



OFFICE OF  
HEALTH POLICY

# HHS Secretary's Report on: Addressing Surprise Medical Billing

A Report Required by Executive Order 13877

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**U.S. Department of Health & Human Services**

Office of the Assistant Secretary for Planning and Evaluation

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## I. Summary

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Surprise medical billing is a widespread and costly problem in the U.S. A person may receive a large bill for medical services received in an emergency situation where there is no realistic opportunity to select providers. Or a person may receive a bill for medical care received at an in-network facility that is provided by an out-of-network provider, without being forewarned that this is occurring. In these situations, patients are not able to engage in informed decision-making and lack basic consumer protections, such as transparent pricing and informed consent, which help prevent providers from price gouging. Congress needs to enact legislation now to protect patients from surprise billing. Sound surprise billing legislation will not only protect patients but will also encourage a fairer, patient-centered healthcare system.

Over the past year since the issuance of Executive Order 13877, *Improving Price and Quality Transparency in American Healthcare to Put Patients First*, the Administration has taken regulatory action to encourage price transparency by hospitals and insurers, which can serve as the backbone for a more comprehensive surprise billing solution. Moreover, given the potential risk that patients treated under emergency conditions by providers outside of their network during the COVID-19 public health emergency could receive substantial surprise bills, the Administration took the initiative within its current authority to implement temporary restrictions on the ability of providers receiving certain assistance from the Provider Relief Fund to surprise bill patients.. This administrative action protects patients from surprise bills for COVID treatment as well as for non COVID-related services. However, the Administration currently does not have the statutory authority to implement a more permanent and comprehensive solution. Congressional action is needed to eliminate the burden of surprise medical bills on patients.

## II. Purpose

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This paper responds to Section 7 of Executive Order 13877, *Improving Price and Quality Transparency in American Healthcare to Put Patients First*,<sup>1</sup> issued on June 24, 2019, that called for a report to the President on additional steps the Administration may take to implement the principles on surprise medical billing announced on May 9, 2019.<sup>2</sup>

The Administration's surprise billing principles include:

- Patients receiving emergency care should not be forced to shoulder extra costs billed by a care provider but not covered by their insurer.
- Patients receiving scheduled care should have information about whether providers are in or out of their network and what costs they may face.
- Patients should not receive surprise bills from out-of-network providers they did not choose and
- Federal healthcare expenditures should not increase.

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<sup>1</sup> <https://www.whitehouse.gov/presidential-actions/executive-order-improving-price-quality-transparency-american-healthcare-put-patients-first>

<sup>2</sup> <https://www.whitehouse.gov/briefings-statements/president-donald-j-trump-wants-protect-patients-families-surprise-billing>

### III. Surprise Billing: An Expensive and Unfair Practice for Patients

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Policymakers have become increasingly aware of the problem of surprise billing, with frequent examples cited in both the professional and mainstream press. People are drawn to the issue because they believe they may be vulnerable to receive such a bill: 41 percent of insured adults were surprised by a medical bill in the past two years and almost half of those, 19 percent, received a surprise medical bill because the provider was out-of-network.<sup>3</sup> The practice of a healthcare provider billing a patient for the difference between what the patient's health coverage reimburses and what the provider charges is often referred to as "balance billing." When such bills are the result of care provided in emergency situations or in non-emergent situations where there is no realistic opportunity for a person to know that care is being provided by an out-of-network provider, this is often referred to as "surprise billing."

Furthermore, people are concerned about affordability: about two thirds of adults worry that they will not be able to afford an unexpected medical bill.<sup>4</sup> While the contribution of surprise billing to medical debt and medical bankruptcies cannot be determined from available data sources, the practice likely plays a role in increasing debt load and stresses on American families who face unexpected bills. Such bills can seem to come out of nowhere, be very costly, and when faced with a surprise bill, people may not feel they have the knowledge or leverage to negotiate lower rates with a provider. They may also fear that if they are unable to afford a surprise bill, the bill may be sent to a collections agency and eventually damage their credit score, if not lead to bankruptcy.

#### Surprise Bills Can Occur for either Emergency or Scheduled Care

There are two main scenarios for a surprise out-of-network bill.

- A. **Emergency services:** In an emergency, when immediate care is required, a person may receive care at a facility or from providers that are outside his/her insurance network. This can happen when the emergency incident takes place away from the consumer's home area, but it can also occur when the person's in-network hospital staffs its emergency room with out-of-network providers. In these situations, a person receives a bill (or multiple bills) for not only the cost-

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<sup>3</sup> K Pollitz, L Lopes, A Kearney, et al., Statistics on Surprise Medical Billing, JAMA Infographic. 2020;323(6):498. 10.1001/jama.2020.0065

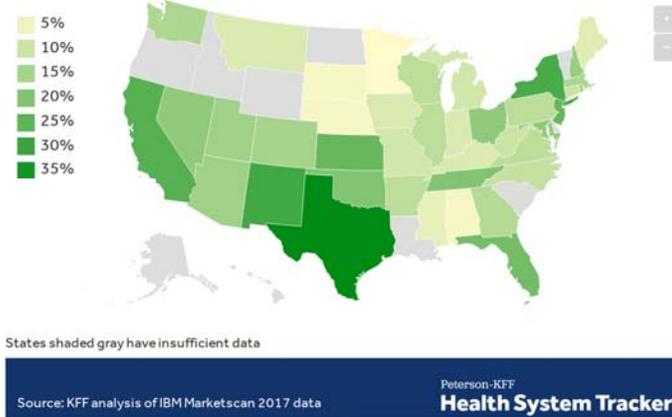
<https://jamanetwork.com/journals/jama/fullarticle/2760721#:~:text=Overall%2C%20two%2Dthirds%20of%20adults,but%20rates%20vary%20by%20state>.

<sup>4</sup> A Kirzinger, B Wu, C Muñana, and M Brodie, Kaiser Health Tracking Poll – Late Summer 2018: The Election, Pre-Existing Conditions, and Surprises on Medical Bills, September 5, 2018 <https://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-late-summer-2018-the-election-pre-existing-conditions-and-surprises-on-medical-bills/>

sharing (copay, coinsurance, and deductible) amount for out-of-network care, but also for the additional amount the provider charges above the amount paid to the provider by their insurer for out-of-network care. This “balance bill” is often multiples of the allowed in-network charge paid by the insurer and can amount to thousands of dollars. An uninsured person receives the same high charge, but is responsible for the whole payment. While trend data on the scope of the problem in emergency situations is not available, an analysis of large insurer claims in 2017 found that, on average, 18 percent of emergency visits and 16 percent of hospital in-patient stays resulted in a surprise bill, although the rates vary by state, with the highest emergency room surprise billing rate in Texas (38 percent) and the lowest in Minnesota (3 percent).<sup>5</sup> Figure 1, based on the above data, shows the share of emergency room visits with at least one out-of-network charge by state for people with coverage from a large employer in 2017.

**Figure 1.**

Among people with large employer coverage, the share of emergency visits with at least one out-of-network charge, 2017



In emergency situations, air ambulance service surprise bills are especially concerning. Air ambulance service, whether by fixed wing aircraft or helicopter, is expensive. A 2019 study by the Government Accountability Office (GAO) found that in 2017, the median price charged by air ambulance providers was approximately \$36,400 for a helicopter transport and \$40,600 for a fixed-wing transport, an increase of over 60 percent from 2012. The GAO found that 69 percent of air ambulance transports of privately insured patients were out-of-network.<sup>6</sup>

<sup>5</sup> K Pollitz, M Rae, G Claxton, C Cox and L Levitt. An examination of surprise medical bills and proposals to protect consumers from them, Peterson-Kaiser Health System Tracker, February 10, 2020, <https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them-3/>.

<sup>6</sup> U.S. Government Accountability Office, AIR AMBULANCE: Available Data Show Privately-Insured Patients Are at Financial Risk, GAO-19-292: Published: Mar 20, 2019, <https://www.gao.gov/products/gao-19-292>.

- B. **Scheduled services:** The second surprise billing scenario involves a scheduled procedure in which the facility is in the insured person’s network, but one or more of the providers delivering care, such as an anesthesiologist or pathologist, are not. People may have performed due diligence in selecting an in-network provider only to have the unpleasant surprise of an unexpected, often large, bill due to ancillary out-of-network providers involved in the person’s care.

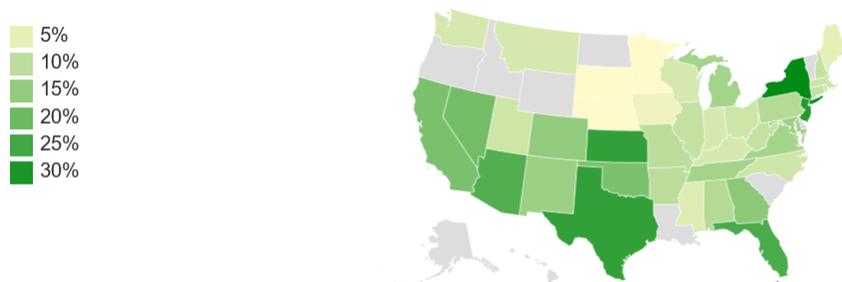
Under both scenarios, the interests of patients are not protected at times when they may be especially vulnerable, as in emergency situations, or, in the case of scheduled procedures, when patients are not provided upfront with the information necessary to make an informed decision. This is especially frustrating for patients with scheduled care who have diligently researched their care options. The examination of 2017 claims noted above found that for scheduled procedures:

- Sixteen percent (16 percent) of in-network inpatient admissions nationwide resulted in at least one out-of-network charge;
- The rate of out-of-network charges varied by state, ranging from 2 percent of in-network inpatient stays in South Dakota, Nebraska, and Minnesota, to about a quarter or more in New York (33 percent), New Jersey (29 percent), Texas (27 percent), and Florida (24 percent); and
- Inpatient stays in urban areas (16 percent) were somewhat more likely to result in at least one out-of-network charge than are stays in rural areas (11 percent).<sup>7</sup>

Figure 2, based on the above data, shows the share of in-network inpatient stays with at least one out-of-network charge by state for people with coverage from a large employer in 2017.

Figure 2.

Among people with large employer coverage, the share of in-network inpatient stays with at least one out-of-network charge, 2017



States shaded gray have insufficient data

Source: KFF analysis of IBM MarketScan 2017 data • [Get the data](#) • PNG

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**Health System Tracker**

<sup>7</sup> K Pollitz, M.Rae, G Claxton, C Cox, and L Levitt, L. op. cit., <https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them-3>.

## Most Surprise Bills Are from Ancillary Providers

Surprise billing most often involves a facility's "ancillary" providers, that is, a hospital's emergency medicine personnel, anesthesiologists, pathologists, radiologists and neonatologists, as well as assistant surgeons, hospitalists and intensivists.<sup>8</sup>

A recent JAMA article examining insurance claims from one large insurer for the years 2012-2017 for privately insured patients receiving elective surgery from in-network surgeons and facilities found that 20.5 percent of these patients received an out-of-network bill. Anesthesiologists and surgical assistants were associated with 37 percent of these bills, with an average out-of-network bill for anesthesiologists of \$1,219 and surgical assistants of \$2,633. Out-of-network billing varied by states, ranging from 3 percent in Nebraska to 46 percent in Alaska. Episodes with out-of-network bills were associated with significantly higher charges than those entirely in-network.<sup>9</sup>

A 2016 data analysis by the Health Care Cost Institute (HCCI), using their commercial claims database, examined how out-of-network professional claims associated with in-network hospital admissions were distributed across medical specialties. This analysis found 16.5 percent of the sample's out-of-network professional claims were performed by an anesthesiologist. Other notable specialties included "other physician" (13.5 percent), primary care (12.6 percent), and emergency medicine (11.0 percent).<sup>10</sup> The HCCI analysis of claims data also found that of the in-network admissions with an independent lab claim, 22.1 percent of those lab claims were out-of-network. Twelve percent of in-network hospital admissions had an out-of-network claim for emergency services.

While there is variation across these studies in the amount of surprise bills, the providers most likely to generate them, and how often they occur across the states, they collectively illustrate that the problem is widespread for patients, adds a sizeable amount to their out-of-pocket medical costs, and often involve ancillary providers.

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<sup>8</sup> These providers are explicitly cited in pending federal legislation discussed below: Alexander-Pallone-Walden Compromise Lower Health Care Costs Act, unnumbered December draft from the Senate HELP Committee and House Energy and Commerce Committee; H.R. 5800, the Ban Surprise Billing Act; and H.R. 5826, the Consumer Protections against Surprise Bills Act of 2020.

<sup>9</sup> K Chhabra, K Sheetz, N Ushapoorna, et al., Out-of-Network Bills for Privately Insured Patients Undergoing Elective Surgery With In-Network Primary Surgeons and Facilities, JAMA. 2020;323(6):538-547, <https://jamanetwork.com/journals/jama/article-abstract/2760735>

<sup>10</sup> <https://healthcostinstitute.org/out-of-network-billing/oon-physician-bills-at-in-network-hospitals>.

## Out-of-Network Billing Increases when Private Staffing Firms Enter the Market

Hospitals are increasingly relying on third party staffing firms to meet their needs for personnel, which is contributing to surprise billing. These private staffing firms are often used to staff emergency rooms and to provide specialty care in areas such as anesthesiology, gastroenterology, urology and orthopedics. Since the contracts hospitals have with providers are not generally available, this paper cites public sources of information.

Private equity plays a large role in third party staffing: the two largest physician staffing firms, Envision/EmCare and TeamHealth, are each owned by private equity firms. Research shows that when private equity firms enter a market the rate of out-of-network billing increases by large percentages: 66 percent for Envision/EmCare and 13 percent for TeamHealth <sup>11 12</sup>

The importance of private equity staffing firms to the surprise billing landscape is illustrated by the lobbying campaign waged by Doctor Patient Unity, a coalition of doctors' groups owned by private equity firms and funded by Envision/EmCare and TeamHealth. As of May 2020, Doctor Patient Unity has spent approximately \$58 million on television and radio commercials and nearly \$1 million on Facebook ads since last summer in order to influence the surprise billing debate, according to ad tracker Kantar/CMAG.<sup>13</sup>

## A Market Based Problem that Demands Attention

Surprise billing in private health insurance represents a market failure that will not correct itself. It is rooted in the complex web of contractual arrangements between patients, employers who sponsor health plans, and health plans and their provider networks and the contractual arrangements between these parties within a network-based service delivery model. For surprise bills associated with emergency care, the patient generally has neither the information nor the option to seek care elsewhere and should be protected from abnormally higher out-of-network prices. For surprise bills associated with scheduled procedures, the patient usually lacks information about the use of out-of-network ancillary providers and generally does not have the opportunity to weigh options or provide informed consent, or they may be faced with these decisions while already in the process of receiving care. In these situations, whenever possible, patients should be informed of their options upfront, by either provider or insurer, and given

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<sup>11</sup> Z Cooper Z, F Scott Morton, N Shekita, A Surprise! Out-of-Network Billing for Emergency Care in the United States, NBER Working Paper No. 23623, July 2017.

[https://isps.yale.edu/sites/default/files/publication/2017/07/surpriseoutofnetwrokbilling\\_isps17-22.pdf](https://isps.yale.edu/sites/default/files/publication/2017/07/surpriseoutofnetwrokbilling_isps17-22.pdf).

Cited in Kaiser Health News, Bluth R and Huetterman E, Investors' Deep-Pocket Push To Defend Surprise Medical Bills, September 11, 2019, <https://khn.org/news/investors-deep-pocket-push-to-defend-surprise-medical-bills/>  
Out-of-network billing rates went up 81 to 90 percent, when EmCare entered a market, 33 percent when TeamHealth did.

<sup>12</sup> However, TeamHealth's entry led to a 30 percent increase in admissions through the hospital's emergency room.

<sup>13</sup> Wall Street Journal, May 14, 2020, <https://www.wsj.com/articles/congress-debates-push-to-end-surprise-medical-billing-11589448603>.

possible, patients should be informed of their options upfront, by either provider or insurer, and given information on how these options affect the cost of their care before the person has already made the decision to undergo a procedure. Currently, in too many cases, consumers are left to make decisions with incomplete information about the network status of providers and the estimated costs of care and are caught between provider and payer, neither of which have sufficient incentive to protect the consumer.<sup>14</sup> Basic consumer protections that provide cost transparency, informed consent, and anti-price gouging should also apply to the uninsured.

## IV. Federal Legislation is the Appropriate Remedy

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Addressing surprise billing has proven challenging because of the complicated structure of health insurance regulation in the United States.

### Health Insurance Regulation is a Complex Mix of Federal and State Oversight

In general, the U.S. Department of Health and Human Services (HHS) has oversight responsibility for insurance plans that participate in the Medicare program and in the Medicaid program where it shares responsibility with the states. Surprise billing generally has not been an issue for Medicare beneficiaries because the statute tightly governs the extent to which balance billing is permitted in the program<sup>15</sup>. HHS also sets minimum standards for health insurers participating in state and federal health insurance exchanges.<sup>16</sup>

Historically, however, states have been the primary regulators of “the business of insurance” as established in the McCarran Ferguson Act of 1945. Further, under title XXVII of the Public Health Service Act (PHS Act), states exercise primary enforcement authority over health insurance issuers in the group and individual markets to ensure compliance with applicable federal requirements. In the event that a state notifies HHS that it does not have statutory authority to enforce or that it is not otherwise enforcing

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<sup>14</sup> This point is underscored in a Georgetown Law Journal article: “Surprise Medical Bills: How to Protect Patients and Make Care More Affordable” by David A. Hyman, Benedic Ippolito and Charles Silver. Vol.108:1655-1678 [https://www.law.georgetown.edu/georgetown-law-journal/wp-content/uploads/sites/26/2020/06/Hyman-Ippolito-Silver\\_Surprise-Medical-Bills-How-to-Protect-Patients-and-Make-Care-More-Affordable.pdf](https://www.law.georgetown.edu/georgetown-law-journal/wp-content/uploads/sites/26/2020/06/Hyman-Ippolito-Silver_Surprise-Medical-Bills-How-to-Protect-Patients-and-Make-Care-More-Affordable.pdf). The authors argue for contractual reform as an alternative to government (state or federal) regulation.

<sup>15</sup> For example, surprise billing is not usually an issue in Medicare Advantage (MA) plans in many cases because CMS regulates the amount and prompt payment requirements for covered out-of-network services and there are rules regarding when MA plans must cover out-of-network care. MA patients are not responsible for out-of-network charges for emergency care and when seeking care at an in-network facility in non-emergency situations only pay the cost-sharing amounts their policies call for and cannot be balance-billed. Federal law limits the amount providers can charge Medicare beneficiaries for Medicare-covered services. The MA plan pays the out-of-network providers Medicare FFS rates, taking into account both enrollee cost-sharing and the plan payment, for covered services that are furnished out-of-network.

<sup>16</sup> See sections 1311(c)(1) and 1321(a) of the PPACA.

one or more of the provisions of title XXVII, or if HHS determines that the state is not substantially enforcing the requirements, HHS has the responsibility to enforce these provisions with respect to health insurance issuers in the state.<sup>17</sup> This enforcement framework, in place since 1996, ensures that consumers in all states have the minimum protections established under federal law. However, state insurance rules do not apply to self-insured employee benefit plans established or maintained by private sector employers. Such plans generally have been under the purview of the Department of Labor (DOL) since the enactment of the Employee Retirement and Income Security Act (ERISA) in 1974, which preempts state regulation of these plans. ERISA sets minimum standards for these health plans and DOL monitors employer compliance. Roughly, 61 percent of workers with employee-sponsored health insurance are enrolled in self-insured ERISA plans, meaning any state efforts to address surprise billing necessarily leave a major gap, since addressing surprise billing for all ERISA plans requires Federal action.<sup>18</sup>

The Department of the Treasury (Treasury), through the Internal Revenue Service, is responsible for administering healthcare related provisions of the federal tax code as they affect either individuals or employers. For example, the Treasury regulates the rules for employers to provide health coverage to their employees without including the contributions or benefits in income, for individuals to report minimum essential healthcare coverage when filing their tax returns, and is jointly responsible, with HHS and DOL, for providing guidance on certain market requirements for group health plans.<sup>19</sup> While the rules administered solely by Treasury are only indirectly relevant to the surprise billing discussion, the Treasury's involvement in the regulation of group health plans adds to the complexity of the Federal role in health insurance regulation of health plans and health insurance. Thus, to change federal law governing surprise billing, legislation must address the roles of these three major federal Departments<sup>20</sup>. In addition,

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<sup>17</sup> HHS is also responsible for enforcing the provisions of the PHS Act applicable to “group health plans that are Non-Federal Governmental Plans.” Examples of Non-Federal Governmental plans are plans sponsored by states, counties, school districts, and municipalities for their respective employees. For self-funded Non-Federal Governmental plans, CMS is the primary regulator of the group health plan. For fully-insured Non-Federal Governmental plans, CMS regulates the group health plan and the applicable state regulator regulates the issuer (unless HHS determines the state is failing to substantially enforce, in which case HHS is responsible for ensuring compliance with applicable PHS Act requirements by issuers in that state).

<sup>18</sup> J Hoadley, K Lucia, and Maanasa, To the Point: State Efforts to Protect Consumers from Balance Billing, the Commonwealth Funds, January 18, 2019, <https://www.commonwealthfund.org/blog/2019/state-efforts-protect-consumers-balance-billing>

<sup>19</sup> HHS, Labor, and the Treasury operate under a Memorandum of Understanding (MOU) that implements section 104 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and subsequent amendments, and provides that requirements over which two or more of the Secretaries have responsibility (“shared provisions”) must be administered so as to have the same effect at all times. See 64 FR 70164 (December 15, 1999). HIPAA section 104 also requires the coordination of policies relating to enforcing the shared provisions in order to avoid duplication of enforcement efforts and to assign priorities in enforcement.

<sup>20</sup> The Federal Employees Health Benefits Program, managed by the Office of Personnel Management (OPM) manages health insurance benefits for federal employees and annuitants. While surprise billing is not banned, OPM's program carrier letter for plan year 2021 encourages price transparency by noting that it has required carriers to develop and implement online provider search tools that, no later than plan year 2022, ensure that listings for in-

Congressional action is particularly tricky because of the differing, yet sometimes overlapping, jurisdictions of Congressional committees.

One additional complication is that the Airline Deregulation Act of 1978 makes economic regulation of air ambulances services an exclusively federal responsibility, under the purview of the Federal Aviation Administration.<sup>21</sup>

## Overview of Federal and State Legislative Action on Surprise Billing

Most of the legal action regarding surprise billing has taken place at the state level. The Patient Protection and Affordable Care Act (PPACA) addressed some issues related to surprise billing.<sup>22</sup> PPACA provides that if a non-grandfathered self-insured group health plan, or non-grandfathered health insurance issuer offering large-group, small group, or individual market health insurance provides any benefits for emergency services in an emergency department of a hospital, the plan or health insurance issuer must cover emergency services without regard to whether a particular healthcare provider is an in-network provider for those services. Through a tri-departmental rule, HHS, with the DOL and Treasury, has developed minimum payment standards for such plans to apply to such services to protect patients from unexpectedly high emergency room bills.<sup>23</sup> Payment by such plans for out-of-network emergency services must be at least the greatest of these payment standards: (1) the median amount the plan or insurer has negotiated with in-network providers for the furnished service; (2) the amount for the emergency service calculated using the same method the plan or insurer generally uses to determine payments for out-of-network services (such as, the usual, customary, and reasonable amount) the insurer pays out-of-network providers for the furnished service); or (3) the amount that would be paid under Medicare for the furnished service.<sup>24</sup> In addition, such plans generally cannot impose any copayment or coinsurance that is greater than what would be imposed if these services were provided in-network. However, PPACA and its implementing regulations addressed surprise billing only in this limited instance, and group health plans and health insurance issuers are not required to cover the amounts that out-of-network providers might balance bill, leaving out a crucial patient protection.

At the state level, health plans offered by state-licensed insurers in the individual and group markets are also generally primarily subject to state law. As a result, state actions on surprise billing have been limited

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to look for ways to address surprise billing for FEHB enrollees in the future.” See: <https://www.opm.gov/healthcare-insurance/healthcare/carriers/2020/2020-01.pdf>

<sup>21</sup> Government Accountability Office, Available Data Show Privately-Insured Patients Are at Financial Risk, GAO 19-292, March 2019. State efforts to address air ambulance prices have been unsuccessful in court.

<sup>22</sup> Congressional Research Service (CRS), surprise billing in Private health Insurance: Overview and Federal Policy Considerations, December 12, 2019, <https://crsreports.congress.gov/product/pdf/R/R46116>.

<sup>23</sup> See 45 C.F.R. § 147.138(b)(3).

<sup>24</sup> *Ibid.* without regard as to whether a particular healthcare provider is an in-network provider for those services.

to health insurance coverage and have led to a national patchwork of varying requirements that differ across states, where the degree of consumer protection depends on which state the consumer lives in. As of April 2020, over half of the states (29) had taken some action to address surprise billing.<sup>25</sup> State legislation varies in scope; as to which providers or services are covered, the types of insurance to which the laws apply, disclosure requirements, and most notably in how payment is determined. Approaches states have taken include: establishing payment based on a percentage of Medicare rates or establishing payment based on average network payments or provider charges; or through an arbitration process.

The legislation of 15 states meet criteria that researchers at Georgetown have identified as comprehensive.<sup>26</sup> That is, they:

- Extend protections to both emergency and non-emergency services;
- Apply balance billing laws to all types of insurance that are subject to state regulation, including Health Maintenance Organizations and Preferred Provider Organizations;
- Protect consumers both by requiring that insurers hold them harmless from extra provider charges – meaning they are not responsible for the charges – and by prohibiting providers from balance billing; and
- Adopt an adequate payment standard – a rule to determine how much the insurer pays the provider – or an arbitration process to resolve payment disputes between providers and insurers.<sup>27,28</sup>

It is too early to evaluate the impact of most of these state surprise billing laws. In many cases, they are the result of incremental changes over time, with relatively short track records for a complete package of provisions. Two large states whose legislation has been implemented for several years are New York and California. Details regarding the experience of these states with surprise billing legislation, including considerations regarding the impact of different payment mechanisms on overall healthcare spending and on provider networks, are provided in the Appendix.

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<sup>25</sup> The Commonwealth Fund, “State Balance Billing Protections”  
<https://www.commonwealthfund.org/publications/maps-and-interactives/2019/jul/state-balance-billing-protections>.

<sup>26</sup> The states are: California, Colorado, Connecticut, Florida, Illinois, Maryland, New Hampshire, New Jersey, New Mexico, New York, Oregon, Texas, and Washington. Two additional states, Maine and Virginia will have comprehensive legislation take effect in January 2021.

<sup>27</sup> State Approaches to Protecting Consumers from Surprise Medical Bills, Statement of Jack Hoadley, Ph.D. Research Professor Emeritus Health Policy Institute, McCourt School of Public Policy Georgetown University Before the House Committee on Education on Labor Subcommittee on Health, Education, Labor, and Pensions Examining Surprise Billing: Protecting Patients from Financial Pain April 2, 2019,  
<https://edlabor.house.gov/imo/media/doc/2019-04-02%20HELP%20Hearing%20Hoadley%20Testimony.pdf>.

<sup>28</sup> These states are California, Colorado, Connecticut, Florida, Illinois, Maryland, New Hampshire, New Jersey, New York, Oregon, Texas and Washington. Pollitz et al., op. cit.

In order to effectively address surprise billing, federal legislation is needed to address all ERISA group health plans, including self-insured ERISA arrangements that state legislation cannot address, and to provide a national surprise billing standard that would apply to all states. Legislation needs to be simple and fair for patients and not place implementation barriers on health plans, insurers, and providers.

## V. Price Transparency: Foundational but More is Needed to Fully Address Surprise Billing

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On June 24, 2019, President Trump signed Executive Order 13877, *Improving Price and Quality Transparency in American Healthcare to Put Patients First*, establishing the federal policy to make health care price and quality information more easily accessible to patients. In 2019, HHS published two rules supporting the Administration's mission to improve accessibility of healthcare price information to help patients make informed decisions about their use of health care services.

The first rule, which pertains to hospital price transparency, was published on November 27, 2019 and will go into effect January 1, 2021. This final rule implements new requirements under 42 U.S.C. § 300gg-18(e), which requires hospitals operating in the United States to establish, update, and make public at least annually a list of their standard charges for the items and services that they provide.

Under this rule, hospitals must make public their standard charges online in two ways as follows:

1. For each hospital location, most hospitals must make public all their standard charges (including gross charges, payer-specific negotiated charges, de-identified minimum and maximum negotiated charges, and discounted cash prices) for all items and services they provide online in a single digital file in a machine-readable format.
2. Hospitals must also make public at least annually payer-specific negotiated charges, de-identified minimum and maximum negotiated charges, and discounted cash prices for at least 300 "shoppable" services (which are defined as services that can be scheduled in advance), or if the hospital does not provide 300 shoppable services, then for as many shoppable services as it provides. Of the 300 shoppable services, 70 are specified by the Centers for Medicare & Medicaid Services and 230 are hospital-selected. The shoppable service information must be made public in a consumer friendly manner. Information must also be provided on corresponding ancillary services, as applicable;; codes used for billing; and location in the hospital where the shoppable service is provided.

A second, companion proposed rule pertaining to most health insurance plans, was issued jointly by the Treasury, DOL, and HHS and published in the Federal Register on November 27, 2019. The intent of this proposed rule is to empower consumers to shop for their health care services based on value, and to be able to make more informed decisions about their care, while also promoting consumerism and competition in the health care industry.

Provisions of this proposed rule address some surprise billing issues by proposing to require most group health plans and health insurance issuers offering health insurance coverage in the individual and group markets to make available to participants, beneficiaries or enrollees (or their authorized representatives) personalized out-of-pocket cost information for health care items and services through both an internet-based, self-service tool and, upon request, in paper form, and by incentivizing consumers to shop for and receive care from lower-cost, higher-value providers. These provisions would encourage and allow consumers to receive an estimate of their cost-sharing liability before receiving care, informing consumers of their expected out-of-pocket costs and incentivizing them to shop and compare costs for items and services from different providers.

Specifically, the November 27, 2019 proposed rule included proposals to require most employer-based group health plans (including self-insured) and individual health insurers to:

- Create a consumer tool: Disclose personalized and real-time price and cost-sharing information to participants, beneficiaries, and enrollees in an internet-based self-service tool. The tool must include personalized information for each requested health service:
  - *Estimated cost-sharing liability,*
  - *Accumulated amounts (i.e., amount of financial responsibility that an enrollee incurred toward applicable limits, including deductibles and out-of-pocket cost limits, at the time the request for cost-sharing information is made),*
  - *Negotiated rate,*
  - *Out-of-network allowed amount,*
  - *Items and services list for bundled payments,*
  - *Notice of prerequisite to coverage, if applicable,*
  - *A disclosure that out-of-network providers' balance billing is not included in these estimates, and that actual charges for items and services may differ, and*
  - *A statement that the estimated cost-sharing liability for a covered item or service is not a guarantee that coverage will be provided for those items and services.*
- Publish Prices: Publish in-network negotiated rates and historical out-of-network allowed amounts for covered services in a machine-readable format. Information the rule requires in the machine-readable files includes: name or identifier for each plan, billing codes, and either in-network negotiated rates or out-of-network historical payments. It is anticipated third party application developers will use these files to create consumer cost estimating tools tailored to specific coverage that provide a consumers a more complete picture of costs for episodes of care.
- Share Savings with Consumers: Through proposed changes to the medical loss ratio (MLR) rules, issuers offering group or individual health insurance coverage would receive credit in their MLR calculations for savings they share with enrollees that result from enrollees shopping for receiving care from lower-cost, higher-value providers.

The Administration's price and quality transparency regulations provide a foundation of information to help empower patients to shop for cost-effective health care. If finalized and implemented, these rules would provide price transparency tools to complement those of other organizations. For example, FAIR Health, a national, independent nonprofit organization, provides access through its website and app to information on privately billed insurance claims and Medicare Parts A, B and D claims, including uniform, reasonable and customary Medicare rates and median in-network prices.

However, the information that will be available through these rules and consumer resources like FAIR Health, while helpful to address issues around lack of price transparency, will not protect patients from surprise billing. For instance, as noted above, this rule will not provide information on potential out-of-pocket costs that consumers may incur from balance billing and may not flag instances where an out-of-network provider is practicing at an in-network facility. Nor do they provide redress to a person who has received a surprise bill.

## VI. Brief Summary of Recent Congressional Activity Addressing Surprise Billing

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Deliberations over surprise billing legislation are continuing in Congress and the below summary of pending legislation may not reflect the most recent Congressional activity. Nevertheless, we discuss three bills to illustrate the major themes in Federal surprise billing legislation, areas of agreement and issues that have not yet been resolved.

In early 2020, there were three major surprise billing bills at various stages pending in Congress:

1. The Alexander-Pallone-Walden Compromise, a December 2019 bicameral compromise draft (December comprise) from the Senate Health Education, Labor and Pensions (HELP) Committee and the House Energy and Commerce Committee;<sup>29</sup>
2. H.R. 5800, the Scott-Foxo “Ban Surprise Billing Act,” which the House Education and Labor Committee approved by a large margin on February 11, 2020; and
3. H.R. 5826, the Neal-Brady “Consumer Protections against Surprise Bills Act of 2020,” which was approved by the House Ways and Means Committee by a voice vote on February 12, 2020.

These three bills have much in common. They:

- Address the Administration’s four surprise billing principles in that they:
  - Take the patient out of negotiations between providers and payers regarding how to settle surprise bills in emergency situations and require transparency in non-emergent situations;
  - Apply to emergency and non-emergency surprise billing situations;
  - Require the patient’s informed consent for non-emergent out-of-network care; and
  - Do not directly raise Federal costs.
- Apply to both practitioners and facilities.
- Apply to private health plans, including fully-insured and self-funded plans.
- Hold the patient responsible only for the cost-sharing required for in-network care and remove the patient from any subsequent dispute resolution between health plan and providers.
- Defer to state dispute resolution mechanisms and/or payment standards with respect to insured coverage.

The primary difference among these bills is in how disputes between insurance plans and providers are resolved and how the level of payment is set when a surprise bill is triggered.

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<sup>29</sup> This version of the bill is unnumbered and has not been acted on by either committee

The December compromise bill and the Scott-Foxo bill, both set the benchmark payment at the plan or health insurance issuer's median contracted in-network rate for 2019 and provide for its annual adjustment by the consumer price index for all urban consumers. For claims over \$750, they both provide for a process of "baseball" style "independent dispute resolution (IDR)", similar to that used in New York, where each party submits a proposed payment to a neutral unbiased arbitrator, chosen from a federally compiled list, who makes a final binding selection. The "loser" pays the administrative costs of the IDR.

In contrast, the Neal-Brady bill does not offer a payment benchmark. Instead, it provides for voluntary negotiations between parties over a 30-day period. If there no agreement is reached, there is a mediated negotiation process, with the loser paying the process costs. There is no minimum threshold for this process. There is also an annual administrative fee for parties who wish to take part in the mediation process to defray federal costs of establishing and operating the mediation process.

In addition, the bills differ on the treatment of air ambulances. Both the December compromise bill and the Scott-Foxo bill apply provisions to air ambulances, with eligibility for the IDR applying to bills in excess of \$25,000. The Neal-Brady bill does not include air ambulances, but does provide for establishing an air ambulance reporting system to track costs. None of the proposals address surprise ground ambulance bills, although the Education and Labor Committee bill provides for an advisory commission to make recommendations on ways to prevent balance billing for these services, potential state actions, and possible federal legislation.

Unique among pending pieces of legislation, the Neal-Brady bill requires HHS to establish a dispute resolution process for instances when uninsured individuals who receive prospective estimates for the costs of services are then billed for charges "substantially in excess" of that estimate.

## Impact on Federal Healthcare Spending

The Congressional Budget Office (CBO) has scored the Scott-Foxx bill<sup>30</sup> and the Neal-Brady bill.<sup>31</sup> As previously noted, the surprise billing provisions of the bicameral compromise bill closely resemble those of the Scott-Foxx bill. The CBO estimates that each bill would save the federal government money because they believe the average of payment rates for both in- and out-of-network care would move toward the plan or health insurance issuer's median in-network rate, which tends to be lower than average rates. Differences in impact on Federal spending result from the different approaches these bills take toward IDR, with the more stringent IDR requirements of the Scott-Foxx bill providing for lower insurance premiums and thus more Federal savings.

- Under the Neal-Brady bill, the CBO estimated that the federal deficit would be reduced by approximately \$18 billion over 10 years, because CBO believes average payment rates for both in- and out-of-network services would move toward the plan or health insurance issuer's median in-network rate, which tends to be lower than average rates.
  - Lower payments to some providers would reduce premiums by between 0.5 percent and 1 percent.
  - Lower costs for health insurance would reduce federal deficits because of the federal government tax subsidy for employer-based health insurance and through lower prices for plans participating in the state and federal health insurance Exchanges.
- Due to the Scott-Foxx bill's use of a payment benchmark and its more limited use of IDR, the CBO estimated that this bill would reduce premiums by 1 percent, reducing the Federal deficit by almost \$24 billion over ten years.

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<sup>30</sup> Congressional Budget Office Cost Estimate, H.R. 5800, the Ban Surprise Billing Act, as ordered reported by the House Education and Labor Committee on February 11, 2020, February 13, 2020 <https://www.cbo.gov/system/files/2020-02/hr5800.pdf>

<sup>31</sup> Congressional Budget Office Cost Estimate, H.R. 5826, the Consumer Protections Against Surprise Medical Bill Act of 2020, as introduced on February 10, 2020, February 11, 2020, <https://www.cbo.gov/system/files/2020-02/hr5826table.pdf>

## VII. Surprise Billing and the COVID-19 National Emergency

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The general disruption of local health care delivery systems caused by the COVID-19 public health emergency (PHE) has raised concerns about the costs related to COVID-19 testing and treatment and the potential for surprise billing in this environment.

Two pieces of legislation Congress enacted to respond to the PHE have included provisions that address surprise billing in certain situations. The Families First Coronavirus Response Act, as amended by the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), requires group health plans and health insurance issuers offering group and individual health insurance coverage to cover certain COVID-19 diagnostic testing and certain related items and service without any cost-sharing (such as a copay or coinsurance), prior authorization, or other medical management requirements if furnished on or after March 18, 2020 and during the applicable emergency period. Section 3202(a) of the CARES Act requires plans and health insurance issuers to reimburse providers of COVID-19 diagnostic testing at either rates the plan has negotiated or an amount that equals the cash price for such service that is listed by the provider on a public website. (The plan or issuer may negotiate a rate with the provider that is lower than the cash price.) In either case, the amount the plan or issuer reimburses the provider constitutes payment in full for the test with no cost sharing to the individual or other balance due. However, section 3202(a) of the CARES Act does not explicitly preclude balance billing for items and services not subject to section 3202(a), although balance billing may be prohibited by applicable state law and other applicable contractual agreements.<sup>32</sup>

Nevertheless, HHS has taken an additional important step toward eliminating the risk of surprise billing during the PHE. The Provider Relief Fund provides financial support to hospitals and other providers that are addressing the COVID-19 emergency and its consequences. In the implementation of this Fund, HHS has demonstrated its commitment to addressing surprise billing by establishing as a condition of receiving certain payments from the Provider Relief Fund a requirement that providers agree not to seek collection of out-of-pocket payments from a presumptive or actual COVID-19 patient that are greater than what the patient would have been required to pay if the care had been provided by an in-network provider.<sup>33</sup> Some of these funds, as well as funding appropriated in the Families First Coronavirus Response Act and the Paycheck Protection Program and Health Care Enhancement Act to reimburse providers for testing are

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<sup>32</sup> Centers for Medicare & Medicaid Services, FAQs about Families First Coronavirus Response Act and Corona Virus Aid, Relief, and Economic Security Act, Part 43, June 23, 2020, <https://www.cms.gov/files/document/FFCRA-Part-43-FAQs.pdf>

<sup>33</sup> <https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html>.

targeted to the uninsured Providers seeking these funds will be reimbursed at Medicare rates and cannot balance bill.<sup>34</sup>

Some states have taken action to protect consumers from coronavirus-related balance billing, or to urge, but not require insurers to protect the insured from surprise bills. For example, New York prohibits private insurance companies from imposing cost-sharing on enrollees when they seek COVID-19 testing and its regulations ensure or encourage coverage of other services related to treatment of COVID-19 and protect from surprise bills from out-of-network providers. States such as Massachusetts and New Mexico, require insurers to cover COVID testing and treatment without cost-sharing.<sup>35</sup> As noted above, these state actions do not cover all consumers within a state.

## VIII. Conclusion

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Many Americans have been affected by surprise billing and even more are at risk for an unexpected bill. The COVID-19 pandemic underscores the urgency of addressing the issue and illustrates that action on surprise billing is possible. In response to the President's release of surprise billing principles, the Administration has taken regulatory and administrative action to increase price transparency permanently and limit the risk of a surprise bill during the PHE. It is imperative for Congress to build on these achievements and permanently remove the threat surprise billing poses for millions of American patients. The problem is well understood. There is bipartisan support that patients should not be subject to surprise billing and senior Committee Chairs have expressed that they are committed to addressing this problem. There may not be a better time to pass legislation to protect patients from balance bills than in the next COVID-19 bill and we strongly encourage Congress to identify and incorporate a bicameral solution into the next COVID-19 bill.

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<sup>34</sup> <https://www.hrsa.gov/CovidUninsuredClaim>

<sup>35</sup> S Corlette, K Lucia, and M O'Brien, What Are State Officials Doing to Make Private Health Insurance Work Better for Consumers During the Coronavirus Public Health Crisis? The Commonwealth Fund, March 20, 2020, <https://www.commonwealthfund.org/blog/2020/what-are-state-officials-doing-make-private-health-insurance-work-better-consumers-during>.

## Appendix

### Discussion of Surprise Billing Legislation in New York and California

New York's surprise billing law was passed in October 2014 and went into effect March 31, 2015. Prior to its passage, the state found that 90 percent of surprise bills were for in-hospital services other than emergency services. In New York, a bill is considered a surprise bill when the patient is treated at any point by an out-of-network provider without giving consent such as when no in-network provider is available or an in-network physician made a referral without explaining the referral provider is out-of-network; or an emergency arises over the course of a visit that requires immediate attention by an out-of-network provider.<sup>36</sup>

New York uses an independent dispute resolution (IDR) process for resolving disputes between providers and health insurance issuers. Each party makes its best offer and an IDR entity decides which is the most "reasonable."<sup>37</sup> The state's guidance provides that arbiters should consider the 80th percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database in determining payment.

The state of New York issued a report on its surprise billing law finding that the law has saved consumers over \$400,000,000 in emergency room services between March 2015 and the end of 2018.<sup>38</sup> The report also cites a separate paper's findings that through 2015 the New York law reduced out-of-network billing by 34 percent and lowered in-network emergency physician payments by 9 percent.<sup>39</sup> For the years 2015 through 2018, the report found that 43 percent of emergency services IDR results were in favor of the health plan, 24 percent were in favor of the provider, and 33 percent were split between both parties. The specialties most often involved in IDR decisions not involving emergency services were neurosurgery (31 percent of IDR disputes) anesthesiology (25 percent), plastic surgery (15 percent) and neurology (12 percent).<sup>40</sup> The state reports that 13 percent of IDR decisions for all health services (not just emergency services) over that time period were in favor of the health plan, 48 percent in favor of the provider, and 39 percent between were split between both parties.<sup>41</sup>

While New York asserts consumer savings from its legislation, researchers at the Brookings Institute suggest that the state's IDR process is increasing health care costs by having the arbiters consider the 80th percentile of billed charges when determining payment in a dispute. Charges are typically much higher

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<sup>36</sup> NYS Health Foundation, Issue Brief: New York's efforts to Reform Surprise Medical Billing, February 2019.

<sup>37</sup> New York State Department of Financial Services, Report on the Independent Dispute Resolution Process September 2019, [https://www.dfs.ny.gov/system/files/documents/2019/09/dfs\\_oon\\_idr.pdf](https://www.dfs.ny.gov/system/files/documents/2019/09/dfs_oon_idr.pdf).

<sup>38</sup> However, it does not provide supporting evidence for this assertion.

<sup>39</sup> Z Cooper, F Scott Morton, N Shekita, A Surprise! Out-of-Network Billing for Emergency Care in the United States, NBER Working Paper No. 23623, July 2017, Revised January 2018, <https://www.nber.org/papers/w23623.pdf>.

<sup>40</sup> New York State Department of Financial Services, op.cit.

<sup>41</sup> *Ibid.*

than negotiated network rates. Moreover, Brookings has found that New York arbitration decisions have averaged 8 percent higher than the 80th percentile of charges. Brookings also finds that when the insurer “wins,” its payment averages only 11 percent below the 80th percentile of charges, far above negotiated rates, implying the process is increasing, not decreasing costs.<sup>42</sup>

California’s surprise billing law, enacted in 2017, requires fully insured plans to pay out-of-network physicians working at in-network hospitals the greater of the insurer’s local average contracted rate or 125 percent of the Medicare rate, and has an independent dispute resolution (IDR) process for resolving differences. Stakeholders are divided on the legislation’s effects. The California Medical Association asserts that the law has resulted in narrower provider networks resulting in reduced consumer access and more patient complaints. In contrast, America’s Health Insurance Plans (AHIP) reports an increase in the number of physicians participating in networks across all specialties, including those hospital-based specialties most affected by surprise billing, with no signs that networks were narrowing.<sup>43</sup> A Brookings Institute study of California’s law comparing time periods pre- and post-implementation found a 17 percent drop in the share of services delivered out-of-network at in-network hospitals and ambulatory surgical centers in the affected specialties. The drop in out-of-network services ranged from 15 percent for pathology to 31 percent for neonatology-perinatal medicine. However, there are significant limitations to this study. Of particular concern is that the dataset used was incomplete (27 percent of relevant claims missing network status) and included self-insured plans, who were not affected by the law. Also, California’s network adequacy standards are more demanding than most states, so results may not be generalizable to other states, and therefore further study is needed.<sup>44</sup> Other writers suggest that the payment benchmarks are too low, the IDR is slow and administratively expensive, and that networks are starting to narrow.<sup>45</sup>

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<sup>42</sup> L Adler, Experience with New York’s arbitration process for surprise out-of-network bills, USC-Brookings Schaeffer on Health Policy, October 24, 2019 <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/10/24/experience-with-new-yorks-arbitration-process-for-surprise-out-of-network-bills/>.

<sup>43</sup> Adler L, Duffy E, Bich L, and Trish E “California saw reduction in out-of-network care from affected specialties after 2017 surprise billing law, USC-Brookings Schaeffer on Health Policy, September 26,2019. <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/09/26/california-saw-reduction-in-out-of-network-care-from-affected-specialties-after-2017-surprise-billing-law/>.

<sup>44</sup> *Ibid.*

<sup>45</sup> Brannon, and D Kemp, “The Potential Pitfalls of Combatting Surprise Billing,” Regulation, Fall 2019, <https://www.cato.org/sites/cato.org/files/2019-10/regulation-v42n3-1-updated.pdf>