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Efforts to Curb Surprise Billing are Ramping Up

Balance billing occurs when a provider bills a patient for the difference between the amount he/she charged and the amount that the patient's insurance carrier paid.

Providers that are **in-network** have contracted with a carrier at specified discounted payment rates. As such, they have agreed to accept the insurance payment as payment-in-full (less any applicable patient co-pay responsibilities) and are not allowed to balance bill the patient. On the other hand, providers that are **out of network (OON)** do not have a contract with the insurance company and, therefore, don't have the same obligation to accept the carrier's payment amount as payment-in-full.

Some insurance plans cover OON services and will pay the provider according to its own established 'reasonable and customary' rate structure for those services. But to that point, OON providers can typically balance bill the patient for the difference instead of writing it off as in-network physicians have to. This is pretty straightforward when it comes to the situation of a patient who chooses to see an OON provider as he/she understands that his/her policy designates significantly higher deductible and co-pay responsibilities for OON services than when those same services are rendered by an in-network provider.

The problem comes in when a patient goes to an in-network hospital and unknowingly receives care from an OON provider there. This results in the facility's claim being processed and paid as in-network but the physician's claim being processed as OON, ultimately creating a situation referred to as 'surprise billing.' If the patient has OON coverage he/she is now responsible for the higher costs plus the balance of the physician's charge. If the patient's insurance policy does not cover OON services at all, the patient can be charged for the physician's entire bill.

Surprise billing mainly occurs in two settings: 1) patients that go to an in-network hospital for emergency care, unaware that the physician/group providing treatment is OON; and 2) diagnostic or other scheduled services – such as pathology or radiology – at an in-network hospital where the provider/group rendering the professional service is OON.

So how common is it that a hospital-based physician is not in-network with an insurance carrier when the hospital in which he/she works is in-network? It's actually an increasingly common scenario due to a number of reasons including narrowing provider networks and insufficient carrier payment rates for contracted providers. Ultimately this means a contracted physician or group can hold a different portfolio of insurance contracts than the hospital.

States are the primary regulators of their respective private health insurers and to that end, some have implemented, or are working on, legislation to address the issue. Unfortunately, the solutions are not necessarily consistent between states and some can carry inherent limitations that patients – and providers for that matter - may not fully understand. For the most part, finding common ground between providers and insurers has essentially remained deadlocked, continuing to keep patients at risk of incurring unexpectedly large bills for medical services and providers bogged down by administrative constraints.

Information provided by APS Medical Billing, September, 2019

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The government historically hasn't involved itself in proposing legislation aimed at lessening the burden of balance billing in the private insurance sector. But toward the goal of implementing a potential national standard, some members of Congress have introduced a number of bills and preliminary drafts over the past several months that speak directly to the issue. Common themes among the initiatives include banning balance billing altogether, capping OON payment rates through federally-set benchmarks, requiring an arbitration process to settle OON disputes between providers and carriers, and forcing OON physicians to join the same networks as their hospitals as a condition of their contracts with those facilities.

Still, the path remains a slippery slope as the industry weighs in on Congress' proposals. For example:

- In his June 19, 2019, memo **FEDERAL "BALANCE BILLING" LEGISLATION: CONSTITUTIONAL IMPLICATIONS**, **Paul D. Clement, currently a Partner at law firm Kirkland & Ellis**, contends that some of the provisions under the proposed legislation oversimplify the issue 'and would give all negotiating power to the insurance companies.' Further, he details his argument that some of the proposals may be unconstitutional. Read the full memo at the following link:
    - https://www.scribd.com/document/414001118/Paul-Clement-Balance-Billing-Constitutional-Implications-June-2019

- According to ***Politico***, the Virginia-based journalism company covering politics and policy in the United States and abroad, a group referring to itself as **Doctor Patient Unity** has spent $30 million on its campaign to stop a leading congressional surprise-billing policy currently under consideration. In its recent article, **HEALTH GROUPS BACKED DARK MONEY CAMPAIGN TO SINK 'SURPRISE' BILLING FIX, *Politico*** explains that while Doctor Patient Unity supports a federal solution to surprise medical bills, it specifically opposes the proposed solution of capping OON payments based on benchmarks set by the federal government. Instead the group, comprised of health staffing companies, doctors and hospitals, promotes the use of independent mediators to settle payment disputes through arbitration – as currently practiced via state policy in New York and Texas today.

- Directly countering Doctor Patient Unity's proposed solution of arbitration, the **Coalition against Surprise Medical Billing**, which is backed by employers and insurers, recently kicked-off its own multimillion dollar ad campaign pushing for federal benchmarking as the key to controlling related costs. Read the full article at the following link:
    - https://www.politico.com/story/2019/09/13/health-groups-dark-money-hospital-bills-legislation-1495697

- One of the most comprehensive articles of feedback came in a September 4, 2019 letter to two government committees involved in developing a legislative solution to surprise billing; the House Committee on Ways and Means, and the Committee on Education and Labor. **The letter, authored by a group of ten medical organizations including the American Medical Association, American College of Radiology and the College of American Pathologists**, presented seven policy proposals for the committees' consideration in developing a process to end balance billing that is equitable to providers as well as patients:
    - Place limits on patient responsibility
    - Avoid rate setting

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- Ensure upfront payment for out-of-network care
- Provide for a robust independent dispute resolution mechanism
- Allow for elective out-of-network care with patient consent
- Oversight and enforcement of provider network adequacy
- Ensure insurer transparency

Read the full letter at the following link:
https://www.acep.org/globalassets/new-pdfs/advocacy/specialty-letter-to-waysmeansedlabor---09.04.2019.pdf

Is there a light at the end of the tunnel? Not quite yet. But unquestionably there is growing attention to the issue with uniform agreement across the healthcare industry that a solution needs to be put in place sooner than later. Bolstered by bipartisan efforts that continue to increase and strengthen, we should be able to expect that momentum to carry on through to resolution in a reasonable timeframe.