



ENDING SURPRISE BALANCE BILLING:

STEPS TO PROTECT PATIENTS AND REDUCE EXCESSIVE HEALTH CARE COSTS

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The Problem

The growth of surprise out-of-network medical bills has risen to be a top health care concern for many people in the U.S.¹ Indeed, even with insurance coverage, many people struggle to pay for their health care. The spread of narrow network plans is part of the reason for this growing problem. Researchers have found that 72 percent of health plans sold on the Affordable Care Act (ACA) Exchange in 2019 have narrow networks with restrictive doctor and hospital choices, an increase from 60 percent in 2016.² As health plan networks become narrower, patients can be exposed to high out-of-network charges when using providers that are not in their health plan's network. The problem is also growing for people with employer-sponsored insurance. Nearly 20 percent of beneficiaries with employer-sponsored coverage have out-of-network claims for inpatient care,³ leaving them with potentially devastating medical debt.⁴ In many cases, consumers receive out-of-network bills in situations where they have no reasonable way of staying in-network, such as in an emergency.

Complicating the situation, the problem of out-of-network bills is linked to another health policy issue: excessive provider prices (which, of course, contribute to higher insurance premiums). Selective contracting, and the resulting narrow networks, are a primary tool that insurers use to hold down provider prices. On the other hand, refusing to join networks is a strategy that providers with monopoly power can use to push prices (and premiums) up.

Studies show that higher spending on health care in the U.S. relative to other countries is the result of the excessively high prices of health care services. This problem is exacerbated by the increase in provider market power.^{5,6, & 7} In the past two decades, we have witnessed steady hospital-physician integrations and mergers of hospitals. There is little evidence that provider integrations improve quality of care and reduce costs. Instead, they enable dominant hospitals and large physician group practices to leverage their monopoly power to negotiate higher prices for their services.⁸ For instance, a study conducted in 2010 by the Massachusetts Office of the Attorney General found that some hospitals (those with brand-name recognition and those that are geographically isolated) charged 10 to 100 times more than others for similar services despite no evidence of better quality.⁹

Consumers are becoming collateral damage in the struggle between health plans and providers. As a result, protecting consumers from the fallout from this struggle is imperative. Policy makers at both the federal and state level are beginning to focus on the problem. While it is encouraging to see members of Congress taking an interest, the extremely volatile and acrimonious atmosphere in Washington, D.C. makes federal action highly uncertain. As is often the case, it may fall to states to take the initial steps to address this problem (and a few have already done so). At the same time, given the role of excessive provider prices in rising health insurance premiums, it is important to devise policies that will put a check on the growing monopoly power of providers at the same time that they protect consumers.

This paper offers guidance for state health care advocates (and policy makers) looking to address the problem of surprise out-of-network bills. It starts with a brief overview of the problem and then highlights how existing federal laws offer both a roadmap for state action but also, in some instances, create barriers. It lays out what we see as the essential elements of a solution to the surprise-out-of-network bill problem that addresses both consumer protection and monopoly power, identifies the best elements from existing state laws and flags areas that states have yet to address. It concludes with some thoughts for advocates about strategy.

A Snapshot of Surprise Balance Billing

Balance billing occurs when providers directly bill patients the difference between what their health plan agrees to pay and what the provider charges. Evidence shows that balance bills often come as a surprise. Nationally, one in three people reported that they have received a surprise medical bill, and many did not know where to get help to resolve their billing issue.^{10 & 11}

Surprise balance billing can happen to anyone, no matter what kind of health insurance they have. A carefully planned visit to an in-network facility or an emergency visit to a local hospital could result in services delivered by out-of-network physicians—for instance, an anesthesiologist in the emergency room assisting a surgery; a pathologist examining a biopsy; or taking an ambulance (ground or air) trip to a hospital.¹² According to the Kaiser Family Foundation, unexpected medical bills are what patients fear most, more than they worry about prescription drug costs, premiums and other cost-sharing requirements, or other costs of goods and services (such as rent, food, utilities and transportation).¹³

Stories of patients experiencing surprise medical bills

Early this year, Scott Kohan had a surgery for a broken jaw at Dell Seton Medical Center's emergency room in downtown Austin, Texas. While the hospital was in his insurance network, the oral surgeon working at that emergency room was not. Mr. Kohan ended up with a \$7,924 bill. (*Vox*, May 23, 2018)

After her triplets were born prematurely, Stella Apo Osae-Twum received a balance bill of over \$50,000. Despite going to a hospital covered by her insurance, none of the neonatologists who attended to her sons were "in-network." As a result, her insurer only agreed to pay 94 percent of the total hospital bill of \$877,000. (*The Guardian*, January 16, 2018)

Three-year-old West Cox arrived to the emergency room at Princeton Community Hospital, the only medical center in the small town on the southern edge of West Virginia. Within an hour of his arrival, an air ambulance took him to the CAMC Women and Children's Hospital in Charleston as his fever hit 107 degrees. While West recovered from apparent encephalitis, the for-profit helicopter operator Air Method billed his parents \$45,930 for his 76-mile flight. (*Los Angeles Times*, June 11, 2018)

Dave Ross' teenage son had sharp chest pains. His doctor feared a punctured lung and ordered an ambulance to take Dave Jr. to a local hospital in Framingham, Massachusetts. Ross was shocked when he received an ambulance bill for \$2,400 for a ride of less than two miles. Because the ambulance service (American Medical Response) was an out-of-network provider, his insurance covered only \$400 of the ambulance bill, leaving him responsible for the rest. (*NBC News*, March 6, 2018)

Existing Federal Laws Can Be Both a Model and Barrier to State Action

Before turning to state-level approaches to end surprise balance billing, it is important to understand how federal laws can inform state actions. Federal protections against surprise balance billing exist, but they are only applicable in the Medicare context.¹⁴ For example, Medicare Advantage (MA) patients are not responsible for out-of-network charges in emergency care settings. For covered non-emergency services, MA plans reimburse the balance bills directly to out-of-network providers and Medicare patients only pay the cost-sharing amounts specified in their policy. However, if a MA patient in a closed-network plan¹⁵ opts to use an out-of-network provider without authorization by the plan, they would be responsible for the entire billed charge. Importantly, federal law also limits how much providers can bill MA plans for out-of-network services.

Unfortunately, similar protections do not exist for patients enrolled in private insurance plans outside of Medicare. Under the ACA, for example, qualified health plans sold in the individual market are required to cover out-of-network emergency care services and pay providers at in-network rates. However, the ACA does not prohibit out-of-network emergency providers from balance billing patients for these services.

Additionally, it is important to understand existing federal laws that create barriers to states looking to end surprise balance billing at the state level. For instance, the [Employee Retirement Income Security Act of 1974](#) preempts states from regulating self-funded plans.¹⁶ According to the 2017 Annual Survey on Employer Health Benefits conducted by the Kaiser Family Foundation, nationally, more than half of insured workers are currently enrolled in self-funded plans.¹⁷ Thus, even if a state takes action to protect consumers from balance billing, workers enrolled in self-funded plans would not necessarily benefit from state protections (although employers could voluntarily take advantage of state protections for their workers).

Another federal law interfering with state protections is the [Airline Deregulation Act of 1978](#), which explicitly precludes states from regulating air transportation, including air ambulances. This means patients living in many rural parts of the country, who sometimes rely on air ambulance services to access emergency care, are subject to exorbitant out-of-network charges from for-profit air ambulance companies. In an effort to raise awareness about air ambulance pricing, state officials in Montana and Michigan reviewed 58 cases of balance billing resulting from air ambulances since 2013 and found that patients were balance billed an average of \$31,000.^{18 & 19}

The federal barriers to state solutions to end surprise balance billing present a compelling argument that federal policymakers are in a better position to tackle this issue as they have the power to amend these existing laws. There is growing interest in Congress to address this issue and two proposals recently emerged in the Senate: the [Protecting Patients from Surprise Medical Bills Act](#), sponsored by a bipartisan group of six senators, and the [No More Surprise Medical Bills Act of 2018](#), sponsored by Maggie Hassan (D).²⁰ While Congressional interest in this issue is promising, Congress's ability to pass bipartisan health care legislation remains to be seen. Therefore, states should not wait for a federal solution and should continue to explore state-based policies to end surprise balance billing.

A State Policy Framework to End Surprise Balance Billing

Ending surprise balance billing requires a comprehensive approach, which should include the following policy elements:

- ✓ Prohibiting surprise balance billing;
- ✓ Establishing a process to resolve payment disputes between insurers and out-of-network providers;
- ✓ Setting provider payment standards for out-of-network care in surprise scenarios;
- ✓ Requiring transparency and disclosure of provider network status and estimated out-of-network charges;
- ✓ Notifying patients of their rights; and
- ✓ Oversight, evaluation and enforcement.

A recent study found that 25 states have taken at least some steps to protect their residents from out-of-network balance billing.²¹ These state laws include many although not all of these above policy elements. This section discusses each of the key policy components that should be included in comprehensive legislation to end surprise balance billing.

Prohibit surprise balance billing. To hold patients harmless from unfair billing practices, states should explicitly prohibit providers from balance billing patients in all situations where they cannot reasonably be expected to ensure they are receiving in-network care. Those situations include:

- **Emergency care, including ambulance transportation and pre-hospital emergency services provided to patients who are seriously ill or injured before they reach hospital and during emergency transfer to hospital or between hospitals:** In many cases, emergency physicians and the hospitals where they work do not contract with the same insurers. As a result, despite going to an in-network hospital for emergency care, a patient might be treated by an out-of-network physician.²² Evidence shows nationwide one in five in-patient emergency admissions leads to surprise medical bills, and more than half of these cases involved ambulance transportation.²³

Currently, holding patients harmless in emergency settings is found in 22 state laws.²⁴ For example, [Missouri](#) recently requires insurers to pay providers for all emergency services. Patients are only responsible for standard cost-sharing specified in their insurance policy.²⁵ However, none of these state laws includes protections for out-of-network ambulance and pre-hospital emergency services.

- **Inadvertently receiving care from out-of-network providers at an in-network facility:** Similar to emergency physicians, providers such as anesthesiologists, pathologists, radiologists, neonatologists or assistant surgeons might be out-of-network even though they work at an in-network facility. For example, a patient could arrange for a hip replacement with an in-network surgeon at an in-network facility, but the assistant surgeon helping with the surgery and the radiologist performing their MRI could be out-of-network. In these situations, patients have no means to check if any out-of-network providers are part of their care team. A 2017 study published in the Journal of the American Medical Association (JAMA) found that the average anesthesiologist, radiologist and

pathologist charge four times more for their services than what Medicare pays for similar services. When these providers are out-of-network, patients can be stuck with large surprise medical bills.²⁶

Only 17 states have laws offering their residents protections in this surprise balance-billing scenario.²⁷ For instance, [Florida](#) requires health plans to hold patients harmless from surprise medical bills when they are inadvertently treated by out-of-network physicians at an in-network facility.²⁸ Florida law specifically states that an insured patient who does not have the ability and opportunity to be treated by an in-network provider at an in-network facility is only responsible for paying the cost-sharing amount that they would have paid to in-network physicians.

- **Inadvertently receiving care from out-of-network providers due to inaccurate provider directories:** A patient could do everything right to make sure they receive care from providers that have contracted with their health plan, but if they unknowingly rely on an inaccurate provider directory, they could end up inadvertently receiving care from an out-of-network provider. As a result, they could face high out-of-network charges.

States could include this hold harmless provision in legislation that deals specifically with surprise balance billings or in a separate law on provider directories, as [California](#)²⁹ and [Georgia](#)³⁰ did. Both states require health plans to keep their provider directories current at all times and clearly state that enrollees are not responsible for out-of-network charges if they rely on inaccurate provider directories.

Additional 'hold harmless' considerations

Ensure timely access to care. Health insurance is meaningless if patients cannot get the benefits promised to them due to network constraints. To ensure timely access to needed care, states should consider requiring insurers to allow patients to receive care from out-of-network providers at in-network rates for covered benefits when in-network providers are not available. In this scenario, patients are only responsible for standard cost-sharing specified in their insurance policy.

Address continuity of care. As states work to hold patients harmless from surprise balance billing, they should also consider provisions to hold specific populations harmless when a provider's network status changes or they are reclassified into a higher cost-sharing tier. These populations should include: women who are in their second or third trimester of pregnancy through the post-partum period (commonly defined as the six weeks after birth), people with terminal illnesses; and patients being treated for a life-threatening condition, a serious acute condition, or another health condition (such as severe depression or a mental health condition). These patients should be allowed to continue their treatment at in-network rates or at the lower cost-sharing tier for at least 90 days, or until their treatment is complete. This protection would minimize disruptions in care and ensure uninterrupted access to medically necessary services.

Establish a binding arbitration process. Consumer advocates working on surprise balance billing legislation typically focus on holding the patient harmless, but state regulation must also address the payment disputes between insurers and providers.

The first step is to require insurers and providers to settle their payment disputes between themselves. Additionally, states should establish an arbitration process as a fallback option if these two parties are unable to reach a resolution on their own. To provide some protections to patients enrolled in self-funded plans, states can work around the preemptions under the Employee Retirement Income Security Act of 1974 by allowing these plans and their members to opt-in to the arbitration process like [New York](#)³¹ and [New Jersey](#)³² did in their legislation to prohibit balance billing.

Limit out-of-network payment rates to a benchmark rate. Excessive rates lead to higher prices paid in-network and higher premiums. Consumers have an important stake in this because without a meaningful cap on out-of-network charges, providers have a financial incentive to remain out-of-network and can exploit their monopoly power to drive up reimbursement and premiums. In addition, given the need to restrain health care costs, states should consider setting a limit on reimbursement rates for out-of-network services in surprise scenarios as outlined above in the first key policy. An ideal approach would be to set both a floor to prevent insurers from forcing unreasonably low rates, but also a ceiling to keep providers from pushing the rates too high.

Medicare Advantage (MA) has had success by capping the payment rate for out-of-network services at the Medicare fee schedule. This has enabled MA plans to negotiate lower provider rates overall. Studies show MA plans are able to extract lower prices from in-network hospitals: 92 cents for every dollar of what these hospitals would receive from fee for service Medicare.³³ As states look for effective ways to improve affordability for patients and lower health care prices, they should consider using an approach similar to the MA rate setting as a model. This approach would help reduce providers' monopoly pricing power and bolster health plans' ability to negotiate lower prices with hospitals and physicians.^{34 & 35}

Require transparency and disclosure of provider network status and out-of-network charges. To ensure that patients make informed decisions when selecting providers for their care, states should require providers and insurers to provide patients accurate information regarding their network status and potential out-of-network charges. For instance, on the date when a patient makes an appointment, they must be notified if the provider is out-of-network and any charges that exceed their standard in-network cost sharing. The patient should then have the option to be transferred to an in-network provider. If a patient chooses to remain in the care of the out-of-network provider, they should receive a written notice that clearly explains their financial obligations that includes estimated cost information. However, note that price transparency is not a substitute for protecting patients from surprise bills; it is a complement. The patient should only be responsible for these additional charges if they sign the financial consent.

Inform patients of their rights. To fully hold patients harmless from surprise balance billing, both health plans and providers should inform patients of their rights with regard to surprise balance billing and where to file complaints if they are billed by an out-of-network provider. To process these complaints, as well as other insurance issues, states should make funding available for patient assistance via an independent advocate or ombudsman.

Oversight, evaluation and enforcement. To ensure that patients are effectively protected from surprise balance billing, states should consider requiring mechanisms to oversee, evaluate and enforce these protections. These are areas that most states have not yet clearly addressed in their laws.

- **Oversight and evaluation:** A division of insurance or another relevant state agency could be required to collect and analyze consumer complaints data involving surprise balance billing. This would help states track the prevalence of and resolutions to the issue as well as help develop improvements and enforce corrections. Additionally, a state could require an agency to do annual evaluations, in the beginning of implementation at the very least, to understand the impact of certain policy decisions such as the out-of-network rate setting and how it has impacted overall health care costs and patients' access to care. For example, [New Jersey](#) law requires the Department of Banking and Insurance to report to the Governor and legislature annually on how this law results in savings for insured patients and the healthcare system.³⁶ In addition, health plans are required to calculate, as part of rate filings, the savings that result from a reduction in out-of-network claims payments.
- **Enforcement:** A state should consider giving a relevant state agency sufficient enforcement authority to make regulatory changes as well as impose monetary penalties and other formal enforcement actions for noncompliance with the balance billing protections.

These key policies work together to protect patients from receiving a surprise bill under circumstances where even the most prudent person could not have anticipated the circumstances, and ensure that if a patient does choose to receive out-of-network care that choice is fully informed by the potential financial consequences.

SURPRISE BALANCE BILLING: When It Occurs and How to Prevent It

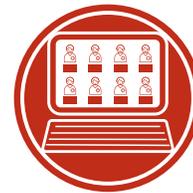
SURPRISE BALANCE BILLING: *Three Main Scenarios*



Inadvertently receiving care from out-of-network providers at an in-network facility



Emergency care, including ambulance transportation and pre-hospital emergency services provided to patients who are seriously ill or injured before they reach hospital and during emergency transfer to hospital or between hospitals



Inadvertently receiving care from out-of-network providers due to inaccurate provider directories

A COMPREHENSIVE APPROACH

Consumer Protections



Prohibiting surprise balance billing



Notifying patients of their rights



Requiring transparency and disclosure of provider network status and estimated out-of-network charges



Establishing a process to resolve payment disputes between insurers and out-of-network providers



Setting provider payment standards for out-of-network care in surprise scenarios



Oversight, evaluation and enforcement

Turning Policy Recommendations Into Reality

Despite bipartisan interest in solutions to end surprise balance billing, it is challenging for many states to enact legislation that includes all of the above policy components. In the past few years, many states have proposed comprehensive solutions to address this issue, but only a few states have successfully made it to the finish line. Before embarking on a campaign to end surprise balance billing, there are several key considerations to keep in mind.

Prepare your evidence. In order to develop the right policy framework, it is important to have a solid understanding of the problem. A state could consider legislation to create a study committee or task force to assess the magnitude of balance billing in the state and the cost of inaction. In the absence of a state-sponsored study, consumer health advocates should consider conducting their own research; quantitative and qualitative studies are both important. For example, in 2017, the [Center for Public Policy Priorities](#) in Texas conducted research to assess the magnitude of surprise balance billing, which led to the enactment of [SB 507](#) expanding access to balance billing mediation so more Texans are able to get help when they receive a surprise balance bill.³⁷

In other cases, consumer health advocates have lead the way collecting stories of patients who have experienced surprise balance bills, working with insurance commissioners to review and analyze consumer complaints on the topic, or conducting public opinion polling on health care concerns to better understand the prevalence of this issue.

Create a winnable policy menu tailored to your state. Given the complex and multifaceted nature of the issue, it is worth reviewing current state law and regulations relevant to surprise balance billing to identify policy gaps that need to be filled. Although we have identified a comprehensive model in this paper, depending on your state's political environment, you might consider taking smaller steps to tackle issues that have a more promising path to victory. Those include, but are not limited to ensuring accuracy of provider directories, prohibiting balance billing in emergency settings, or strengthening network adequacy standards that both ensures sufficient and quality networks and keeps provider rates in check. A critical task for advocates is to seize the window of opportunity for the winnable policy. For example, this year in Missouri, with the help of a campaign led by [Missouri Health Care for All](#), the state passed [SB 982](#) that prohibits surprise balance billing at in-network emergency facilities. Although Missouri was not able to pass the full range of balance billing protections, this is an example of a solid first step.

Understand stakeholder opposition. While there is often consensus on holding patients harmless, policymakers, insurers and providers largely disagree on out-of-network payment standards—a big obstacle to the successful passage of a comprehensive bill. To maximize their payment rates, many hospitals, specialists and other providers will push for their rates to be set based on usual customary and reasonable (UCR) charges, which are typically at 180 to 360 percent of the Medicare rate.³⁸ However, if out-of-network reimbursement rates are set too high, insurers will pass the cost to patients by imposing higher premiums and cost sharing or further narrow provider networks. Given these dynamics, insurers could be allies to consumer advocates in pushing back against higher provider rates.

California failed its first attempt to prohibit balance billing because of powerful lobbying from provider groups who were unhappy with the bill's floor for an out-of-network payment rate, which was set at 100 percent of the Medicare rate. After months of negotiations among stakeholders, California was able to pass revised legislation ([AB 72](#)) that set the minimum out-of-network payment at 125 percent of Medicare or the average contracted rate. This approach would prevent insurers from underpaying providers. However, the lack of a rate cap would still leave the door open for excessive provider prices.

Post-passage follow-up. This is an important step to ensure proper implementation of any balance billing protection. One way advocates can accomplish this is to work with their state department of insurance or other relevant state agency on regulations that clarify areas left unclear in the newly enacted legislation. For instance, New Jersey recently passed [A. 2039](#) into law to end surprise medical bills in the state. Now, advocates in New Jersey, the [NJ for Health Care Coalition](#), are working with the Department of Banking and Insurance on guidance to strengthen disclosure requirements and patients' rights and protections when receiving inadvertent or involuntary out-of-network treatment.

Conclusion

As individuals and families struggle to pay for health care services, it is clear that what people want is for policymakers to find a way to make their health insurance premiums and out-of-pocket cost sharing more affordable. If done correctly, ending surprise balance billing is one way to not only protect people from excessive bills and the risk of medical debt, but also to work to lower health care costs overall. As described in this paper, advocates can draw on the best of existing federal and state law to advance this important goal.

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