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Using the "Reasonable Allowed Amount" to Resolve Surprise Emergency Medical Billing

Bipartisan draft legislation was released in late 2018 to address a health care problem for which almost all Americans—even those with health insurance—are at risk: surprise medical billing.[1] The sticking point for any surprise medical billing legislation is setting the appropriate reimbursement amount. However, federal legislators need not look any further than the most recent precedent addressing this issue to set a reimbursement amount—the Affordable Care Act ("ACA"). The "reasonable allowed amount" (or a multiple thereof) as it was defined by the ACA can be used as the cap on provider reimbursement for noncontracted emergency services.

Surprise medical bills arise when a patient receives care in a facility or with a medical provider that does not have a contract with the patient's insurance or health plan, often during emergencies. If a provider is not bound by a contract to accept a certain amount for services, there is no limit on the amount that the provider can charge, resulting in large surprise bills for patients.

The ACA's level cost-sharing provisions imposed restrictions on payors with respect to the costs of emergency care services.[2] The ACA requires insurers and health plans to pay a "reasonable allowed amount"[3] to a noncontracted provider for emergency services. The reasonable allowed amount for an item or service generally is the greatest of:

- the in-network rate - the amount negotiated with in-network providers for the emergency service furnished. If a plan has more than one negotiated amount for a particular emergency service, the amount is the median of these amounts;
- the Medicare rate - the amount that would be paid under Medicare (Part A or Part B) for the emergency service; and
- the usual out-of-network rate - this amount must be calculated using the same method the plan generally uses to determine payments for out-of-network services.

The ACA does not permit the insurer or health plan to require the patient to share more in payment of the reasonable allowed amount than the patient would have shared in the payment if the provider was contracted. There cannot be a higher coinsurance rate, copayment or any additional deductible for noncontracted emergency services.[4]

However, the ACA did not impose any restrictions on providers with respect to the costs of emergency care services. Providers may bill any amount for these services and may directly bill patients for the difference between the billed amount and the amount the insurer or health plan is required to pay under the ACA.

Consider an example. Say an insurer normally agrees to pay $5,000 for a contracted emergency service and requires a patient to cover 10 percent of that cost, then the insurer pays $4,500 and the patient pays $500. For simplicity, assume that this amount is also the reasonable allowed amount because the in-network rate is the greatest of the three variables. If the patient receives the same emergency service from a noncontracted provider, then, according to the ACA, the insurer must cover at least $5,000 and the insurer can only require the patient to pay $500 (or 10 percent of the amount). However, the provider is not bound by any contract or law to accept the reasonable allowed amount of $5,000. So, for instance, if the noncontracted provider charged $25,000 in this

[1] See the Protecting Patients from Surprise Medical Bills Act released in September 2018 in draft form.
[2] See 29 CFR § 2590.715-2719A - Patient protections, (b) Coverage of Emergency Services.
[3] See 29 CFR § 2590.715-2719A(b)(3)(i).
[4] See 29 CFR § 2590.715-2719A(b)(3)(i) & (ii).

example, the patient would receive a $20,000 bill from the provider for the balance of charges (i.e., $25,000 of billed charges - $5,000 reasonable allowed amount paid).

If federal legislation was passed to require providers to accept the reasonable allowed amount (or a multiple thereof), then the amount of medical bills for noncontracted emergency services would no longer be a surprise and would be correlated to the contracted rate for the same services. For instance, in the example above, if the provider was required by federal law to accept two times the reasonable allowed amount, the patient would know the balance bill could not exceed $5,500 ($10,000 (two times the $5,000 reasonable allowed amount) - $4,500 reasonable allowed amount paid by the plan).

Resolution of surprise medical billing should build on existing federal law. The efforts invested to develop level cost-sharing regulations and guidance on the reasonable allowed amount under the ACA can be used to take the next step: using the reasonable allowed amount to set a cap on provider reimbursement for noncontracted emergency services.

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