"Surprise" Medical Bills: States Opportunities to Protect Patients

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Most people hope and expect that being covered by health insurance will protect them from financial ruin if they are sick or injured. Sometimes, however, having health insurance coverage is insufficient to shield people from serious financial pressure from medical bills. People with insurance can face not only copayments and deductibles, but also unexpected "surprise" medical bills after they seek care, even if they were treated at a hospital or health care facility that is in their health insurance company's network.

People use the term "surprise bill" to describe many different types of medical bills that a patient did not expect to receive. Most commonly, however, it refers to unexpected "balance billing," when the provider sends a bill directly to the patient for the balance of the amount above and beyond what insurance covers and what was expected by the patient.[1]

These surprise bills have emerged as a growing complaint-- and a source of fear-- for many Americans. One study, which examined one insurer's data from January 2014 through September 2015, found that 22% of emergency department cases involved out-of-network care.[2] Another study, which examined a collection of insurers, found that in 2014, 20% of hospital inpatient admissions led to a surprise bill.[3] A Kaiser Family Foundation survey found that 38 percent of people are very worried about being able to afford unexpected medical bills for themselves and their families, with an additional 29 percent being somewhat worried.[4]

This increased anxiety may be driven by narrowing insurance networks, a strategy used by health plans to reduce premiums by excluding higher cost providers from their networks. These networks, however, can create limited choices for patients as they seek care. Anxiety around surprise bills may also be driven by a decline in the number of plans offering out-of-network benefits in the individual and small-group markets. A recent Robert Wood Johnson Foundation report found that the percentage of plans offering out-of-network benefits is decreasing, dropping from 58 percent to 29 percent in the individual market from 2015 to 2018, and from 71 percent to 64 percent in small group market plans over the same time period. This decline in out-of-network coverage leaves more patients exposed to unexpected charges. [5]

COMMON SURPRISE BILLING SCENARIOS

Recent news reports have helped highlight and illustrate common surprise bill scenarios.

Scenario 1: A patient seeks care at a facility that is in their insurance network, but is treated by a provider that is outside of their network, like an out-of-network anesthesiologist working at a hospital in a patient's network.

- In emergency situations, patients have no time to research whether the specialist treating them in the emergency department participates in their insurance network. Scott Kohan was transported to a Texas emergency room with a broken jaw. While the hospital was in his insurance network, he received a $7,924 bill from the out-of-network oral surgeon who operated on him.[6]

- Patients can still encounter out-of-network providers even if a procedure is planned in advance, and they have tried to avoid out-of-network providers. Leanne Tiede researched her coverage to make sure that both the hospital and surgeon she selected for breast cancer surgery were in her insurance network. She later received a surprise $800 bill from the anesthesiologist, who was out-of-network.[7]

Scenario 2: A patient requires immediate emergency medical care and is transported and, in many cases, admitted to a hospital outside of his or her insurance network.

- A teacher in Texas suffered a heart attack and was transported to a hospital that did not participate in the network of the insurance plan offered by his school district. His insurance company paid approximately $55,000 for 4 days of inpatient care, leaving him with a balance bill of $108,951.[8]

Scenario 3: A patient is transported in an air or ground ambulance that does not participate in their insurance network. One study found that more than half of ambulance transport in 2014 occurred

out-of-network and had the potential to generate a surprise bill.[9]

- A West Virginia toddler with a fever of 107 degrees was transported from one hospital to another in an air ambulance. His parents' insurance paid $6,704, leaving the family with a bill of $45,930 for a 75 mile helicopter flight.[10]

CONSIDERATIONS FOR STATE POLICYMAKERS

As press reports draw attention to particularly egregious examples of surprise bills, state policymakers are moving to protect consumers through different approaches. At least 21 states have some type of law addressing surprise bills, ranging from relatively comprehensive protection to more limited policies, which cover only some potential surprise bill situations and/or apply only to certain segments of the insurance market.[11] State laws to address surprise billing typically address several common components.

When and where protections from surprise bills will apply. State policymakers have taken varying approaches to the circumstances in which they choose to protect consumers from surprise bills, ensuring that consumers do not pay more than they would have paid for in-network care.

- Emergency care: Almost all states that have tackled surprise bills have addressed the threat of a surprise bill that results from out-of-network care provided in the emergency department.

- Care at in-network facilities delivered by out-of-network providers: Several states go further, with at least 13 states extending protections from surprise bills to other out-of-network care provided in an in-network facility.[12]

The type of insurance coverage for which the surprise bill protections apply. Some states have applied these protections more broadly than others.

- The majority of states that have addressed surprise bills apply these protections to Preferred Provider Organization (PPO) and Health Maintenance Organizations (HMO) enrollees.[13]

- However, a few states have only addressed surprise bills for people enrolled in HMOs. States with HMO only protections include West Virginia, Texas, Rhode Island, New Hampshire and Indiana.[14]

Transparency requirements to prevent surprises. States are employing many policies that help to empower consumers to avoid surprise bills, through requirements on insurers and/or health care providers. Some states have passed bills that require prior notification of out-of-network care for patients so they can make an informed choice. In addition, states have added requirements for insurers to update network directories and provide more transparent information about the limits of their network to consumers. Complying with these types of requirements can pose additional administrative burdens on health plans and providers. While access to this information may help people avoid using out-of-network physicians for planned treatments, providing patients with notification about network status—or expecting patients to research provider directories—will not remedy all surprise billing situations.

Examples of transparency requirements for providers:

- Louisiana requires hospitals to inform patients prior to receiving care from an out-of-network provider.[15]

- In Texas, in-network hospitals must provide information on the percentage of out-of-network providers who have privileges and practice at the hospital.[16]

- Arizona requires a health care provider who is out-of-network to provide a disclosure notice to the patient before they receive their health care service that includes an estimated cost.[17]

Examples of transparency requirements for insurance companies:

- In several states, insurers must provide transparent and up-to-date network provider directories that are easily accessible.[18]

- California requires that provider directories are updated as frequently as every week.[19]

A process to settle the balance bill. Protecting patients from surprise bills does not mean that the costs simply evaporate. Even if the patient pays no more than the in-network amount, the patient's insurance company and providers need to settle the bill.

- Establishing a payment rate: States can establish a set payment rate for the out-of-network provider in an applicable surprise bill situation. California, for example, requires that health plans pay out-of-network physicians the greater of the plan's

average contracted rate or 125% of the Medicare rate, though providers can appeal this rate through a binding arbitration process.[20]

- Creating an arbitration process: Other states lay out an arbitration process through which the provider and insurance company can settle the bill, without dictating a particular payment rate as a starting point. New York, for example, relies on a "baseball-style" arbitration process in which each party submits a proposed payment amount to a third party.[21]

- Consumer initiated process: Some states rely on consumers to seek relief from a surprise bill. Patients in Texas can utilize a mediation process for surprise bills over $500, but they must initiate the process through the state's Department of Insurance.[22] As of May 2018, only 3,824 Texas patients had used the process since 2009.[23]

ERISA LAW: A UNIQUE ROLE FOR FEDERAL POLICYMAKERS

Despite a variety of state actions to protect consumers, people covered by self-insured plans (which are governed by the federal Employee Retirement Income Security Act of 1974, commonly known as ERISA[24]) remain unprotected. Self-insured plans cover 60% of all worker with employer-sponsored insurance, who are therefore exempt from state laws on surprise bills. A joint team from the Brookings Institution and USC Schaeffer Center have argued that federal action is critical to protecting those in ERISA plans and have advanced potential policy options.[25]

Members of Congress have introduced a variety of legislative approaches to creating new federal protections from surprise bills, which, given consumers' concerns about surprise bills and growing momentum in states, could be on the agenda next year, as members search for potential areas of bipartisan cooperation.[26]

State to watch: New Jersey

After several years of debate, New Jersey enacted legislation in 2018 that is considered by many to be the nation's most comprehensive approach to protecting consumers from surprise bills.

Insurance companies cannot charge a patient more in out-of-pocket costs than the in-network amount for emergency or urgent out-of-network care, or for "inadvertent" out-of-network care by a provider at an in-network facility. The law prevents patients from being in the middle of a billing dispute, placing responsibility with the insurance company to settle with providers on a payment when a relevant out-of-network service is provided. Providers and insurance companies will use an arbitration process in cases in which they cannot agree on payment for an out-of-network service.

The law contains robust disclosure requirements that apply to providers and insurance companies. Providers must publicly disclose the health plans they participate in and the facilities with which they are affiliated. Before scheduling a non-emergency procedure, the provider needs to inform a patient if they are out-of-network and that the patient will have financial responsibility as a result. Physicians must also give patients the name, practice, and other information about other providers who will participate in the scheduled procedure, such as anesthesiologists and radiologists.[27]

Notably, the law allows self-insured plans to opt into some of the protections in the law, including the arbitration process, creating a way for consumers in large employer plans to benefit from the new law, if their employer opts in.[28]

While a broad coalition of health care advocates and businesses supported the legislation, some physicians have cautioned that the new law will limit their negotiating power and result in access to care problems for patients.[29] For state policymakers considering additional protections against surprise bills, the impacts of New Jersey's new comprehensive approach warrant watching.

ADDRESSING SURPRISE BILLS FROM AMBULANCES

Surprise billing laws generally do not apply to either ground or air ambulances. In an emergency, a patient has no control over the ambulance that responds to a call for help, and whether or not that ambulance is in their insurer's network. The fear of incurring a large ambulance bill can discourage people from calling for help, or accepting emergency care when they desperately need it. Earlier this year, a Boston woman told bystanders not to call an ambulance for her after her leg was trapped under a train because she could not afford it.[30] Surprise bills can also result when an ambulance transports a patient from one hospital to another.

Some states legislatures have pursued legislation that would include protections

from ambulance balance bills along with other protections. Legislation in New Mexico to address surprise bills included ambulances, but did not advance.[31] Similarly, bipartisan surprise bill legislation that included ambulance services passed both the state House and Senate in Georgia, but has not been signed.[32]

Regulations surrounding air ambulance surprise bills are even more complex. While some states have enacted legislation that limits surprise bills related to air ambulances, Courts have found that the Airline Deregulation Act of 1978, which prohibits states from regulating prices, routes, or services of air carriers, preempts these state regulations. Courts have ruled against state attempts to address air ambulance surprise bills in West Virginia, North Carolina, Texas, Wyoming and North Dakota.[33] Despite these rulings, states continue to explore policy options.

- After a North Dakota law to restrict air ambulances was struck down by the Courts, the legislature enacted a new law that caps reimbursements for out-of-network air ambulances.[34] Guardian Flight, an air ambulance company, filed a lawsuit, which is still pending, arguing that the new approach violates the federal preemption.[35]

- The California legislature passed legislation this year that would have prohibited air ambulances from charging more than an in-network rate and also would have increased Medi-Cal reimbursement rates. The legislation was vetoed by the Governor.[36]

- Montana enacted legislation that prohibits air ambulance providers from submitting adverse information to credit reporting agencies if consumers are unable to pay balance bills resulting from air ambulance services.[37]

Ultimately, federal legislative action may be needed to give states clear authority to protect consumers from surprise air ambulance bills.

CONCLUSION

Addressing surprise bills is essential to making sure that health insurance actually provides the financial protection it promises. A patient experiencing a health emergency should be able to focus solely on getting better, not whether the ambulance that arrives or the treatment they need will leave them with a financial shock. Solving problems requires players across the health care system to come together and contribute to solutions.

State policymakers interested in protecting their constituents from surprise bills can learn a few important lessons from state policies. First and foremost, limiting charges to consumers to in-network rates in both emergency and inadvertent surprise billing situations are critical to creating meaningful protections. While the addition of transparency requirements can make it easier for people to avoid out-of-network charges, even the most committed consumers may still have their blood work sent to an out-of-network lab-- or be admitted to the hospital in an emergency situation with no time to research possible providers.

Thanks to Penn LDI, and members of the United States of Care Founders Council and network for their valuable review and feedback

Second, the strongest state laws do not make the patient the middle man; instead, they set payment rates or create an arbitration process to settle the bill, without putting the onus on the patient. The outcome of these processes is important, since protecting the patient from a charge does not make it go away. Successful laws will make sure that doctors and other health care providers are fairly compensated for their care and services, without subjecting insurance companies to large charges that ultimately raise rates for everyone.

Thanks to Penn LDI, and members of the United States of Care Founders Council and network for their valuable review and feedback

FURTHER RESOURCES

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ENDNOTES

1 This is a common occurrence if a provider is outside of a patient's network. For example, an insurance company may negotiate a payment of $600 on a $1,000 charge. The patient then has to pay their 10% co-pay ($60), plus the other $400 the insurance did not pay.
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