applies arbitration only to those medical bills above a certain threshold amount, according to Work.

"The providers are really spending money and putting pressure on members of Congress to flip towards arbitration," Work said. "We'll see how this debate heads over the next few months, but I really see a more middle-of-the-road compromise between a benchmark and arbitration."

Regardless of what the final measure contains, it is very likely that something will pass this year, according to Work.

"There's a big bipartisan focus. The Administration, and the Department of Health and Human Services specifically, has been pushing this transparency agenda," he said, pointing to the executive order that the president signed on June 24 that calls for upfront disclosure by hospitals of prices for common tests and procedures to give patients the information they need to shop for better deals.

"It is important to note that this is the third executive action this year related to price transparency," he noted. "The Affordable Care Act addressed accessibility, now the focus is on cost and transparency."