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Answering the Thousand-Dollar Debt Question: An Update on State Legislative Activity to Address Surprise Balance Billing

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As the newly insured use their coverage, increased scrutiny is being drawn toward the experiences of consumers who are receiving care. One issue of growing concern is the accumulation of medical debt, even among the insured. According to a recent study from the Kaiser Family Foundation, more than a quarter of adults in the United States report that, within the past year, they or someone in their household have had challenges paying medical debt. This includes 20 percent of individuals under the age of 65 who are insured. Also striking, 51 percent of insured individuals reported owing sums of over $5,000, a significant sum for many households (see Figure 1).[1]

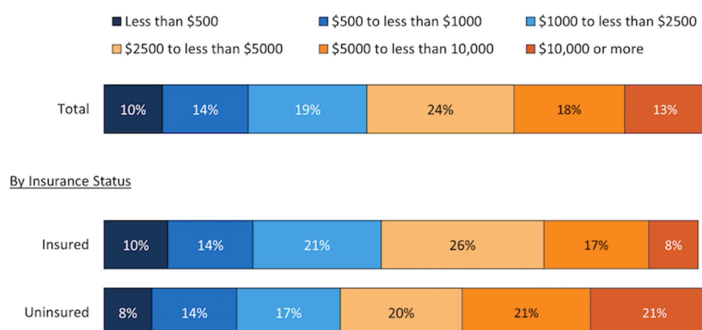
The issue is especially complicated as recent fluxes in the health care industry - triggered by growth and shifts in coverage - are occurring in tandem with experimentation by providers and insurers to reduce costs. As the industry stabilizes, it is yet to be seen what methods of controlling costs may prove most effective at lowering those costs and improving affordability for consumers.

One contributing factor under scrutiny is the occurrence of balance or "surprise" billing which happens when patients receive a higher than expected bill from providers, even after factoring for the amount paid by a consumer's insurer to the provider. States are also taking action to explore the impact of surprise billing, managing the interests of carriers, providers, and consumers to address the issue. This brief examines the emergence of surprise billing and relevant state and federal activity, including state legislation that has been proposed during this legislative session.

Figure 1

People Report Problems Paying Medical Bills of Varying Dollar Amounts

AMONG THOSE WHO HAD PROBLEMS PAYING HOUSEHOLD MEDICAL BILLS IN THE PAST 12 MONTHS: What was the TOTAL amount owed for the medical bills you've had problems paying?



NOTE: Don't know/Refused responses not shown.
SOURCE: Kaiser Family Foundation/New York Times Medical Bills Survey (conducted August 28-September 28, 2015)

The Rise of Surprise Billing

Insurers are experimenting with narrowing provider networks, which allows them to negotiate lower rates with selected providers in order to increase the affordability of plans. This is especially true for plans sold through the health insurance marketplaces. While federal and state laws provide some protections over the minimum scope of a plan's network, 49 percent of marketplace plans are described as narrow (22 percent) or ultra-narrow (17 percent), meaning that they limit their contracting to 40 to 70 percent or 0 to 30 percent of local hospitals, respectively.[2] While narrowed networks require consumers to bear greater responsibility for seeking appropriate in-network services, the cost benefits achieved through competitive provider negotiations and contracts have proved to be a popular option among purchasers. In 2015, only 17 percent of narrow network purchasers switched to a broad network plan.[3] Yet, even as consumers take appropriate steps to receive in-network care, they are receiving surprise balance bills.

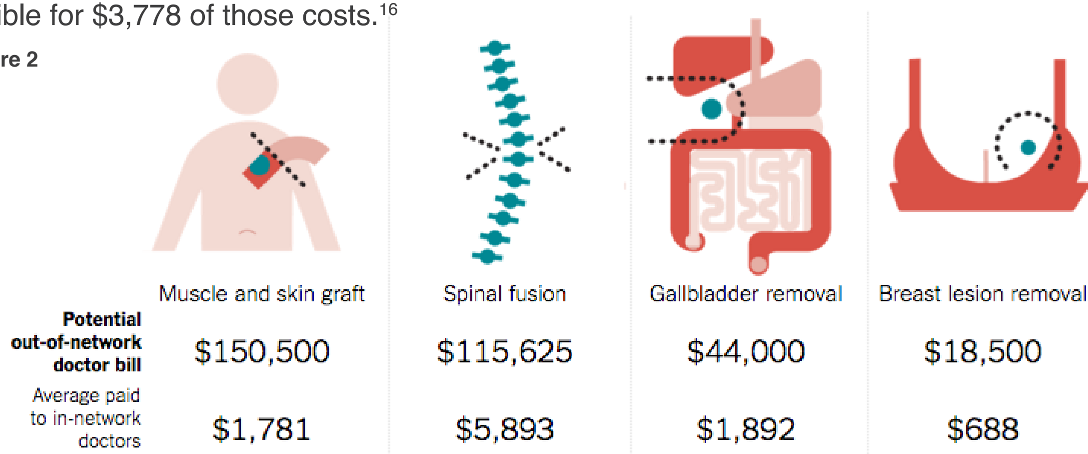
Surprise balance billing is a growing trend in the U.S, with a 2015 Consumers Union poll finding that nearly one-third of privately insured Americans have received a surprise medical bill within the past two years.[4] In 2014, the New York Department of Financial Services named it as a top complaint from consumers.[5, 6]

Thirty-two percent of insured non-elderly adults who reported challenges paying medical bills named care received by out-of-network providers as a factor contributing to costs,[7] with many factors affecting the likelihood of receiving out-of-network services. In many cases, patients are unaware or reported being inadequately informed that they were receiving care from an out-of-network provider. According to Kaiser, 69 percent of those who were billed for out-of-network services did not realize that their provider was not in-network.[8] Similarly, a Consumer Union survey found that one of four respondents received bills from unexpected physicians they did not expect to receive bills from.[9] This preponderance of out-of-network services is affected by provider "outsourcing;" when hospitals or other large providers contract with independent or outside providers to render services within their facilities.

In these cases, while the hospital may be in a health plan's provider network, the actual practitioner providing services may not. This leaves consumers vulnerable to out-of-network fees by rendering physicians, which can be as much as 20 to 40 times the rate of services negotiated between insurers and an in-network provider.[10] Susceptibility increases in instances when multiple practitioners or procedures are involved in the treatment of an illness, such as anesthesiologists and radiologists, sometimes without notice to the patient.[11] Costs are also further amplified by "provider-based billing" in which healthcare organizations bill for use of facilities and equipment separate from the charges incurred by the rendering providers.[12]

Consumers are more likely to experience provider outsourcing in hospital emergency room (ER) settings, especially as 65 percent of hospitals contract out emergency medical services.[13] A report by Heath Services Research found that 68 percent of patient contact with an out-of-network provider took place in an emergency setting.[14] Similarly, a study focused on Texas' three largest insurers, found that 21 to 45 percent of the insurer's in-network hospitals had no in-network ER physicians. The report further cited that between 41 and 68 percent of emergency medical bills received by patients were from out-of-network physicians.[15] This is especially concerning given that consumers often have little choice in providers when admitted in an emergency situation, as well as the especially high average costs of care for emergency services. A 2012 study issued by the New York Department of Financial Services found that the average bill for out-of-network emergency services was over $7,006, with consumers directly responsible for $3,778 of those costs.[16]

Figure 2



Sources: America's Health Insurance Plans; Healthcare Bluebook

Illustrations by Jennifer Daniel/The New York Times

Elisabeth Rosenthal. "After Surgery, Surprise $117,000 Medical Bill From Doctor He Didn't Know." *The New York Times*. September 20, 2014 http://www.nytimes.com/2014/09/21/us/drive-by-doctoring-surprise-medical-bills.html

Federal Activity Around Surprise Billing

Federal administrative and legislative officials have taken incremental steps to address balanced billing (see Box 1). Most significant of these are limitations on this practice imposed under Medicare by the Omnibus Budget Reconciliation Act of 1989. The Kaiser Family Foundation estimates a $2.5 billion reduction in balanced billing as a result of these provisions between 1983 and 2011.[17]

President Obama addressed the issue of balance billing in his **Fiscal Year 2017 budget**. The budget outlines a provision to "eliminate surprise out-of-network healthcare charges for privately insured patients" by requiring hospitals "to take reasonable steps to match individual patients with providers that are considered in-network for their plan" and physicians who regularly provide services at the hospital to "accept an appropriate in-network rate as payment-in-full."[18] Additionally, 25 Democratic members of the House have co-sponsored, the **End Surprise Billing Act**, introduced in October 2015. While unlikely to gain traction, the bill proposes to require providers to notify patients about receipt of out-of-network services and estimated charges. The bill also restricts balance billing in the case of receipt of emergency services.[19] Most recently, the **HHS Notice of Benefit and Payment Parameters for 2017** requires that, beginning in 2018, plans participating as qualified health plans (QHPs) count the cost of essential health benefits (EHBs) received from out-of-network ancillary providers to a consumer's annual limitation for cost-sharing unless advanced notice is given. Importantly for states, the limited rule allows the Centers for Medicare and Medicaid Services (CMS) to "monitor ongoing efforts…and amend [their] policy to accommodate progress on the issue."[20] This gives states added flexibility to innovate around this issue in their respective environments and potentially influence or inform future federal policies.

Box 1. Federal Legislation Addressing Balanced Billing

- The Bipartisan Budget Act of 2015: Signed in November 2015, the Act eliminates Medicare incentives for hospitals or other providers to contract with supplementary providers "off-campus". The Act restricts new off-campus outpatient facilities from receiving reimbursements at, the often enhanced, outpatient prospective payment system (OPPS) rates, instead tying them to other Medicare payment schemes such as the physician fee schedule.

- The Patient Protection and Affordable Care Act (ACA): The ACA requires non-grandfathered health plans to cover emergency services received at out-of-network facilities at least at the same rate of cost-sharing requirements stipulated for in-network emergency services. The ACA also compels the health insurance marketplaces to collect and make public information on cost-sharing and payments for out-of-network services, though these provisions have yet to be enforced.

- The Omnibus Budget Reconciliation Act of 1989: Governing physician fee schedules for Medicare, the Act limits non-participating Medicare providers to only billing up to 115 percent of Medicare's fee-schedules. Furthermore, balance billing is prohibited in Medicare Advantage with the exception of private fee-for service plans.

State Actions to Address Surprise Billing

States have taken several actions to offer at least some protections from surprise billing. A July 2015 report from the Robert Wood Johnson Foundation (RWJF) describes four approaches states have taken to protect consumers from balanced billing: 1) enhanced disclosure and transparency requirements; 2) prohibitions on balance billing by providers; 3) requirements for insurers to hold consumers harmless from surprise charges; and 4) regulations that ensure fair payment for billed services (see the report for a case study of laws implemented in California, Colorado, Florida, Maryland, New Mexico, New York, and Texas).[21]

Forty-nine states have enacted some consumer protections against balance billing for managed care enrollees. Of these, 27 states apply protections against out-of-network providers in PPO plans and 13 apply them for HMO plans. Usually protections relate to care delivered in emergency settings.[22, 23] Other state legislation is aimed at enabling independent legal resolution between providers and providers without involving the consumer, as in Illinois,[24] and laws the empower consumers to dispute billing issues, like in Texas.[25] New York's law, enacted in April 2015, includes some of the most comprehensive protections to date. The law protects consumers from owing more than their in-network copayment, coinsurance, or deductible when receiving emergency care even from out-of-network providers. It also enables consumers to sign an "assignment of benefits form" that allows providers to pursue payment directly from insurers in the case of a dispute.[26]

During this legislative season, several states are considering actions to address surprise billing. Proposals range from improving the processes by which patients are notified about the receipt of out-of-network services to setting cost limits on charges assessed for out-of-network care. below is a summary of current bills active in state legislatures.

Chart A. 2016 Pending State Legislation to Address Surprise Balance Billing

State/ Bills	Improve patient out-of-network disclosures and cost estimates	Establish a process to resolve billing disputes	Cap or limit charges for emergency services delivered out-of-network	Cap or limit charges for non-emergency services delivered out-of-network	Incentivize out-of-network care received at a lower cost than in-network services	Standards for delivery and	Assess the impact and potential parameters for balanced billing:	Status
AL SB 116	X				X			Senate 3/10/16
CT SB 289	Clarifies CT's prior out-of-network protections to • Indicate that hospital out-of-network notification requirements can be satisfied through posing information on websites. • Clarify that notification requirements do not apply in situations of unscheduled services or those scheduled three days prior to occurrence. • Limits amounts that can be collected from uninsured patients below 250 percent FPL							Senate 4/6/16
FL SB 1442	X	X	X			X		Senate 3/3/16
FL H1175	X							Presented to Governor 3/30/16

State/ Bills	Improve patient out-of-network disclosures and cost estimates	Establish a process to resolve billing disputes	Cap or limit charges for emergency services delivered out-of-network	Cap or limit charges for non-emergency services delivered out-of-network	Incentivize out-of-network care received at a lower cost than in-network services	Standards for delivery and	Assess the impact and potential parameters for balanced billing:	Status
GA SB 382	X	X	X			X	X	Introduced
GA SR 974							X	Passed by Senate 3/22/16
GA SR 566							X	Senate 2/17/16
HI SB 2668	X		X	X				Passed by House 4/4/16
HI HB 1952	X	X		X				Introduced
LA SB 316				X				Senate 3/14/16
LA HB 412			X					House 3/14/16
MA HB 3931				X				Introduced
MD SB 334						X		Senate 2/10/16
	Places burden on carrier to pay claims (at the provider's customary rates) if a consumer received care from an out-of-network provider as a result of failure to comply with network reporting standards							
MN HF 2725				X				Introduced
NH HB 1516				X				House 3/9/16
NH SB 495							X	Passed by Senate 3/24/16
NJ A 1664			X					Introduced
NJ A 1952; S1285	X	X	X			X		Introduced
NJ A 2935	X							Introduced
NJ A 1653								Introduced
NJ S 285		X	X					Introduced
NJ S 289	X							Introduced
NJ S 786			X					Introduced
NY AO 4151				X				Introduced

State/ Bills	Improve patient out-of-network disclosures and cost estimates	Establish a process to resolve billing disputes	Cap or limit charges for emergency services delivered out-of-network	Cap or limit charges for non-emergency services delivered out-of-network	Incentivize out-of-network care received at a lower cost than in-network services	Standards for delivery and	Assess the impact and potential parameters for balanced billing:	Status
NY SO 1846	Requires every HMO to offer out-of-network coverage as an optional rider to any contract. They must also offer at least one contract option inclusive of out-of-network coverage.							Senate 1/6/16
NY AB 3526	X							Introduced
OK SB 1363			X					Introduced
OK HB 3065					X			House 2/2/16
PA SB 1158		X	X					Senate 3/22/16
RI HB 7474						X		Held for further study 3/23/16
TN SB 2232; HB 2005	X							Senate 2/24/16
TX HB 3133		X						House 4/8/16
WA HB 2447							X	House 3/10/16
WV HB 4593	X	X						House 2/17/16
	Defines certain conditions under which insurers are required to assure that a consumer can obtain a covered benefit at an in-network level from a non-participating provider							

- **Improving patient disclosures, cost estimates, and network transparency:** Most state activity to address balanced billing revolved around methods to increase consumer understanding and awareness of situations, which may result in a surprise bill. Nine states are considering legislation to enhance requirements for patient notifications regarding the delivery of out-of-network services. These bills vary by entity responsible for creation and distribution of notices (e.g., carriers, hospitals, all health care providers, all health care facilities); the method by which notices should be delivered (e.g., via web or written); and the appropriate time for delivery of notices (e.g., prior to the delivery of services, prior to an appointment, within a specified time window triggered by a request). Bills in **Alabama, Florida, Hawaii, Oklahoma, and West Virginia** require providers to deliver "good faith" estimates of charges to consumers or, at minimum, inform consumers of their ability to request such an estimate. A bill in **New Jersey** explicitly requests that consumers consent before receiving services from an out-of-network provider in non-emergency situations.

  In addition to improved notices and cost estimates, six states **(Florida, Georgia, Hawaii Maryland, New Jersey, and Rhode Island)** are considering legislation that would require insurers to include information about hospital affiliations and/or privileges as part of information included in provider directories. Moreover, the bills include time restraints to ensure that directories stay

current. **New Jersey** proposes to require updates within 20 days of a change in a provider's network status, and **Georgia** requires updates annually. A bill in **Hawaii** would require insurers to share clear descriptions of how out-of-network costs are calculated and to post information via website to enable consumers to estimate potential out-of-network costs.

- **Capping or limiting charges for services delivered out-of-network:** Eleven states seek to limit or restrict costs of services performed by out-of-network providers. **Florida, Georgia, Hawaii, New Jersey, Oklahoma, and Pennsylvania** propose limitations in circumstances of care delivered in an emergency setting or on an emergency basis, usually limiting consumer liability to cost-sharing that would have been incurred if the care had been delivered in-network. **Oklahoma** and **New Jersey** place responsibility on providers to limit billing to consumers to specified rates, while **Florida** and **Georgia** hold carriers accountable to ensure that consumers are not charged higher than in-network rates. **New Jersey** proposes to cap payments to providers for out-of-network services at 150 percent of Medicare payment rates.

  Hawaii, Louisiana, Massachusetts, Minnesota, New Hampshire and **New York** extend protections to non-emergency circumstances. **New Hampshire's** bill protects against provider outsourcing by mandating "outsourced" providers accept in-network payments when they see individuals who are in-network at the hospital. **Hawaii** and **Massachusetts** propose caps or limits to how much out-of-network providers can charge for delivered services. **New York** protects against out-of-network billing in cases where providers direct specimens to out-of-network clinical labs. **Minnesota** limits coverage restrictions and cost-sharing requirements on unauthorized provider services to those of participating providers. **Louisiana** has proposed two bills that establish rates at which insurers would be required to pay claims –one is focused on all "non-contracted facility-based" physicians, the other on emergency medical services.

- **Establishing a process to resolve billing disputes: Proposed legislation from Florida, Georgia, Hawaii, New Jersey, Pennsylvania,** and **West Virginia** seeks to establish a process to assist in resolution of billing disputes. In case of billing, often there is confusion about the rights and liabilities of consumers, insurers, and providers to resolve the issue. All proposed bills outline a process for providers and insurers to negotiate directly in the case of specified balance billing disputes. A proposed bill in **Texas** modifies current law to remove a $1,000 minimum threshold for consumers to seek mediation in out-of-network billing cases.

- **Assessing the impact and potential parameters for balanced billing:** Prior to enacting other legislation four states have proposed vehicles to study the effect of balanced billing in their respective states. **Georgia** currently has three bills that would establish slightly different workgroups (e.g., based in the Senate or Office of the Governor) to study the issue; similarly a bill in **Washington** proposes that the Insurance commissioner establish a workgroup to study the elimination of balance billing. **New Hampshire's** bill would contract with a consultant to study retiree health plans including "populations impacted by in-network versus out-of-network care." Tying their approach to data, **New Jersey's** legislation would enable the state to use data from a proposed all-payers claims database to establish reasonable payment rates for "medically necessary out-of-network services."

- **Incentivizing consumers for out-of-network care received at a lower cost than in-network services:** In rare circumstances out-of-network services may actually be delivered at lower cost than in-network, saving both insurers and consumers. In the case of such circumstances, **Alabama** and **Oklahoma** have proposed incentives for consumers that receive lower cost-care in the form of direct payments from saved costs or reductions to the consumer's cost-sharing responsibilities, respectively.

Conclusion

Medical billing and debt is a complex issue, and as illustrated above, states are taking many steps to address one root cause, surprise billing. As legislation continues to evolve and be enacted, it will be important to monitor trends and how bills ultimately will impact not only consumer debt, but also cost and complications for health care providers and insurers. At issue are trade offs: insurers limit provider reimbursement and networks to bring down premium costs. But that requires a highly informed consumer to understand the implication of those limits on choice and out of pocket exposure. As states examine the complicated issues in these trade-offs it will be important to keep an eye on emerging state policy approaches to determine how they inform and protect consumers and if they impact price.

End Notes

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