TMA Tennessee Medical Association — Physicians Caring for Tennesseans

FINAL FEDERAL BALANCE BILLING LEGISLATION 2020

BASICS

- Part of 2020 COVID-19 stimulus package.
- Surprise or balance billing is prohibited for out-of-network emergency care and most out-of-network care at in-network facilities.
- Patients are only required to pay the in-network cost-sharing (i.e., copayment, coinsurance, and deductibles) amount for out-of-network emergency care, 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.
- Allows patients to access an external review process to determine whether surprise billing protections are applicable when there is an adverse determination by a health plan.
- Requires health plans to provide an Advance Explanation of Benefits for scheduled services at least three days in advance to give patients transparency into which providers are expected to provide treatment, the expected cost, and the provider's network status.
- Only applies to self-insured (ERISA) plans.

WINS FOR MEDICINE'S ADVOCACY

TMA has lobbied at the state and federal levels to include the following provisions in all balance billing legislation. These are wins for medicine in the federal bill:

- Patients only pay their in-network obligations for the care they received.
- Patients who do their due diligence are held harmless from balance or surprise bills.
- Disputes between payers and providers are settled by an arbitration process
- Patients are not involved in arbitration disputes over payment between doctors and health plans.
- A 30-day period during which the health plan and the doctor try to negotiate a payment for the out-of-network claims. If they don't reach an agreement, then binding arbitration would be the next step.
- No minimum payment threshold to enter arbitration.
- Baseball-style arbitration with each party submitting one offer and the arbitrator picks one of them. Congress chose the arbitration process over a geographic benchmark median rate for out-of-network charges.
- Permits claims to be batched or bundled in the arbitration process.
- Arbitrators may consider the training of the provider, the parties' market share, the prior contracting history between them, complexity of the services rendered, location of services performed and other information submitted in choosing the payment amount submitted by the parties.

- Arbitrators may not consider or certain public payer [e.g., Medicare, Medicaid, CHIP, etc.] payment amounts in choosing the payment amount submitted by the parties.
- Loser pays cost of arbitration.
- If the doctor wins, payment must be made within 30 days of arbitrator's selection.
- If a patient receives sufficient notice from an out-of-network provider in advance of treatment and consents to being treated, the out-of-network provider may avoid the potential dispute resolution procedures outlined above. Sufficient notice means that the patient receives and acknowledges notification of its out-of-network care, including an estimation of the cost for such care, at least 72 hours in advance. The notice and consent exception does not apply to out-of-network providers of radiology, pathology, emergency, anesthesiology, diagnostic and neonatal services; assistant surgeons, hospitalists, intensivists, and providers offering services when no other in-network provider is available.
- Insurance cards must include deductible, out-of-pocket maximum, phone number, and website for assistance.
- A plan must provide an advanced explanation of benefits in advance of the service.
- If the provider contract is terminated, a "continuing patient" can continue for 90 days.
- Payer provider directories must be updated and verified every 90 days.
- Establishes a grant program to create and improve or create State All Payer Claims Databases.

COMPROMISES

TMA has lobbied at the state and federal levels to keep provisions favoring health plans out of balance billing legislation. Of course, a compromise had to occur, and the following provisions favoring health plans were left in the federal legislation:

- Initial payment determined by the health plan.
- Out-of-network providers prohibited from billing a patient for the balance of the bill unless they provided notice of their network status and an estimate of charges 72 hours in advance, and the patient consents to receive out-of-network care.
- Requires the arbitrator to consider the "qualifying payment amount," which is defined for 2022 as the median of the contracted rates recognized by the plan or issuer, as specified, under the plan or coverage on January 31, 2019, and which will be increased based on the CPI-U for subsequent years.
- Prohibits arbiters from considering doctors' usual and customary charges or billed charges.
- 90-day window before the parties can return to arbitration for the same service.
- Parties who use arbitration must pay an annual fee to the US Department of HHS.
- Improves the accuracy of provider directories by holding doctors accountable for inaccurate health plan directories.

