American Hospital Association™
Advancing Health in America

Fact Sheet: Surprise Medical Billing Legislation Rural Impact

The Senate Health, Education, Labor and Pensions Committee in June 2019 passed the Lower Health Care Costs Act (S.1895), legislation to prevent surprise medical bills, reduce prescription drug prices, improve transparency in health care, invest in public health and improve health information exchange.

The House Energy and Commerce Committee in July passed legislation, The No Surprises Act (H.R. 2328), to prevent surprise medical bills, and the House Education and Labor Committee Feb. 11 passed the Ban Surprise Billing Act (H.R. 5800).

AHA Ask: AHA supports protecting patients from surprise medical bills. Policymakers should focus on assisting rural hospitals in their negotiations with payers and providing the incentives and resources needed to maintain local access to care and not undermine these communities with potentially harmful national policy changes.

Addressing Surprise Medical Billing

The Lower Health Care Costs Act, the No Surprises Act and the Ban Surprise Billing Act would hold patients harmless from surprise medical bills. Patients would be required to pay the in-network cost-sharing amount for out-of-network emergency care and for care provided by ancillary out-of-network practitioners, and for out-of-network diagnostic services at in-network facilities. Facilities and practitioners would be barred from sending patients "balance" bills in these scenarios for more than the in-network cost-sharing amount.

Policy: To resolve payment disputes between a provider and a health plan, all of the bills would require the health plan to pay the practitioner and/or the facility based on the median in-network rate for services in the geographic area. H.R. 2328 provides for an arbitration process for hospitals and physicians that receive a median in-network payment of more than $1,250. H.R. 5000 sets the threshold for arbitration at $750.

- Rural hospitals are closing and facing high rates of negative operating margins. A benchmark rate set in statute would further reduce reimbursement for rural hospitals, as it would place downward pressure on already low commercial payments.
    - Rural hospitals are especially vulnerable to policy changes in payment for services. Medicare and Medicaid made up 56% of rural hospitals' net revenue in 2017 and, as these programs already pay less than the cost of care, further reductions in commercial insurer payments will increase the already heavy financial burden on rural hospitals.
    - More than 40% of rural hospitals have negative total operating margins.
    - 121 rural hospitals have closed since 2010, including 19 last year alone.
- Implementing a benchmark rate in statute would result in even lower payment rates for rural providers or discourage payers from contracting in rural areas, which are already experiencing limitations in network adequacy.

American Hospital Association™
Advancing Health in America

- According to a 2018 Health Resources and Services Administration report, even in locations with well-intentioned network adequacy requirements, "current market-based models encourage marginal thinking and can incentivize insurers to pressure providers that are needed for network adequacy purposes to accept lower rates or to omit providers who cannot accept lower rates and are not needed for network adequacy purposes."[1]

- According to a Kaiser Family Foundation report, single-insurer counties are more likely to be rural,[2] which advantages the insurer in negotiating rates.

- Network development and adequacy are problematic in rural areas because of low population density and workforce shortages. Insurance companies are less willing to set lower premiums in markets with lower patient volumes and higher costs of providing care. Fewer providers with which to contract leads to insufficient health care networks. Any further disincentives would lead to significant challenges in access to care for rural patients.

  - While almost 20% of the U.S. population lives in rural areas, less than 10% of U.S. physicians practice in these communities.[3]

  - The patient-to-primary care physician ratio in rural areas is 55 physicians per 100,000 people, compared to 79 physicians per 100,000 in urban areas.

  - People in rural areas have access to 30 specialists per 100,000 residents, while those in urban areas have access to 263 specialists per 100,000 residents.[4]

Sources

1. *https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2018-Rural-Health-Insurance-Market-Challenges.pdf*

2. Cox, Cynthia and Ashley Semanskee. "Preliminary Data on Insurer Exits and Entrants in 2017 Affordable Care Act Marketplaces." Kaiser Family Foundation. 28 Aug 2016. Web. *https://www.kff.org/health-reform/issue-brief/preliminary-data-on-insurer-exits-and-entrants-in-2017-affordable-care-act-marketplaces/*

3. Johnt E. K., Nguyen N., Samson W. L., Snyder E. J. (2016 October 19). Rural Hospital Participation and Performance in Value-Based Purchasing and Other Delivery System Reform Initiatives. ASPE Office of Health Policy Retrieved from: *https://aspe.hhs.gov/system/files/pdf/211061/RuralHospitalsDSR.pdf*

4. *https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2018-Rural-Health-Insurance-Market-Challenges.pdf*