

insights

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Surprise billing legislation: What employers need to know

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In December 2011, my husband suffered a type of cardiac arrest, commonly referred to as a “widowmaker” heart attack. The good news is that he was one of the few individuals who survive such an attack. The bad news is that the ICU doctors who treated him for the first seven weeks of his 5½-month hospitalization were out-of-network under my firm’s medical plan. As a result, I subsequently received a six-figure bill for services rendered by the ICU doctors. The bill was unexpected because I had been careful to call my plan shortly after my husband was admitted to confirm that the hospital was in-network. In today’s news, this is referred to as “surprise medical billing.”

What is surprise medical billing?

Surprise medical billing primarily occurs in two situations: (1) emergency medical services rendered by an out-of-network provider, or (ii) emergency or non-emergency medical services rendered by an out-of-network provider in an in-network facility. In both circumstances, patients and their families have little control over the selection of the out-of-network provider. Once the patient’s health plan pays the out-of-network percentage under the terms of the plan, the patient is responsible for the rest. This practice is referred to as “balance billing.” Often, patients and their families are not aware that a provider is out-of-network until the bill for services is received.

According to a recent study of large employer plans by the Kaiser Family Foundation, about 18% of inpatient admissions result in out-of-network charges.¹ Even if services are provided at an in-network facility, 15% of admissions include out-of-network charges. This percentage jumps to 24% in the case of emergency room services provided at an in-network facility.²

State laws

Twenty-one states have adopted statutes or regulations to protect patients from the impact of balance billing by out-of-network providers.³ In some cases, the protections are limited, e.g., to emergency services or health maintenance organizations (HMOs).⁴ Six states have adopted comprehensive laws addressing balance billing by out-of-network providers.⁵ However, these laws can only apply to insured medical plans due to the preemption rules under ERISA.⁶

Federal legislative activity

Congress is also beginning to take action to address the issue of surprise medical billing via the introduction of three bills.

Protecting Patients from Surprise Medical Bills Act

On September 18, 2018, six senators introduced legislation in a bipartisan effort to address the issue of surprise medical billing. The bill, titled the “Protecting Patients from Surprise Medical Bills Act,” was introduced by Senator Bill Cassidy (R-La.) and co-sponsored by Sens. Top Carper (D-Del.), Tod Young (R-Ind.), Claire McCaskill (D-Mo.) Michael Bennet (D-Colo.) and Chuck Grassley (R-Iowa) (the “Cassidy bill”). The Cassidy bill includes the following protections:⁷

Emergency services and post-stabilization services

- The amount of cost-sharing or coinsurance applied with respect to emergency services provided by an out-of-network provider must not exceed the cost-sharing or coinsurance imposed with respect to emergency services provided in-network.

- Plans or insurers would be required to pay any excess charges by out-of-network providers for emergency services subject to a cap established by state law. If no state law cap is established, the plan or issuer would be required to pay the excess based on the greater of:
 - The median in-network rate negotiated by plan and insurers for providers in the same or a similar specialty in the same geographical area; or
 - The usual, customary and reasonable charges for the service, defined as 125% of the average allowed amount for all private health plans and insurers for the geographic area as determined by the state insurance regulator or the U.S. Secretary of health and Human Services.
- Out-of-network providers or facilities that have provided emergency services to a patient would be required to provide written notice to the patient prior to providing subsequent non-emergency services, (i) informing them that the provider or facility is an out-of-network provider and the potential for higher cost-sharing, and (ii) requiring a signed acknowledgement by the patient or receipt of the notice. The patient would also need to be given the option to transfer to an in-network facility.

Non-emergency services

- Plans or insurers must not impose cost-sharing with respect to services provided by an out-of-network provider at an in-network facility for non-emergency services that is greater than the cost-sharing that would apply had such services been provided by an in-network provider.
- Plans or insurers would be required to pay any excess charges by out-of-network providers for non-emergency services provided by an out-of-network provider at an in-network facility subject to the same types of caps described above for emergency services.

No More Surprise Medical Bills Act of 2018

On October 11, 2018, Senator Maggie Hassan (D-NH) introduced the No More Surprise Medical Bills Act of 2018 (the "Hassan bill"). Senator Jeanne Shaheen (D-NH) cosponsored the bill. The bill includes the following provisions:⁹

Notice and consent requirements

The Hassan bill includes the following notice and consent requirements:

- On the date an appointment is made and on the date services are rendered, a provider must give:
 - An oral explanation of the written notice described below and documentation of such oral explanation; and
 - A written notice that includes the following information:
 - Whether the provider is out-of-network with respect to the patient's health plan or insurance, and, if so, the estimated amount the provider will charge above the cost sharing obligation the patient would have if the provider were in-network; and
 - In the case of a provider that is a hospital, critical access hospital or ambulatory surgical center, whether any of the providers or suppliers of such hospital or center who will provide services are out-of-network, and, if so, the estimated amount such provider will charge above the cost sharing obligation the patient would have if the provider were in-network.
- An out-of-network provider must also obtain a consent from the patient, signed not less than 24 hours prior to services being rendered, that (i) acknowledges that the patient has been provided with a written estimate and an oral explanation of the charges for services by the out-of-network provider, (ii) informs the patient that the charges will not count toward meeting limitations under the plan or insurance with respect to cost-sharing, and (iii) reflects the consent of the patient to be furnished services by the out-of-network provider and to be charged based on the cost estimate.

Limitations on balance billing

The Hassan bill sets forth the following limitations on balance billing:

- If an out-of-network provider fails to satisfy the notice and consent requirements described above, such provider may not charge the patient more than the in-network charges for services rendered.
- In the case of same-day emergency services, an out-of-network provider may not charge the patient more than the in-network charge for such services.

Surprise billing situations

If services are provided by an out-of-network provider who fails to satisfy the notice and consent requirements in the Hassan bill, referred as a “surprise billing situation,” the following rules will apply:

- Amounts paid by a patient in a surprise billing situation will count toward meeting any annual limitation on cost sharing under the plan or insurance.
- Payment disputes between plans or insurers and out-of-network providers will be resolved via an independent dispute resolution process established by the Secretary of Health and Human Services.

Reducing costs for out-of-network services act of 2018

On October 3, 2018, Senator Jeanne Shaheen (D-NH) introduced the Reducing Costs for Out-of-Network Services Act of 2018 (the “Shaheen bill”).⁹ The Shaheen bill caps the amount that out-of-network providers can charge in any situation to the rate established by the State. A state may choose its rate from the following three options:

- 125% of the applicable Medicare fee-for-service rates;
- 80% of the usual and customary rate for the service as determined by a database of usual, customary, and reasonable charges chosen by the State; or
- 100% of the charges that would be imposed for such service by an in-network provider.

Conclusion

All of the above bills could affect the services offered by employers under their group health plans. In the case of the Cassidy bill, the legislation could also impact the costs borne by the employer for certain services provided to employees. Employers will want to carefully monitor future congressional action in the area of surprise medical billing.

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1. Claxton, Gary, Rae, Matthew, Cox, Cynthia and Levitt, Larry, An Analysis of Out-of-Network Claims in Large Employer health Plans, Kaiser Family Foundation, <https://www.healthsystemtracker.org/brief/an-analysis-of-out-of-network-claims-in-large-employer-health-plans> (posted Aug 13, 2018) ↩
2. Id. ↩
3. Lucia, Kevin, Hoadley, Jack and Williams, Ashley, Balance Billing by Health Care Providers: Assessing Consumer Protections Across States, <https://www.commonwealthfund.org/publications/issue-briefs/2017/jun/balance-billing-health-care-providers-assessing-consumer> (June 13, 2017) ↩
4. Id. ↩
5. These states are California, Connecticut, Florida, Illinois, Maryland and New York. Id. ↩
6. The Section 415 of the Employee Retirement Security Act of 1974, as amended (ERISA) that preempts state laws that “related to plans governed by ERISA does not apply to state laws that regulate insurance. ERISA §514(b)(2)(A). ↩
7. <https://www.cassidy.senate.gov/imo/media/doc/Discussion%20Draft%20Protecting%20Patients%20from%20Surprise%20Medical%20Bills%20Act.pdf> ↩
8. <https://www.congress.gov/bill/115th-congress/senate-bill/3592> ↩
9. <https://www.congress.gov/bill/115th-congress/senate-bill/3541> ↩

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