NO SURPRISES:
PEOPLE AGAINST UNFAIR MEDICAL BILLS

Comparing Federal Surprise Medical Bill Proposals: How Do Consumers and Families Fare in the Current Debate?

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The current Congress, with the support of the Administration, is taking real action to ban the abusive practice of surprise billing. *No Surprises: People Against Unfair Medical Bills* assesses various legislative proposals based on three clear principles:

Principle 1: Protect patients in all care settings

All of the proposals ban surprise bills in hospitals, clinics, and doctors' offices, where most surprise bills occur. Two out of four bills — those passed by the Senate Health, Education, Labor and Pensions (HELP) Committee and the House Education and Labor (E&L) Committee — ban surprise bills by air ambulance companies. Disappointingly, none of the bills bans surprise billing by ground ambulances.

Principle 2: Do not increase health care costs across the system

The Senate HELP, House Energy and Commerce (E&C), and House E&L committees' legislation all save at least $24 billion in federal spending. The House Ways and Means (W&M) Committee's proposal still saves a significant amount — $18 billion — but its savings is roughly one-quarter less than that of the other committees due to a meaningful difference in how it manages payment disputes between plans and providers (more on that below).

Principle 3: Apply to all private insurance plans

All of the bills meet this principle, applying patient protections to all private insurance plans. (Medicare and Medicaid already prohibit surprise billing.)

Over the past several months, all four committees with jurisdiction over aspects of surprise medical bills have marked up their own versions of legislation to ban surprise bills. Lawmakers and stakeholders alike have worked to understand the differences between the pieces of legislation and to assess which of the proposals are best for consumers. The chart below provides a quick thumbnail sketch of the primary differences between these bills.

Table 1: Comparison of Key Features in Committee-Passed Surprise Billing Legislation

	Senate HELP (S. 1895, Title I)	House E&C (H.R. 2328, Title IV)	House E&L (H.R. 5800)	House W&M (H.R. 5826)
Protects patients from surprise bills in hospitals, doctors' offices, and clinics	Yes	Yes	Yes	Yes
Protects patients from surprise bills by air ambulance providers	Yes	No	Yes	No
Protects patients from surprise bills by ground ambulances	No	No	No	No
Applies patient protections to all private insurance plans	Yes	Yes	Yes	Yes
Stipulates market-based automatic payment from plan to provider	Yes	Yes	Yes	No
Allows providers or plans to appeal to independent dispute resolution (IDR), or arbitration	No	Yes, For bills where median in-network rate exceeds $1,250	Yes, For bills where median in-network rate exceeds $750	Yes, For all bills, regardless of amount
Allows IDR to combine related bills into one process	N/A	No	No	Yes*
Provides guidance to IDR on how to settle bills	N/A	Yes, Bans consideration of billed charges.	Yes, Bans consideration of billed charges.	Yes, Bans consideration of provider billed charges and "usual and customary" rates. Requires IDR to consider median in-network rate.
Congressional Budget Office score	Saves $25 billion over 10 years**	Saves $24 billion over 10 years	Saves $24 billion over 10 years	Saves $18 billion over 10 years

(Source: Families USA analysis of legislation and Congressional Budget Office cost estimates)

* The Department of Health and Human Services is instructed to develop a mechanism to combine related bills, if it deems such a mechanism will make the IDR process more efficient.

** Based on 2019 baseline. The CBO scores for other bills are based on a 2020 baseline. If scored on a 2020 baseline, the HELP Committee bill would save more than $25 billion.

The Biggest Difference: How to Settle Payment Once a Patient Is Protected

The most significant difference among the proposals — and the issue that led to millions of dollars in ad spending and lobbying by powerful special interests — is how to settle the payment rate a health plan pays to a provider once a patient is protected from a surprise bill. In all cases, patients will not receive a bill in excess of their normal in-network copay or coinsurance rate. There are three different ways in which the various bills would solve this problem.

Senate Health, Education, Labor and Pensions Committee

Automatic Payment of Market-Based Rate

The HELP Committee offers the most straightforward approach to settling a final payment rate. In the event of a surprise bill, the health plan will be obligated to pay the provider an amount equal to the market rate in that geographic area. Specifically, the plan will determine the median payment it has negotiated with all like in-network providers for that service (meaning half of its in-network contracts include lower payment rates and half include higher rates).

This process is the most administratively simple and provides the greatest level of certainty to plans and providers alike. It ensures providers are paid promptly and at a rate they can plan on ahead of time. It also provides the highest level of federal budget savings and would do the most to reduce health care premiums and increase wages.[1]

Despite these benefits, many providers disapprove of this approach as they would have no ability to appeal for higher payment rates if they believe the median in-network payment is inappropriate in their specific circumstance.

House Ways and Means Committee

No Automatic Payment, Unilateral Payment Decision by Plan, Provider May Appeal to IDR

The Ways and Means Committee bill takes a different approach. The bill stipulates no automatic payment rate. Instead, health insurers would be allowed to unilaterally set a payment. This rate could be above, equal to, or below its median in-network rate in the geographic area and above, equal to, or below the in-network rate that provider normally receives for that service. If the provider is unhappy with the payment made by the health plan, the provider could request the issue be taken to an independent dispute resolution (IDR) process, also known as arbitration.

In this process, both parties would submit a "best final offer" for consideration by the arbitrator. The arbitrator would be required to choose one offer or the other — a process known as "baseball-style" arbitration. The "loser" of this decision would be required to pay for the cost of arbitration. The legislation provides strong guidance to the arbitrator when deciding how to rule in these cases. The arbitrator is not allowed to consider (often wildly inflated) provider billed charges or "usual and customary" rates, and would be required to consider the median in-network rate in the geographic area.

This process gives health care providers the appeals right they demand, but it comes at a significant administrative cost and financial risk to providers. For each case, providers would face a difficult decision: accept the payment unilaterally offered by the health insurer or begin a long and arduous process to try to make the case for higher payment — a process they could lose.

The Congressional Budget Office (CBO) finds this process saves the federal government a significant amount of money (nearly $18 billion over 10 years), but that savings is roughly 25% lower than savings achieved by other bills.[2] This is because the CBO finds that the average final payments to providers will be higher than under an automatic payment mechanism, thus leading to higher premiums and reduced wages compared to other plans.

House Energy and Commerce and Education and Labor Committees

Blended Approach: Automatic Payment at Market-Rate, IDR "Backstop" for some Bills

The Energy and Commerce and Education and Labor committees opted to effectively "split the difference" between the two previous approaches. For all surprise bills, the plan would be required to pay an automatic, market-based payment rate, just as in the HELP Committee bill. For certain higher-cost bills — those with a market rate exceeding $1,250 in the E&C Committee bill and $750 in the E&L Committee bill — providers or plans could appeal to an IDR process if they feel the automatic payment rate is inappropriate in a specific case. As in the W&M Committee's approach, the arbitrator would be banned from considering billed charges.

The CBO has scored the E&C and E&L committees' bills as saving $24 billion over 10 years, slightly less than the savings achieved by the HELP Committee proposal. The reduced savings is a direct result of the use of arbitration in some higher-cost surprise bills.[3]

Endnotes

[1] Congressional Budget Office, "Cost Estimate: S. 1895, Lower Health Care Costs Act," July 16, 2019, https://www.cbo.gov/system/files/2019-07/s1895_0.pdf.

[2] Congressional Budget Office, "Cost Estimate: H.R. 5826, the Consumer Protections Against Surprise Medical Bills Act of 2020," February 11, 2020, https://www.cbo.gov/system/files/2020-02/hr5826table.pdf.

[3] Congressional Budget Office, "Cost Estimate: H.R. 5800, the Ban Surprise Billing Act," February 13, 2020, https://www.cbo.gov/system/files/2020-02/hr5800.pdf.