Congress Passes Ban on Surprise Billing

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Implications for Commercial Market

On December 27, 2020, President Trump signed into law an omnibus spending bill[1] that included key provisions that, for the first time, provide national protections from surprise billing. Starting in 2022, patients will no longer be responsible for surprise out-of-network bills, with those costs distributed between insurers and providers. This brief will provide a key summary of the provisions in the bill, the potential impact of the bill, and other considerations.

Limitations on Surprise Billing

For several years now, the topic of surprise billing has been debated in Congress. Surprise billing happens when patients receive "surprise" out–of-network bills, where the cost for the service and member cost share are well in excess of what they would be if the services were considered in-network. Often these surprise bills typically occur when a members goes to an in network facility but unknowingly receives services at the facility from an out of network provider. They also often happen in environments were patients have no choice or are unaware of the provider status (i.e., ambulance or emergency room). Insurers typically pay some of the excess charges but not all of them. The excess costs are often balanced billed onto patients, which can result in large bills for the patient. Consequently, surprise billing can be thought of as the higher (relative to in-network cost-sharing) and unexpected out of pocket costs patients are charged.

To address these growing concerns, Congress included a number of provisions to reduce surprise billing. The key provisions included:

- Patients are protected in most settings from surprise billing. Emergency services (excluding ground ambulances) are not allowed to surprise bill patients. Patients are also protected from surprise billing in nonemergency settings (one of the key exceptions is in situations where patients have the option of selecting an out-of-network provider, in which case the provisions would not apply).
- In situations of surprise billing, patients will only be liable for cost-sharing amounts that apply to in-network services. The excess charges that previously had been sent to patients would instead

[1] https://www.congress.gov/bill/116th-congress/house-bill/133/

be divided between providers and insurers. If the two sides cannot settle on a split, the amount goes before arbitration. The arbitration is binding with the arbitrators instructed to rely on multiple factors, including: market share of the healthcare provider, median in-network rates, good faith efforts to join the insurers' network, etc. After a ruling, both sides would need to wait 90 days before filing any additional arbitration claims against the other party.

Potential Impact

The impact of the bill can be thought of from three prespectives: from the consumer perspective, from insurer perspective, and from the provider perspective. Consumers are expected to have lower cost-sharing (as there are now limitations). For consumers, that do not experience surprise bills, there experience may dependent on how the law impacts premiums.

According to CBO estimates, insurers costs (and therefore premiums) are actually expected to decrease. The CBO estimated that a similar bill to the bill that passed would result in premiums to be 1% lower). This is because that average payment rates (e.g., in-network payment), according to CBO estimates, would shift to the median payment rate. In other words, CBO expects the bill to result in lower in-network rates. The decrease in-network rates impact on premiums is somewhat offset by the increased costs for insurers to cover out-of-network care costs that was previously the responsibility of the patient.

The converse of this effect is that provider revenue would decrease revenue for providers, especially those that derive significant revenue from surprise billing.

While CBO estimates that the impact would be positive from the perspective of all consumers and insurers, state experiences with arbitration and surprise billins have differed. For example in New York and New Jersey, surprise billing restrictions has reduced cost-sharing for patients although has likely increased premiums, insurer costs, and provider revenue.[2]

Other Considerations

- Rulemaking due by July 1, 2021 - One of the key questions is what the methodology will be for median in-network rates, which is the basis for arbitration. The exact rules as to how the rates are calculated could influence the ultimate impact of the new law.
- Interactions with States- Currently, 17 states have some form of law in place to protect patients from surprise billing for their respective fully insured market (state laws cannot pre-empt self-insured plan dynamics due to ERISA). The Federal legislation would not pre-empt the state laws that are in place and instead would only apply to the self-insured

[2] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.00217?journalCode=hlthaff

market in these state. However, states may want to change their current laws so that the self-insured market requirements (i.e., the new Federal standard) in their state aligns with the fully-insured market (i.e., the current state requirement).

- Forthcoming report to Congress- HHS must regularly report to Congress as to the impact of the legislation. This will provide further data and potentially result in additional legislative actions on the topics.

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