



The Advocate's Guide to:

**ADDRESSING PAYMENT IN
BALANCE BILLING LEGISLATION**



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Problem: Debate over payment for out-of-network services can be roadblock to enacting badly-needed consumer protections

Legislation to protect consumers from surprise medical bills is under consideration at the state and federal levels, in many cases with bipartisan support. The lead committees in the U.S. Senate and House of Representatives have marked up legislation in each chamber¹ and the White House has issued principles for addressing balance billing. Five states enacted balance billing legislation this year.

The proposals under consideration offer varying degrees of protection for consumers billed for provider charges not paid in full under their plan – in some cases, offering protection only where a provider fails to provide notice of what a consumer can expect to pay, or in some health care settings but not all – and consumer advocates will have a critical role to play in ensuring protections are robust and comprehensive. But legislation can get sidelined by disputes over how to address how much health plans must pay to out-of-network providers when patients are hit with surprise balance bills. How this question is resolved can have implications for consumer choice and affordability, as well as overall health care costs.

Potential Solution: Define payment standard or process for reimbursing out-of-network providers

In order to provide comprehensive protection against balance billing, legislation must keep patients out of the middle of disputes between plans and providers. To do that, legislation should include a payment standard or a process for determining an amount to be paid to out-of-network providers, but resolving payment of out-of-network bills can be a sticking point to getting agreement on balance billing legislation. Consumer advocates have an interest in finding a resolution to that sticking point that protects against higher health care costs, including higher premiums, or creating disincentives for providers to contract with plans. The optimal solution, therefore, will be one that limits either party's ability to exploit market dominance to demand rates that are too high or too low.

What is balance billing?

Balance billing can occur when consumers unavoidably or unintentionally obtain care out-of-network by, for example, seeking emergency care or getting scheduled care at an in-network hospital that includes out-of-network providers. The issue is a top concern for consumers and has garnered bipartisan support.² As of July 2019, twenty-eight states have enacted balance billing legislation.³ Federal proposals under consideration in both the House and Senate would extend protections to those privately insured patients who are covered under ERISA plans that fall outside state jurisdiction.

For advocates and policymakers, *Ending Surprise Balance Billing: Steps to Protect Patients and Reduce Excessive Health Care Costs* sets out a framework for a comprehensive approach to protecting consumers against balance billing, including prohibiting surprise balance billing and requiring transparency and disclosure of provider network status and estimated out-of-network charges.⁴ This brief will explore one key issue to be addressed in any state or federal proposal under consideration: how to resolve the issue of health plan reimbursement for out-of-network care when providers are prohibited from balance billing patients.

Policy Considerations:

State-level protections⁵ and those included in legislation under consideration in Congress have taken three different approaches to resolving the payment issue.⁶ Each of the approaches comes with pros and cons, and one may be more politically achievable than the other two or better suited to a state's particular market dynamics.⁷

Establish a payment standard for what plans must pay to providers, for example, a share of billed charges, the median contracted rate, or a multiple of Medicare reimbursement rates. Maryland and Oregon laws take this approach.⁸ This approach allows for quick resolution of outstanding bills when a provider is prohibited from balance billing, but getting the standard right for any given state or market is important – for addressing competing interests in the legislative debate and, longer term, for the implications for health care costs and contracting incentives. It will be important to consider the implications for premiums and incentives for contracting for both health plans and providers. For example, if the payment standard is set relative to usual and customary rates, it may give greater leverage to providers to charge higher out-of-network rates over time and avoid contracting with a health plan to be in-network.

Establish a process to resolve disputes between what the plan will pay and what a provider charges. The process may include factors to consider in establishing the payment amount, for example, case-specific information or network adequacy. New York and New Jersey laws take this approach.⁹ Dispute resolution avoids debates over the right payment standard, but is potentially time and resource intensive. It also raises operational and design issues that will need to be addressed. For example, legislation can establish factors and data that can or must be considered and set a time limit for resolving payment disputes. The process may be “baseball style” arbitration, in which the arbitrator must choose one or the other party's offer, or the process may allow the arbitrator to determine a different amount, potentially within a floor for the lowest possible payment amount and a cap on how high it can go.¹⁰ Depending on how the process is triggered and structured, parties may be able to negotiate a payment that is acceptable to both parties, outside of an independent dispute resolution or arbitration process, and rely on the resolution process only where they fail to agree. For example, in New York insurers and physicians reportedly work to resolve payment disputes prior to requesting use of the independent dispute resolution process created under the state's balance billing law.¹¹

Define a blended approach that establishes a standard for an automatic payment from the health plan to the provider, with the option for the provider to appeal and request consideration of a higher amount. Colorado law takes this approach, with an automatic payment based on facility type and timely submission of the claim. Providers and facilities that deem the rate insufficient based on complexity or circumstances of the services can initiate binding, baseball-style arbitration.¹² California also takes this approach for non-emergency care at an in-network hospital, setting the payment rate at the greater of 125% of Medicare or the average contracted rate, with the option for either party to elect independent dispute resolution if the rate is not satisfactory.¹³ A blended approach allows for quick payment of bills, with the safety valve of providing a way for either party to contest the payment amount or ask that the standard be adjusted. This approach may reduce the administrative burdens of arbitration if providers are generally willing to accept the initial payment.

Another proposed approach is known as “network matching.”¹⁴ It was among the original Senate proposals under consideration, though was not in the bill that advanced through committee and has not been enacted at the state level. This approach would require in-network hospitals to either compel

providers practicing at the hospital to accept payment from all health plans that contract with the hospital or to take responsibility for negotiating payment directly with non-participating providers and hold the consumer harmless from balance billing. However, this approach may be difficult to implement in practice and the implications for cost and contracting incentives are unclear.

Implementation Considerations:

Experience in states that have implemented a payment standard or dispute resolution process has demonstrated the need to consider the resources required to implement the approach well.

- If using dispute resolution process: Existing external review organizations can provide the infrastructure to implement independent dispute resolution, but not all states have that infrastructure in place.
- If setting a payment standard or using a dispute resolution process: Existing claims databases, for example, All Payer Claims Databases (APCDs), can provide information needed for setting a payment standard or the parameters for consideration in an independent dispute resolution, but not all states have claims databases and those that do are limited to requiring submission of claims from fully insured plans only.¹⁵

If a federal standard is created, states that have already enacted balance billing protections will need to understand how federal proposals will interact with state laws. If state protections are in place, will consumers have different protections depending on whether they have coverage under a state regulated plan or an ERISA-governed plan? Will federal protections allow for states to enact more consumer protective laws? States may also want to consider where any federal law leaves consumers without protections. For example, no federal bill currently under consideration addresses balance billing by ground ambulance service providers, which have been a major source of out-of-network bills for consumers.

Cost Considerations:

There is no quantitative analysis that indicates one approach is superior to others in all respects. The impact on health care costs and contracting incentives will vary by markets, which the Congressional Budget Office (CBO) noted in its estimate of the cost implications of the bill reported from the Senate HELP committee, the Lower Health Care Costs Act (S. 1895). The HELP bill would ban balance billing by out-of-network providers and require insurers to pay them at a rate based on the insurer's median contracted rate.¹⁶ CBO estimates that approach would save almost \$25 billion over 10 years and lower premiums by just over 1 percent. However, CBO cautions that the premium changes will vary based on type of coverage (employer plan vs. individual market plan) and by type of plan (HMO vs. PPO or POS) and that changes in contracted rates, over time, will vary and are hard to predict, noting:

“Because in-network rates reflect the dynamics of local health insurance and health care markets, actual median in-network rates vary tremendously across the nation, as do the relative differences between the average and median rates in a given market...(As a result) effects in any given market could be quite different.”

Advocacy Considerations:

Consumer advocates have a critical role in policy discussions on balance billing protections. State efforts to enact balance billing legislation have demonstrated that disputes between providers and payers over a payment rate or process can become an impediment to enacting protections. Ongoing federal discussions

reflect this dynamic as well. Consumer advocates' paramount concern must be to make inaction unacceptable. Consumer advocates must therefore keep up the pressure to find a legislative solution so providers and payers don't walk away from negotiations and make legislative compromise impossible to achieve. One way to do that is to keep patient stories front and center, so that the clear cost of inaction compels all stakeholders to find a compromise.

At the same time, as long as there is an opportunity to have input on the best way to address a payment rate or process, advocates can play a role in protecting against an approach that contributes to higher health care costs or weaker incentives for providers to join networks. Too often, cost containment comes in a form that is harmful to consumers, such as benefit cuts, increased cost-sharing or network restrictions. Providers who oppose any benchmark rate, regardless of where it is set, may use misleading information or unfounded claims to push back against that approach. It may be difficult to know how any given approach or benchmark will affect cost and network incentives, so at a minimum advocates should ask for a study of the effects of the adopted approach on networks, provider charges and premiums.

Beyond their advocacy on the best way to address payment disputes, advocates must work to ensure key consumer protections are defined as broadly as possible – defining the providers and facilities to which protections apply and ensuring protections apply regardless of whether notice of out-of-network costs was provided to a patient in advance of their care. Consumer advocates will be the strongest – and potentially only – voice on those important provisions of any balance billing legislation.

Conclusion:

In the absence of state and federal protections against surprise balance billing, consumers will continue to be subject to crippling costs for care inadvertently received out-of-network. Consumer advocates have a powerful role to play in making the case for enacting surprise balance billing legislation. Advocates should also work to ensure protections are robust. But any legislation that purports to help patients must establish a way for health plans and providers to resolve payment issues without putting consumers in the middle. Not all payment resolution approaches are created equal. Payment standards set too high will contribute to higher health care costs and make it less likely that providers will contract with health plans, and payment standards tied to Medicare may engender opposition as “government price setting.” Consumer advocates should press for legislation that meets the demands of fairness, efficiency and economy.

This policy brief was developed with the support of JoAnn Volk and Rachel Schwab of Georgetown University's Center on Health Insurance Reforms. For questions please contact Quynh Chi Nguyen, policy analyst, at qnguyen@communitycatalyst.org

Endnotes

- 1 The Senate Health, Education, Labor and Pensions committee reported S. 1895 on July 8, 2019. The House Energy and Commerce committee reported H.R. 2328 on July 17, 2019.
- 2 [Surprise Medical Bills Survey: Nationally Representative Online Survey](#). Yonkers, NY: Consumer Reports National Research Center, May 2015. Ashley Kirzinger, Bryan Wu, Cailey Munana and Mollyann Brodie. [Kaiser Health Tracking Poll – Late Summer 2018: The Election, Pre-Existing Conditions, and Surprise Medical Bills](#). The Kaiser Family Foundation, September 5, 2019.
- 3 Jack Hoadley, Kevin Lucia and Maanasa Kona. [States Are Taking New Steps to Protect Consumers from Balance Billing, But Federal Action is Necessary to Fill Gaps](#). The Commonwealth Fund, July 31, 2019.
- 4 Quynh Chi Nguyen and Michael Miller, [Ending Surprise Balance Billing: Steps to Protect Patients and Reduce Excessive Health Care Costs](#), Community Catalyst, February 2019.
- 5 For more information on specific state approaches, see Maanasa Kona, “State Balance-Billing Protections,” The Commonwealth Fund, July 2019. Accessed at <https://www.commonwealthfund.org/publications/maps-and-interactive/2019/jul/state-balance-billing-protections>.
- 6 Quynh Chi Nguyen. [Policy Brief: Congressional Action on Surprise Medical Bills](#). Community Catalyst, August 1, 2019.
- 7 Sabrina Corlette, Jack Hoadley and Kevin Lucia, [Successfully Splitting The Baby: Design Considerations For Federal Balance Billing Legislation](#), Health Affairs, July 15, 2019.
- 8 Maryland established different payment rates for services depending on whether coverage is provided under an HMO or a PPO. Rates are based on various standards, including the state’s all-payer rating setting body, the Health Services Cost Review Commission; average rates paid by the insurer for the same covered service provided by similar, contracted providers; or Medicare rates for a similar service provided by a similarly licensed provider. See [Md. Code Ann., Ins. § 14-205.2](#) for PPOs and [Maryland Code, Health-General § 19-710.1](#) for HMOs. Oregon convened an advisory committee to adopt rules for calculating the reimbursement rate. The rule, ID39-2018, can be found at: <https://dfr.oregon.gov/help/committees-workgroups/Pages/balancebilling-reimbursement-rac.aspx>
- 9 New York [Fin. Serv. Law § 604](#) requires an independent dispute resolution entity to consider all relevant factors, including: whether there is a gross disparity between the fee charged by the physician for services rendered as compared to fees paid to the involved physician for the same services rendered by the physician to other patients in health care plans in which the physician is not participating and, in the case of a dispute involving a health care plan, fees paid by the health care plan to reimburse similarly qualified physicians for the same services in the same region who are not participating with the health care plan; the level of training, education and experience of the physician; the physician’s usual charge for comparable services with regard to patients in health care plans in which the physician is not participating; the circumstances and complexity of the particular case, including time and place of the service; individual patient characteristics; and the usual and customary cost of the service.

New Jersey [P.L. 2018, Chapter 32](#) requires the arbitrator to consider the following factors: the level of training, education and experience of the health care professional; the health care provider’s usual charge for comparable services provided in-network and out-of-network with respect to any health benefits plans; the circumstances and complexity of the particular case, including the time and place of the service; individual patient characteristics; and, as certified by an independent actuary, the average in-network amount paid for the service by that carrier; and the average amount paid for that service to other out-of-network providers by that carrier.
- 10 Generally, Medicare payment rates are lower than commercial insurers’ negotiated rates. Billed charges would represent the highest rates. A floor, then, would likely be a share of Medicare rates (e.g., 140% of Medicare rate) and a cap might be a share of billed charges (e.g., 80% of charged rates), though a rate tied to billed charges is subject to gaming by providers.
- 11 Sabrina Corlette and Olivia Hoppe, [New York’s 2014 Law to Protect Consumers from Surprise Out-of-Network Bills Mostly Working as Intended: Results of a Case Study](#), Robert Wood Johnson Foundation, May 2019.
- 12 See Colorado House Bill 19-1174 at https://leg.colorado.gov/sites/default/files/2019a_1174_signed.pdf
- 13 See California Assembly Bill 72 at https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB72
- 14 Loren Adler, Matthew Fiedler, Benedic Ippolito, [Network Matching: An Attractive Solution to Surprise Billing](#), Health Affairs, May 23, 2019.
- 15 Erin Fuse Brown and Jaime King, [The Consequences of Gobeille v. Liberty Mutual For Health Care Cost Control](#), Health Affairs, March 10, 2016.
- 16 Congressional Budget Office, Cost Estimate of S. 1895, Lower Health Care Costs Act, accessed at <https://www.cbo.gov/publication/55457>

Appendix 1:

“Typical” Provider Rates Vary Across Practices, States

A study^a by the USC-Brookings Schaeffer Initiative for Health Policy found that average contracted payment relative to Medicare rates show wide variation between different medical specialties^b:

- Anesthesiologist: 344 percent of Medicare
- Emergency physicians: 306 percent of Medicare
- Radiologists: 200 percent of Medicare
- All physicians: 128 percent of Medicare

A FAIR Health study^c found discrepancies between provider charges and allowed amounts for the same billing code, as well as variation across states:

- Median charges^d for CPT code 12011, simple repair of superficial wounds of face, ears, eyelids, nose, lips (2.5 cm or less), 2018-2019:
 - New York: \$351
 - New Mexico: \$383
 - Nevada: \$478
- Median allowed amount^e for CPT code 12011, simple repair of superficial wounds of face, ears, eyelids, nose, lips (2.5 cm or less), 2018-2019:
 - New York: \$143
 - New Mexico: \$188
 - Nevada: \$235
- 80th percentile of charges in Colorado, Connecticut and New York for CPT code 99284, emergency department visit high/urgent severity, 2015-2018
 - 2015: Colorado: \$473, Connecticut: \$832, New York: \$664
 - 2016: Colorado: \$495, Connecticut: \$833, New York: \$763
 - 2017: Colorado: \$665, Connecticut: \$896, New York: \$806
 - 2018: Colorado: \$880, Connecticut: \$946, New York: \$806

A RAND Corporation study^f found a wide range of relative prices^g paid for inpatient and outpatient services across states:

- In 2017, the average relative price across states was 204 percent of Medicare prices for inpatient care, 293 percent of Medicare prices for outpatient care, and 241 percent of Medicare prices for both combined (risen from 236 percent in 2015).
 - On the low end, Michigan, Pennsylvania, New York and Kentucky had relative prices for inpatient and outpatient care combined ranging from 150 to 200 percent of Medicare prices;
 - On the high end, Colorado, Montana, Wisconsin, Maine, Wyoming and Indiana had relative prices for inpatient and outpatient care combined ranging from 250 to over 300 percent of Medicare prices.

a Adler et al, “State Approaches to Mitigating Surprise Out-of-Network Billing,” USC-Brookings Schaeffer Initiative for Health Policy, February 2019. Accessed at: <https://www.brookings.edu/research/state-approaches-to-mitigating-surprise-out-of-network-billing/>.

- b Prices relative to Medicare stem from different sources between specialties – anesthesiologists: 2018 relative mean conversion factors; emergency physicians: 2012 relative mean payment rates for CPT code 99285; radiologists: mean commercial payment for CT head/brain scans relative to the Medicare rate (CPT code 70450); all physicians: data from one large national insurer’s commercial PPO claims.
- c FAIR Health, “Teasing Apart the Threads to the Surprise Billing Debate,” Mar. 2019. Accessed at: <https://s3.amazonaws.com/media2.fairhealth.org/brief/asset/Teasing%20Apart%20the%20Threads%20to%20the%20Surprise%20Billing%20Debate%20-%20A%20FAIR%20Health%20Brief.pdf>.
- d “Charges” indicate providers’ non-discounted billed fees for health care services, the amount usually billed for a service provided to an uninsured individual or to an individual who is out of network.
- e “Allowed amounts” indicate the total in-network amount for a service negotiated between an insurer and a provider, including the amount paid by the plan as well as the amount paid by the member.
- f Chapin White and Christopher Whaley, “Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely,” May 2019. Accessed at: https://www.rand.org/pubs/research_reports/RR3033.html.
- g “Relative prices” indicate the negotiated allowed amount paid per service (including amounts from both the health plan and the patient) with adjustments for the intensity of services provided, compared to Medicare reimbursement rates for the same procedure and facility. Data is based on claims from self-insured employers, state-based all-payer claims databases and health plans.