

December 10, 2019

Urge Members of Congress to Reject New Surprise Billing Proposal

On December 8, Senate Health, Education, Labor and Pensions (HELP) Committee Chairman Lamar Alexander (R-TN) and House Energy and Commerce Committee Chairman Frank Pallone (D-NJ) and Ranking Member Greg Walden (R-OR) announced an agreement on legislation to address surprise billing. The agreement sets provider payments for certain out-of-network care using a benchmark rate, defined as the median in-network rate in a geographic area. The deal also includes policies that are unrelated to surprise billing, including price transparency and contracting provisions opposed by IHA. Legislative text has not yet been released. However, key provisions as summarized by the American Hospital Association (AHA) are provided below. Sponsors hope to attach the deal to an end-of-year spending package, which could move quickly through Congress over the next 10 days, when the current funding measure expires.

ACTION REQUESTED: Call or email your federal Representatives and Senators and ask them to oppose surprise billing legislation that uses a government-set benchmark rate to reimburse hospitals, as well as any unrelated, unworkable price transparency and contracting provisions. (To look up the contact information for your members of Congress, [click here](#) and fill in your zip code and address in the “Find Politicians” box.)

Key messages:

- Illinois hospitals support federal legislation to protect patients from surprise medical bills for emergency care or services obtained in an in-network facility that could reasonably have been expected to be in-network.
- Once patients are protected by a ban on balance billing, the standard process of negotiation between providers and health plans should be permitted to continue. We urge Congress to look to successful state-level laws — such as those in Illinois — as models for federal legislation.
- Arbitration is the independent dispute resolution process used in Illinois. This approach allows for more market considerations than a benchmark rate.
- A benchmark rate, defined as the median in-network amount in a geographic area, would establish arbitrary fixed rates for services. These rates would become a “ceiling” for healthcare pricing – not a “floor” – thereby reducing hospital resources and removing the incentive for insurers to create adequate coverage networks.
- Provisions that are unrelated to surprise billing should be rejected, including unworkable price transparency proposals and policies that impede provider and health plan contracting.

AHA Summary of Key Provisions:

- Balance Billing: Providers could not balance bill patients in certain scenarios. Specifically, patients would be required to pay only the in-network cost-sharing amount for out-of-network emergency care (including air ambulance services) for certain ancillary services provided by out-of-network providers at in-network facilities, and for out-of-network care provided at in-network facilities without the patient’s informed consent. The amount the patients pay in cost-sharing for out-of-network services subject to balance billing protections would count towards their in-network deductible.
- Rate Setting: Insurers would be required to, at a minimum, reimburse providers for all claims subject to the balance billing prohibition at the median in-network negotiated rate for the service in that geographic area where the service was

delivered.

- Independent Dispute Resolution (Arbitration): Both providers and insurers would have the right to contest claims paid at or above \$750 (\$25,000 for air ambulance services) using baseball-style, binding arbitration. The arbitrators would be directed to consider information brought by the parties related to the training, education and experience of the provider, the market share of the parties, and other factors such as patient acuity and the complexity of furnishing the item or service.
- Notice/Disclosure: Providers may not balance bill patients unless they have given the patients notice of their network status and an estimate of charges 72 hours prior to receiving out-of-network services and the patient provides consent to receive out-of-network care.
- Contract Provisions: These provisions would restrict certain contracting terms between providers and health plans. Specifically, they would enable health plans to unfairly tier providers, steer patients to particular providers, and contract with only certain providers or “cherry-pick” within a hospital system.
- “Good Faith” Cost Estimates: The bill would require providers and health plans to give patients good faith estimates of their expected out-of-pocket costs within two days of a request.
- Timely Bills: The bill would require providers to give patients an itemized list of services received not later than 15 calendar days after discharge. In addition, the bill would bring billing for most services within a 60-day time period: providers would have 20 calendar days after discharge to bill the health plan; health plans would have 20 calendar days to adjudicate the bill; and providers would have no more than 20 days to send the adjudicated bill to the patient. Patients would have no obligation to pay any bills received more than 60 calendar days after receiving care, subject to some extenuating circumstances identified by the Secretary of the Department of Health and Human Services. Patients would have at least 35 days after the postmark date to pay bills.

Additional IHA resources on surprise billing legislation are available IHA's website, and include letters to the Illinois Congressional delegation sent [June 10](#) and [September 9](#), [advocacy alerts](#), and a [position paper](#).

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