MAHP
MASSACHUSETTS ASSOCIATION of HEALTH PLANS

OnPoint: Issue Brief

A Publication by the Massachusetts Association of Health Plans

Volume XVIII, March 2022

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Putting an End to Surprise Billing in Massachusetts

Three years ago, MAHP published *Surprise Medical Bills: Identifying A Comprehensive Policy Solution to Protect Consumers in the Commonwealth*, which detailed the prevalence of surprise billing in the state. The paper outlined a policy framework for the implementation of surprise billing protections to prevent occurrences where members are subjected to unanticipated higher costs when accessing care and to reduce unreasonable charges that drive up health care expenditures in the Commonwealth. Since that time, policymakers at the state and federal levels have explored ways to address surprise billing, with varying results. This OnPoint examines recent policies enacted at the federal level aimed at curtailing surprise billing and outlines recommendations for state policymakers to strengthen the Commonwealth's efforts to protect consumers from out-of-network charges.

What Is Surprise Billing?

"Surprise billing" occurs when an insured individual receives an unexpected bill for medical care from a provider who is not in their health plan's network, but the individual had no notice they were receiving services from an out-of-network (OON) provider. Surprise billing typically occurs when:

- An insured individual receives services in an emergency from a provider who is not in their health plan's network, either an ambulance service provider or in a hospital emergency department, or
- An insured individual receives treatment at an in-network facility from a provider, most often a radiologist, anesthesiologist, or pathologist, who is not contracted with the individual's health plan.

Health care spending as a result of surprise billing has continued to increase in Massachusetts. Both the charges billed by OON providers and the amounts paid to OON providers have risen substantially.[1] The average spending on claims for services provided by OON radiologists, anesthesiologists, pathologists, and emergency services providers far exceeds the average spending on in-network claims.[2] When health plans are obligated to pay higher rates to OON providers, premiums paid by employers and consumers must increase to cover those health care costs. Additionally, more than 90% of OON claims for professional services have the potential for a bill to the consumer for the balance.[3]

Federal Efforts to Address Surprise Billing

Consumer Protections Enacted Under the Federal *No Surprises Act*

In late 2020, Congress enacted several provisions into federal law in the *No Surprises Act*,[4] which is aimed at lowering health care costs for consumers by holding individuals harmless from surprise medical bills in situations where they do not have the ability to choose an in-network provider. These provisions extend to emergency and post-stabilization services as well as non-emergency services delivered by an OON provider at an in-network facility.

- **Balance Billing Prohibition and Cost Sharing Protections —** The *No Surprises Act* prohibits OON providers and facilities from billing patients for more than the in-network cost-sharing amount for health care services. Additionally, the federal law reduces an individual's cost-sharing liability by requiring OON costs to count toward an individual's deductible and out-of-pocket maximum limits.

- **Notice and Consent Requirements —** The *No Surprises Act* includes provider notification requirements that will increase transparency and protect consumers from unexpected financial obligations. Providers and facilities must inquire about an individual's health insurance status and provide a good faith estimate of the expected charges at scheduling and upon request. OON providers must obtain advance written consent if a patient intends to waive the prohibition on balance billing.
- **Independent Dispute Resolution Process —** Finally, the *No Surprises Act* established a formal independent dispute resolution (IDR) framework to determine the payment rates to be paid by health plans to OON providers when there is no agreement between the parties. Claims for OON services may be brought before a certified IDR entity for resolution, requiring both the health plan and the OON provider to submit offers for payment along with supporting documentation. The IDR entity then selects one of the parties' offers and issues a binding determination. The federal IDR process will apply to determine OON reimbursement rates for services in Massachusetts, and the federal Centers for Medicare & Medicaid Services (CMS) will directly enforce these provisions pursuant to federal authority, given the absence of a state law governing the OON rate.[5]

Identified Weaknesses of the Federal IDR Process to Determine OON Reimbursements

Utilization of the federal IDR process in Massachusetts to determine OON provider reimbursement rates will introduce unnecessary administrative costs and complexity into the state's health care system, inhibit transparency and predictability of health care reimbursement, and increase health care spending for employers, consumers, providers, and health plans:

- **The federal IDR process will introduce operational costs and complexity into the state's health care market by requiring providers and health plans to spend additional resources to participate in the arbitration of an unknown volume of reimbursement disputes.** Arbitration under the *No Surprises Act* imposes explicit financial charges on health plans and providers, including administrative fees to be paid to the federal government by both parties and a larger sum to the IDR entity for their services- between $299 and $670 per dispute in 2022.[6] These expenses will add to health care spending in the state and will be paid for through premium revenue.
- **The federal IDR process will inhibit consumer transparency and OON cost predictability in the state.** With IDR, the cost of an OON health care service for any state resident becomes unknowable until after the provider's bill has been arbitrated, which frustrates notice and transparency goals. In determining which offer is the payment to be applied, the *No Surprises Act* permits an IDR entity to consider multiple factors, including the qualifying payment amount (QPA) for a service. The QPA is defined as the median contracted rate for the same or a similar service from a provider in the same specialty and geographic region.[7] The federal statute lists additional circumstances to be considered by an IDR entity in making a determination, including a provider's training and experience, patient acuity and the complexity of furnishing the service, the teaching status, case mix and scope of services of a facility, good faith efforts to enter into a network agreement, and prior contracted rates during the previous four years. The application of statutory criteria without clear guidance from the federal agencies on how IDR entities should apply, or weight, the factors is likely to result in inconsistent reimbursement decisions.[8]

  Legal challenges have complicated the federal IDR process. A federal implementation rule issued by CMS in September 2021 directed that payment determinations made by IDR entities under the *No Surprises Act* were to be based on the presumption that the appropriate OON reimbursement amount is the QPA.[9] Professional organizations representing anesthesiologists, radiologists, emergency physicians, hospitals, and air ambulance companies filed six lawsuits in five jurisdictions across the country in an attempt to alter the IDR decision-making process. A decision issued in *Texas Medical Association v. the U.S. Department of Health and Human Services* in late February 2022 invalidated provisions in the federal IDR regulations that favor the QPA in OON payment disputes. CMS immediately withdrew guidance documents for amendment.[10] The impact of the judgment is that IDR entities are operating without clear statutory direction on how these various factors should enter into arbitrators' decisions, making reimbursement outcomes inconsistent and unpredictable.

- **The federal IDR process could dramatically increase OON reimbursement in Massachusetts.** Ambiguity in the IDR process presents the risk "that many arbitrators would treat the qualifying payment amount as a floor on the appropriate price and deviate upward (but rarely downward) from that price based on their consideration of the other factors …. [I]f many arbitrators behaved in this way, then it would tend to lead to excessive average arbitration awards."[11]

  Arbitration awards in other states have significantly increased health care spending. Reimbursements in New Jersey to OON providers determined through the IDR process were considerably higher than typical in-network payment amounts, with 31% of cases awarded at more than 1,000% of the median contracted rate.[12] Similarly, IDR decisions in New York have resulted in payment rates to OON providers that are 8% higher than the 80th percentile of charges billed, significantly exceeding in-network rates and typical OON payments.[13] Analysis from the USC-Brookings Schaeffer Initiative for Health Policy warns of the broader adverse effects of IDR decisions on health care prices. "It is likely that the very high OON reimbursement now attainable through arbitration will increase emergency and ancillary physician leverage in negotiations with commercial insurers, leading either to providers dropping out of networks to obtain this higher payment, extracting higher in-network payment rates, or some combination thereof, which in turn would increase premiums. If insurers are additionally increasing out-of-network payment for services in order to reduce the risk of losing in arbitration, that would further amplify this inflationary impact on premiums."[14]

  Payments to OON providers in Massachusetts at the 80th percentile of charges would result in substantially higher reimbursement for services often involved in surprise billing scenarios, varying from 149% to 523% more than the median contracted rate.[15] The volume of provider requests to arbitrate reimbursement in New York has increased exponentially each year since the creation of an IDR process, due to high OON reimbursement now attainable.[16] If the federal IDR process in Massachusetts results in reimbursement awards higher than a health plan's contracted rates, providers will be incentivized to leave networks in order to receive the more favorable default OON reimbursement rate.[17]

State Action Required to Protect Massachusetts Residents

Massachusetts has an opportunity to avoid the adverse impacts of the federal IDR process on health care costs and administrative complexity by establishing default OON reimbursement rates for emergency and non-emergency services. The *No Surprises Act* provides express deference to state laws that clearly establish a payment rate or a process to determine reimbursements for OON services in a state's individual, small group, and large group markets.

Executive Office of Health and Human Services Report and Recommendations on the Establishment of Default Out-of-Network Reimbursement Rates

On January 1, 2021, Governor Baker signed into law *An Act Promoting a Resilient Health Care System That Puts Patients First*, now referred to as "Chapter 260".[18] In Chapter 260, the Massachusetts Legislature directed the Secretary of the Executive Office of Health and Human Services (EOHHS), in consultation with the Health Policy Commission, Center for Health Information and Analytics, and the Division of Insurance, to develop a report and make recommendations on establishing a default OON reimbursement rate. The EOHHS report, issued in September 2021, recommended the legislative establishment of default reimbursement rates for OON emergency and non-emergency health care services in the fully insured market at a health plan's median contracted rate.[19]

- **Establishing a default OON reimbursement rate based on health plans' median in-network contracted rates will result in significant savings over the federal IDR process for consumers in the state.** Based on an assessment of the potential impact of statutory default OON rates on consumer access, out-of-pocket costs, insurance premiums, and overall health care spending growth in the state, the EOHHS report concluded that default OON reimbursement rates utilizing a health plan's median in-network contracted rate for the same service by a provider in the same or similar specialty in a geographic region will produce considerable health care cost savings for individuals and small businesses in the Commonwealth.

The Congressional Budget Office estimated that *No Surprises Act* provisions, including IDR, will reduce health insurance premiums by between 0.5% and 1%.[20] Health policy experts have calculated significantly greater potential cost savings if OON provider reimbursement is equal to a health plan's median contracted rates for the same service. A 15% reduction in average payments for these OON services will reduce commercial health insurance premiums by as much as 5.1%, or $212 per member per year.[21]

Additionally, the median contracted rate is "a reasonable approach that balances the important interests of payers and providers and is administratively feasible for the Commonwealth and relevant parties to implement."[22] The EOHHS report found that use of the median contracted rate ensures fair reimbursement for services that reflects the current, competitively negotiated agreements between health plans and in-network providers, and it accounts for a provider's specialty, geographic market conditions, and business expenses. "In-network rates are market-driven and can more accurately reflect relative costs of providing services. They represent actual payments to providers by a payer in a particular market."[23]

- **A state-established OON rate based on median contracted rates will provide greater predictability of OON health care spending in Massachusetts.** Rates should be calculated on a payer-specific basis, and can be determined easily, as they are "readily ascertainable by payers based on contracting data or through analysis of claims databases, retrospectively."[24] The EOHHS report supported the use of the QPA methodology adopted in the *No Surprises Act* to determine OON reimbursement rates. Health plans must calculate the QPA of OON services to determine OON consumer cost sharing amounts and to submit in IDR disputes. This straightforward approach reduces the unnecessary administrative burden imposed on health plans and providers by the IDR process. [25]

- **Establishing a state default OON rate will expand the protections of the *No Surprises Act* to eliminate additional instances of surprise billing.** Finally, a state default OON rate should apply to ground ambulance services. In Massachusetts, claims for ambulance-based services represent the largest share of OON claims, totaling 52%.[26] OON payment rates for ambulance services in the state exceed health plans' in-network reimbursement rates by 22% to 227%.[27] The *No Surprises Act* regulates air ambulance services, but it does not prohibit OON ground ambulance service providers from billing patients for egregious amounts that unreasonably exceed the cost of care.

Conclusion

Surprise billing by OON providers accounts for more than $40 billion in health care expenditures annually and continues to burden individuals and small businesses.[28] While the *No Surprises Act* includes provisions necessary to increase transparency for consumers, the IDR process threatens to increase health care expenditures and introduce ambiguity into the determination of reimbursement to OON providers. Massachusetts has an opportunity to better protect its residents through state action.

The Massachusetts Legislature should enact legislation establishing a default OON reimbursement rate for emergency and non-emergency services, including ambulances, during this session as a key part of the state's commitment to health care affordability and cost containment. Governor Baker filed a comprehensive health care reform bill this month to target systemic health care cost growth drivers and reduce excess spending and consumer premiums in the state health care system. The bill would establish a default reimbursement rate that health plans in Massachusetts must pay to OON providers for unforeseen OON services, including care resulting from an emergency medical condition and non-emergency health care services rendered by an OON provider at an in-network facility, including anesthesiology, pathology, radiology, and neonatology. The proposed default payment rate of a health plan's median contracted rate is consistent with EOHHS' 2021 report recommendations and the QPA in the *No Surprises Act*. This sound solution is clear and actionable, will streamline the process of determining OON provider reimbursements in the fully insured market, and will ultimately provide the greatest protection for patients.

Footnotes

1. Health Policy Commission, Out-of-Network Billing in Massachusetts Chartpack (2020), *available at* https://www.mass.gov/doc/out-of-network-billing-in-massachusetts-chartpack/download.

2. *Id.*

3. *Id.*

4. Enacted as part of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260).

5. CAA Enforcement Letter. (CMS, 2021). Center for Consumer Information and Insurance Oversight. *Available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAA-Enforcement-Letters-Massachusetts.pdf.

6. List of certified organizations. (CMS, 2022). *Available at* https://www.cms.gov/nosurprises/Help-resolve-payment-disputes/certified-IDRE-list.

7. 26 CFR Part 54. Federal Register Volume 86, Number 131 (July 13, 2021). *Available at* https://www.govinfo.gov/content/pkg/FR-2021-07-13/pdf/2021-14379.pdf.

8. Fiedler, Matthew et al. "Recommendations for implementing the No Surprises Act." USC-Brookings Schaeffer on Health Policy (March 16, 2021), *available at* https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/03/16/recommendations-for-implementing-the-no-surprises-act/.

9. *Id* at 7.

10. Memorandum Regarding Continuing Surprise Billing Protections for Consumers. (CMS, 2022). *Available at* https://www.cms.gov/files/document/memorandum-regarding-continuing-surprise-billing-protections-consumers.pdf.

11. Fiedler, Matthew et al. "'Equal weighting' is a poor framework for arbitration decisions under the No Surprises Act." USC-Brookings Schaeffer on Health Policy (June 24, 2021), *available at* https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/06/24/equal-weighting-is-a-poor-framework-for-arbitration-decisions-under-the-no-surprises-act/.

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14. *Id.*

15. Health Policy Commission, HPC DataPoints, Issue 14: The Price is Right? Variation in Potential Out-of-Network Provider Payment Benchmarks (2019), *available at* https://www.mass.gov/info-details/hpc-datapoints-issue-14-the-price-is-right-variation-in-potential-out-of-network-provider-payment-benchmarks.

16. Adler.

17. Fiedler.

18. Chapter 260 of the Acts of 2020, The 192nd General Court of the Commonwealth of Massachusetts. Accessed on March 14, 2022. *Available at* https://malegislature.gov/Laws/SessionLaws/Acts/2020/Chapter260.

19. Massachusetts Executive Office of Health and Human Services (EOHHS), Report to the Massachusetts Legislature: Out-of-Network Rate Recommendations (September 8, 2021), *available at* https://www.mass.gov/out-of-network-rate-recommendations.

20. Congressional Budget Office, Estimate for Divisions O Through FF, H.R.133, Consolidated Appropriations Act, 2021, Public Law 116-260, Enacted on December 27, 2020 (January 14, 2021), *available at* https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf.

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24. *Id.*

25. *Id.*

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27. *Id.*

28. Cooper, Zack, et al. "Out-Of-Network Billing and Negotiated Payments For Hospital-Based Physicians". Health Affairs, Volume 39, Issue 1, (December 16, 2019), *available at* https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00507.