SHORT COMMUNICATION

Surprise Medical Billing Reform: Considerations for Dermatology

Yuangao Liu, BS[1], Natalie C. Skopicki, Harrison P. Nguyen, MD, MBA, MPH, DTM&H[2], Travis W. Blalock, MD[2]

[1] School of Medicine, Baylor College of Medicine, Houston, TX
[2] Department of Dermatology, Emory University School of Medicine, Atlanta, GA

Surprise billing occurs when patients with health insurance receive care from a clinician or facility included in their insurer's network ("in-network") but unexpectedly receive "surprise" bills from other clinicians involved in their care who are not in the their insurer's network ("out-of-network").[1] Since insurance plans are not required to reimburse out-of-network providers their full charges, those out-of-network clinicians or facilities may bill the patient for the difference between the payment and their charges. Patients are liable for these unexpected charges ("balance bills"), which may be substantial and financially burdensome. In dermatology, surprise medical billing may manifest through consultation (i.e., in the emergency room or inpatient setting) or via dermatopathology services.

Reforming surprise billing is not straightforward since solutions must consider patient protection, physician autonomy, and free market dynamics. As of 2021, 33 states have enacted laws to protect patients from surprise billing, but the scope of these protections varies (Figure 1).[2] Comprehensiveness of protections varies based on setting (emergency department vs. non-emergent care), type of insurance plan (i.e., Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO)), extent of protections, and presence of dispute resolution processes. For example, Texas has comprehensive protection that prohibits out-of-network providers from billing HMO and PPO enrollees for any amount beyond in-network cost sharing in both emergent and non-emergent settings, except enrollees who electively consent to out-of-network non-emergency services. In contrast, Pennsylvania has partial protection covering emergency department services but does not have a dispute resolution process for payments.[2]

The No Surprises Act is a federal bill with the stated intent of reforming surprise medical billing and was signed into law in December 2020 as part of the Consolidated Appropriation Act of 2021.[3] Most of the legislation went in effect on January 1st, 2022 (Table 1). The No Surprises Act seeks to set national standards to protect patients from unexpected medical bills while establishing processes for providers and payers to resolve billing disputes. Arbitrators of billing disputes will be prohibited from considering charges and will instead rely on median in-network rates for services. Furthermore, arbitrators will be required to consider case-specific nuances,

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Figure 1. States' balance-bill protections as of 2021[2]

Table 1. Brief overview of relevant sections in the No Surprises Act.[3]

Sect.	Regulations	Considerations
102	**Cost sharing determination** • Patient cost-sharing limits for out-of-network services are based on a "recognized amount" and a "qualifying amount." • Set based on the median contract rate recognized by the health plan on Jan 31, 2019 within the same insurance market in the same geographic region.	• Protects patients from substantial billing from out-of-network providers. • Diminishes incentive for insurers to expand their networks since anyone outside of the network is being paid at the median rate. • Arbitrators can consider a wide range of factors but not the provider's usual and customary charges.
103	**Independent dispute resolution process (IDR)** • 30-day open negotiation period between provider and health plan to come to an agreement on reimbursement. • Either party may trigger the IDR process if no agreement is reached after the initial 30 days. • The party that submits the losing bid is responsible for the costs of IDR process.	• The IDR process protects patients from being in the middle of payment rate negotiations between providers and insurers. • It may take 60 days for physicians to seek fair compensation and costs involved in IDR process may put small dermatology practices under significant financial strain.
104	**An out-of-network provider may submit balance bills if they satisfy the notice and consent process.** • Notification that the provider is out-of-network. • Good faith estimates of the charges. • A list of in-network providers at the facility to which the patient can be referred. • Information on prior authorization or other care management requirements.	• Providers may not know in advance who will be involved in an episode of care and other providers' contract status. • Uncertainties in the practicality of maintaining an accurate up-to-date provider directory, and inaccuracy in the directory can lead to confusion for patients and providers. • Time spent on consent process may limit the time available for patient care.
112	**Requirement for providers and facilities to share "good faith estimates" of the total expected charges for scheduled items or services.** • Determine the estimate at least 3 business days before service date or no later than 1 business day after scheduling (If the service is scheduled more than 10 business days later, then no later than 3 business days after scheduling). • Establishes a patient-provider dispute resolution process for uninsured patients who receive a bill $400 higher than the "good faith estimate."	• Improved patient protections via price transparency have the potential to alter the patient-provider relationship by adding in financial factors. • Provider may not be able to predict complications, other indicated procedures, or undiscovered diagnosis prior to a procedure for a "good faith estimate", which may induce mistrust and frustration for both providers and patients. • The patient-provider dispute resolution process may put additional strain onto the patient-provider relationship.

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such as clinician expertise and both the payer's and provider's history of "good-faith" practices. While "good-faith" practice is an ambiguous concept, policy analysts believe that this language may de-incentivize insurers from dropping clinicians from their networks.[4] Finally, the law introduces transparency provisions that will require providers to send "good faith estimates" to health plans or patients, if uninsured. The insurers will then provide an "Advanced Explanation of Benefits" (EOB) detailing network information, coverage, and out-of-pocket maximums to patients prior to service.[3]

While effects of this legislation on health insurance premiums, networks, physician reimbursement, and overall health care costs remain to be seen, we hope the added transparency and reform will be ultimately beneficial to patients. The American Academy of Dermatology is in support of measures to increase patient protection and is mindful of the legislation's impact on compensation and administrative work. Future research will be important to evaluate the law's impact on dermatologist network participation and in-network prices.

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Corresponding Author:
Yuangao Liu
1 Baylor Plaza
Houston, TX 77030
Email: yuangaol@Bcm.edu

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