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Bipartisan Senate Group Leads Charge to Protect Consumers From 'Surprise Medical Bills'

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In a departure from the otherwise stark division across party lines when it comes to health care, a new bipartisan effort has emerged to protect consumers from "surprise medical bills" for out-of-network charges. On September 18, Senators Bill Cassidy, M.D. (R-LA), Michael Bennet (D-CO), Chuck Grassley (R-IA), Tom Carper (D-DE), Todd Young (R-IN), and Claire McCaskill (D-MO) released a draft of the "Protecting Patients from Surprise Medical Bills Act," (available at https://www.cassidy.senate.gov/imo/media/doc/Discussion%20Draft-%20Protecting%20Patients%20from%20Surprise%20Medical%20Bills%20Act.pdf) which they aim to formally introduce in January. According to Senator Cassidy, the "proposal protects patients in those emergency situations where current law does not, so they don't receive a surprise bill that is basically uncapped by anything but a sense of shame."

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The draft legislation was announced shortly after a Texas teacher made national news for receiving an alarming bill for more than $100,000 after receiving out-of-network emergency care. The teacher, whose story is highlighted in the senators' press releases (available at https://www.cassidy.senate.gov/newsroom/press-releases/cassidy-bipartisan-colleagues-release-draft-legislation-to-end-surprise-medical-bills), suffered a heart attack and was rushed to the nearest emergency room, which was out of network under his employer-based plan. After his insurance plan paid the out-of-network hospital more than $50,000 for his care, the hospital sent the teacher a bill for the remaining balance, to the tune of $109,000. Although the hospital ultimately waived the bulk of the charges in the wake of national press coverage, the teacher's mortgage-sized hospital bill spurred the bipartisan group of senators to introduce a federal initiative to combat balance billing.

While nearly two dozen states have laws designed to protect consumers from surprise balance bills, many of these state-based measures offer no protection for consumers covered under employer-based, ERISA-governed plans, and the majority of states offer no protection at all. The Surprise Medical Bills Act would offer protection to all consumers with commercial coverage, including those enrolled in self-funded plans under ERISA.

The draft measure specifically prohibits balance billing in two instances: (1) when emergency services are provided by an out-of-network provider in an out-of-network facility and (2) when nonemergency services are performed by an out-of-network provider at an in-network facility. In both situations, the patient's financial responsibility would be capped at the plan's in-network cost-sharing requirement. Any remaining "balance" above this amount would be billed to the patient's health plan at an amount calculated in accordance with the Surprise Medical Bills Act.

The draft legislation provides a two-step process to determine a health plan's responsibility for out-of-network bills. It first looks to state laws. If a relevant state law dictates the amount the insurer must pay for out-of-network care, the state rate will govern.

If there is no applicable state law, or the applicable state law does not provide a method for determining the amount and manner of payment, the plan will be responsible for the greater of the "average amount" for the service or the "usual, customary, and reasonable rate."

The average amount is defined as the median in-network amount negotiated by health plans and health insurance issuers for the service, within the same or similar specialty in

the same geographical area. The usual, customary and reasonable rate is defined as 125 percent of the average allowed amount for all private health plans and health insurance issuers for the service provided by a provider in the same or similar specialty in the same geographical area.

The bill, which is still in draft form and is "intended to jumpstart discussions in Congress about how to best stop the use of balance billing," undoubtedly will raise several questions for payors and providers. First, the analysis contemplated by the legislation could be time-consuming and difficult due to the highly individualized inquiry it requires, making it difficult to integrate into automated claims processing systems.

Payors and providers will also need more guidance to perform the analysis of "average amount" and "usual, customary, and reasonable rate." For example, how is "same or similar specialty" defined? Are sub-specialties included?

Calculating the median or average rate is also not as straightforward as the legislation would suggest. Many insurers have moved away from traditional fee-for-service arrangements and now have value-based reimbursement contracts with providers. As fee-for-service reimbursement rates under value-based contracts do not necessarily reflect the actual final cost of services rendered (which must await final reconciliation of the relevant value or risk targets), the inclusion of rates from value-based or risk-sharing contracts would skew the median and average.

We will continue to monitor this legislation and issue future alerts.

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