

The Devil You Know: Is the Ways and Means Surprise Billing Proposal Actually Good for Doctors?

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Throughout the surprise billing fight of the past 14 months, special interests have poured millions of dollars into lobbying and advertising to move the legislation in their direction. This is not surprising given that billions of dollars of taxpayer and consumer money are at stake. In one corner, health insurers, employers, and labor groups have urged Congress to adopt a market-based automatic payment rate. Providers, including hospitals and physician groups, have pushed Congress instead to use an independent dispute resolution (IDR), or arbitration, process to settle bills.

For most of the debate, providers' ambitions have been frustrated as two leading committees of jurisdiction — the Senate Health, Education, Labor and Pensions (HELP) Committee and the House Energy and Commerce (E&C) Committee — marked up legislation that relies predominantly on the market-based automatic payment. In February, however, providers got the bill they were looking for — a proposal from the House Ways and Means (W&M) Committee that relies more heavily on arbitration. Many provider groups lined up in support of the W&M Committee bill. The same week, the Education and Labor (E&L) Committee marked up a bill that is substantially similar to the bill approved by the E&C Committee.

For more information on the differences between the various proposals, see our policy analysis, [Comparing Federal Surprise Medical Bill Proposals: How Do Consumers and Families Fare in the Current Debate?](#)

Yet a closer look at the W&M Committee package begs a critical question: Are health care providers really better off with the bill?

The Experience of Providers – Two Scenarios

Scenario 1: Automatic Market-Based Payment

Imagine it is 2022, and you are a physician working in a hospital emergency room. Federal surprise billing legislation has gone into effect. The final legislation follows the contours of compromise legislation proposed by the House E&C and E&L committees. You're not part of one of the [private equity-owned physician staffing firms](#), which have intentionally gone out of network to take advantage of the market failure inherent in surprise billing. However, you still occasionally treat a patient who has private health coverage but is not in your network. You treat one such patient today.

Your patient is a high school kid playing in a local soccer tournament. She badly injured her ankle playing in the championship game. Per the federal legislation, your hospital informs her parents that she is out of network, but that they will have to pay only the in-network copay. Days after your patient is patched up and sent on her way for what will hopefully be a quick recovery, your practice sends her insurance a bill for the balance of the payment. Her insurer sends your practice a market-based payment — the median amount the insurer pays its in-network providers for the service you provided. Since the payment is based on a median, it is quite possible that you will get paid more than you usually get paid for in-network care. For this particular bill, your payment is a little lower than what you normally get paid. You could choose to challenge the payment and go to an arbitration process. In the end, however, you decide that since the payment is pretty close, that's the end of it. No muss, no fuss.

Scenario 2: Negotiation and Arbitration

Now consider the same scenario, except that Congress decided to pass a bill along the lines of what the W&M Committee has proposed. You provide ankle care, and the patient's parents pay their copay and are on their way. Again, your practice sends the patient's insurer a bill. This time, the insurer provides a payment that is just a fraction of the billed amount and well below what you normally receive from your in-network contracts. You decide you want to negotiate for a higher payment. By law, the insurer sends you its median in-network payment, and you are required to send the insurer the average rate you've negotiated with your in-network insurers. Your practice spends the next month arguing with the

recalcitrant health plan, exchanging numerous emails, calls, comparisons of medical records, and financial data. After a month of haggling, the plan continues to reject a higher payment.

Now you have to make a choice. Do you accept the insurer's lowball payment, or do you take the case to the next level? You decide to fight. You go through a structured process in which your practice and the insurer mutually agree on a third-party arbitrator. You send the arbitrator the medical records of the particular treatment as well as information regarding your typical payment, local market dynamics, your level of training, and the overhead costs associated with practicing in your hospital. You also send the arbitrator your "best final offer" — the amount you want to get paid for the service. It is lower than your billed amount but somewhat higher than the average amount you receive from your in-network contracts. At this point, you're building in the cost of having to deal with this problem. The entire episode of care only lasted an hour, but you've now spent 10 hours arguing with the insurer.

After all of that, you ultimately win the arbitration. You get paid the amount you asked for, but only after more than two months of arduous haggling. Of course, you could have lost the arbitration, had to accept both the below market payment by the insurer, and get stuck with having to pay for the arbitration process itself — another several hundred dollars.

The next day, you happen to treat another out-of-network patient. You roll your eyes and imagine having to go through all of that again. And again. And again.

Which of these two scenarios is really preferable?

Why Providers Might Support the Ways and Means Committee's Proposal

The Ways and Means Committee's proposal offers two benefits to health care providers when a surprise bill occurs.

- » **Ability to appeal payment of any bill.** This legislation allows providers to appeal any surprise bill payment to arbitration. The ability to go to arbitration is not included in the HELP Committee's legislation and is only available for higher-cost bills in the proposals passed by the E&C and E&L committees.
- » **Projected higher average payment.** The Congressional Budget Office projects that greater reliance on an arbitration-based system will result in somewhat higher average payments as providers will be successful in some cases when they go to arbitration.¹

Why Providers Might Be Better Off with an Alternative

Proposals offered by the other House committees of jurisdiction offer four benefits to providers.

- » **Automatic payment.** Under the E&C and E&L committees' bills, plans will be obligated to provide immediate market-rate payment to

providers. There will be no decision on whether to accept a lowball amount, no headache of fighting for more.

- » **Greater consistency.** Market-rate payments will be consistent and will grow by inflation over time. Providers will be able to plan their finances based on knowable data.
- » **Reduced administrative overhead costs.** The automatic payment imposes no direct or indirect administrative costs to providers.
- » **Ability to appeal to arbitration for higher-cost cases.** While the HELP Committee's proposal does not allow for an appeal to arbitration for any bills, the E&C and E&L committees' bills allow for higher-cost bills to go to arbitration.

Ultimately, the W&M Committee's bill, like those passed out of the other committees, provides protections for patients from surprise billing and will help protect families from these unexpected costs. ***However, providers will have to decide whether the substantially increased administrative headaches and uncertainty embedded in the Ways and Means Committee's bill is worth the chance at higher average overall reimbursement in the long run.***

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; 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>; 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>; Congressional Budget Office, "H.R. 2328, Reauthorizing and Extending America's Community Health Act," September 18, 2019, <https://www.cbo.gov/system/files/2019-09/hr2328.pdf>.