STATE INNOVATION EXCHANGE

MARCH 2020

SURPRISE MEDICAL BILLING RESEARCH BRIEF

Surprise medical billing refers to when a consumer is unaware that health care services will be charged at out-of-network rates, whether by their insurer or by the out-of-network provider. For example, if a patient receives emergency care at an out-of-network hospital or care from an out-of-network provider at an in-network hospital, they could receive a surprise medical bill.

As we face the first global pandemic of the 21st Century, our nation confronts a health care system that is not prepared to deal with an infectious disease at this scale. One of the many challenges we face will be patients who delay or defer care because they are unsure if their visit to a testing facility, urgent care center or emergency room will result in a surprise bill, not covered by their insurance.

Surprise medical bills have two main components, according to a 2019 Health System Tracker brief from Peterson Center on Healthcare and the Kaiser Family Foundation:

1. *The **higher amount a patient owes due to the difference in cost-sharing levels between in-network and out-of-network services.** "For example, a preferred provider health plan (PPO) might require a patient to pay 20% of allowed charges for in-network services and 40% of allowed charges for out-of-network services. In an HMO or other closed-network plan, the out-of-network service might not be covered at all."*
2. *An **additional amount the physician or other provider may bill the patient directly, which is known as "balance billing."** "Typically, health plans negotiate discounted charges with network providers and require them to accept the negotiated fee as payment-in-full. Network providers are prohibited from billing plan enrollees the difference (or balance) between the allowed charge and the full charge. Out-of-network providers, however, have no such contractual obligation. As a result, patients can be liable for the balance bill in addition to any applicable out-of-network cost sharing."*

The problem is widespread: A 2018 University of Chicago survey found that 57% of respondents had experienced a surprise medical bill. Additionally, this survey found that 86% of all respondents blamed health insurance companies and 82% blamed hospitals for surprise medical bills. A large study published in 2020 that looked at over 347,000 surgical patients found that over 20% had incurred out-of-network charges.

The problem has serious consequences, especially for communities of color: Almost half of respondents in a Commonwealth Fund survey said that they could not cover an unexpected medical bill of $1,000 within 30 days. And this can have a disproportionate impact on marginalized communities, with Black (63%) and Hispanic (59%) respondents reporting higher inability to cover such a bill compared to Non-Hispanic White respondents (40%). This issue also impacts the overall cost of employer-sponsored insurance plans, according to a December 2019 article in Health Affairs.

SURPRISE MEDICAL BILLING

MESSAGING

- We need to make health care more affordable and predictable for white, Black and brown people struggling to make ends meet
- As we all make choices about our health that will have an impact on everyone in our community, we cannot continue to force people to choose between keeping a roof over their head and seeing their doctor to get the care they need
- People shouldn't have to pay exorbitant bills when treated by out-of-network providers for reasons outside their control
- Millions of health care consumers are at risk of receiving surprise medical bills. We need to eliminate the potential for surprise medical bills so people are confident seeking medical care when they need it
- Even when consumers make informed and careful decisions about their health care, insurance companies can still bill them for out-of-network care. People deserve to seek medical care without the fear of receiving a surprise bill after seeking care
- Today, certain politicians and greedy lobbyists hurt everyone by handing kickbacks to the rich, and trying to put insurance companies back into the driver's seat when it comes to making decisions about our healthcare
- We can create a health care system that works for us all

PUBLIC OPINION

Public opinion polling shows strong bipartisan support for addressing surprise medical billing.

- A national survey from the Kaiser Family Foundation conducted in September 2019 found that 78% of respondents support legislation to protect patients from paying the medical costs not covered by insurance after receiving care from an out-of-network provider or hospital. This same poll found that this strong support crossed over party lines, with 84% of Democrats, 78% of Independents, and 71% of Republicans supporting this reform. Even after hearing an opposition argument, a majority of respondents remained in support (57%).
- Polling conducted for SiX also indicates broad support:
  - In a January 2020 poll of Virginia voters, over four in five (84%) supported ending surprise medical billing for non-emergency services
  - A focus group of Maine swing voters held in December 2019 found support for cracking down on surprise medical bills from both a group of non-college swing voters and a group of female swing voters age 55 years or older
  - A January 2020 online survey of registered voters in Florida found strong support (an average support of 8.4 out of 10, with 52% rating it a 10) to "eliminate surprise medical billing for non-emergency services by ensuring patients are told beforehand of the cost of any non-emergency service." Support was strongest among respondents 50 years of age or older (8.7 mean rating), but support among those under 50 years of age was also strong (8.0 mean rating)
  - In a Michigan internet and phone survey from November 2019, 84% of respondents were in support of eliminating surprise medical billing for non-emergency services, and 50% indicated that this policy would directly benefit themselves and their families

CORE POLICY ELEMENTS

Advocates for insurers and advocates for providers often disagree on whether independent dispute resolution should be on the table, and have promoted a number of different policy principles. However, advocates for consumers generally have the following recommendations:

- Hold consumers harmless from surprise medical bills in all situations over which they have no control
- Establish a process that prevents either insurers or providers from exercising excessive market power
- Establish a process to set a reimbursement rate for out-of-network services that neither increases premiums for consumers and overall health care costs nor creates incentive for providers to leave the network
- Out-of-network payment rates should not be based on providers' bill charges

The following are core policy components for state surprise medical billing reforms as described by national health policy expert organizations.

A Community Catalyst report from February 2019 lists the following core policy elements:

- ***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 that they are receiving in-network care*
- ***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.*
- ***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.* [NOTE: advocates contend that out-of-network payment rates should not be tied to billed charges.]
- ***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.* [NOTE: advocates stress that transparency should be a part of a broader package of reforms and is not a substitute for other consumer protections.]

Payment Standards

Under this approach, legislation or regulations establish the price providers will be paid for their services.

Policy considerations include:

- What will be the effects on premiums and the dynamics between insurers and providers in negotiations over network participation?
- If billed charges or in-network rates are used as a benchmark, what will be the source of data to support the payment standard? Data could be provided from each insurers' paid claims for in-network services, an all-payer claims database, or some other source
- How much variation in the standard rate will be needed to account for local market conditions, the complexity of the case, the physician's expertise, or other factors?

Pros:

- Easier to administer than arbitration
- Helps ensure prompt payment to providers
- Reduces uncertainty
- Depending on where the rate is set, could help keep health care price inflation in check

Cons:

- Government rate-setting, even in this context, may be politically objectionable for some policy makers

- ***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*

A Commonwealth Fund blog from January 2019 lists the following "critical elements of state laws that offer 'comprehensive' protections against balance billing":

- *Extend protections to both emergency department and in-network hospital settings*
- *Apply laws to all types of insurance, including both HMOs and PPOs*
- *Protect consumers both by holding them harmless from extra provider charges—meaning they are not responsible for the charges—and prohibiting providers from balance billing, and*
- *Adopt an adequate payment standard—a rule to determine how much the insurer pays the provider—or a dispute-resolution process to resolve payment disputes between providers and insurers*

(NOTE: If any pending federal legislation on surprise medical billing is enacted, state policymakers should work with national and local advocates to determine which policy options to prioritize.)

STATE LEGISLATION

A 2019 resource from the Commonwealth Fund on state balance-billing protections provides an overview of how states are addressing this issue. It should be noted that, as mentioned in a December 2019 Commonwealth Fund blog post, while states have taken the initiative to address surprise medical billing, federal law (ERISA and ADA) prevents states from regulating self-funded employer health plans and air ambulance services.

Overall, there has not been a uniform approach taken by the states to address surprise medical billing. The 2019 Health System Tracker brief referenced above also includes an overview of state action on surprise medical bills:

At least thirteen states have enacted and implemented laws taking a comprehensive approach to surprise bills (California, Colorado, Connecticut, Florida, Illinois, Maryland, New Hampshire, New Jersey, New Mexico, New York, Oregon, Texas, and Washington).

- It may be difficult to set a rate that accurately reflects local market conditions, service complexity, quality, and provider experience
- A rate set too high could increase premiums and create incentives for providers to remain out of network (or to drop out of networks)
- A rate set too low could create financial difficulties for some physicians or make it more challenging to recruit certain specialties to work at some facilities

Dispute Resolution

Under this approach, disagreements between insurers and providers over the appropriate out-of-network price for a service are subjected to a dispute resolution process detailed in legislation or regulations.

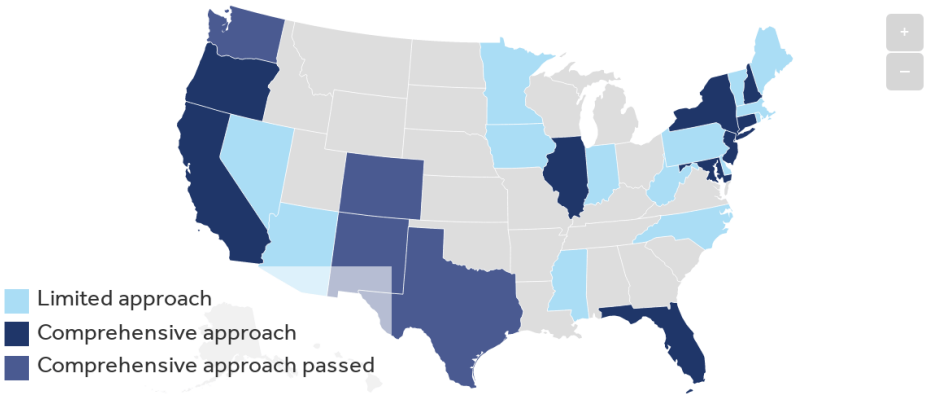
Policy considerations include:

If using binding arbitration, how are the arbitrators chosen and what qualifications must they have?

Should "baseball-style" arbitration be used, so that the arbitrator must choose from the final offer of one party or the other, or may the arbitrator choose a different payment amount?

What data are arbitrators allowed or required to consider during the decision-making process? Should information about the complexity of the patient's case and the physician's experience be factors to consider?

State balance billing protections for state-regulated plans



Note: Four states have passed comprehensive protections that have not yet gone into effect as of June 2019

Source: See Jack Hoadley, Kevin Lucia, and Maanasa Kona, "State Efforts to Protect Consumers from Balance Billing" for summary of state laws enacted through 2018. Updated by KFF to reflect action as of June 2019.

Peterson-KFF Health System Tracker

What are reasonable time limits for resolving the dispute?

Who pays for the dispute resolution process?

Pros

- Allows the parties to present case-specific information, including clinical factors, network adequacy issues, and provider expertise
- Creates incentives for the parties to reach a voluntary agreement before submitting to the uncertainty of winner-take-all baseball arbitration

Cons

- Depending on the design, arbitration may be administratively burdensome for the parties and result in delays in provider payment
- Depending on requirements placed on arbitrators as well as actual practice, decisions could result in either price inflation or cuts in provider revenue

(Health Affairs Blog, July 15, 2019)

The next section is a selection of sample legislation that **prohibits surprise medical billing**, followed by samples of legislation related to **independent dispute resolutions**, which are often a component of the former but are highlighted due to their more complex nature. The next two sections look at methods of reducing the utilization of out-of-network providers through improved **network adequacy standards** and **accessible network directories**. The final set of example legislation is based on **transparency and cost disclosures** to patients.

Please note that this information is meant to serve as a starting point for advancing this issue. We do not offer a comprehensive list of legislation below, nor necessarily a list of the most progressive policy reforms possible in your state. When moving forward with legislation, we recommend working with local and national advocates to craft the best solution for your state.

SURPRISE MEDICAL BILLING PROHIBITION

State laws which impose billing prohibitions, like limiting balance billing and adjusting network status billing, are the most direct tool for legislators to combat surprise medical bills in their communities. Often paired with "hold harmless" provisions, these billing prohibitions protect patients from costly bills by shifting the burden of paying additional costs from insurance-enrolled patients to health insurers. While most states that have addressed surprise medical billing cover emergency care, such as was recently passed in **Nevada** (2019 NV AB 469/ Chapter 62), a more comprehensive approach would be to also cover non-emergency care that results in a surprise medical bill. The following are examples of state laws that include these types of comprehensive surprise medical billing prohibitions.

California passed a bill (2016 CA AB 72/Chapter 492) which states that an enrolled patient who receives covered services from an out-of-network provider at an in-network health facility is not responsible for more payment than the cost sharing that the enrolled patient would cover for the same services from an in-network provider. An enrolled patient is responsible for out-of-network cost sharing only if an enrollee's health care plan covers out-of-network benefits and the patient signs a consent form at least 24 hours in advance. This law also requires out-of-network providers to compensate patients for any amount the patient

pays over the in-network cost sharing amount for similar services rendered by in-network providers. If the out-of-network provider does not refund a patient within 30 days, the refund begins to accrue interest (at a rate of 15% per year).

Colorado passed a law (CO HB 19-1174) ensuring that enrolled patients are not liable to cover more of the cost sharing amount for emergency services from out-of-network providers than they would be for emergency services from in-network providers. This law similarly requires that patients are reimbursed by facilities if they overpaid for emergency services at an out-of-network facility. Facilities are also required to pay 10% interest per year on any unreimbursed overpayments.

Connecticut passed a bill (2015 CT SB 811/Public Act 15-146) which prohibits patients who receive surprise bills from being charged coinsurance, copayments, deductibles, or other out-of-pocket expenses greater than what they would have been charged for an in-network provider. It also provides a reimbursement benchmark for emergency services provided by out-of-network providers.

Maine passed a bill (2017 ME LD 1557/Chapter 218) that prohibits both balance billing and additional charges for non-emergency, covered services rendered by an out-of-network provider at an in-network facility when the enrolled patient did not know the provider was out-of-network. LD 1557 prohibits out-of-network providers from charging patients more than the patient would normally pay through cost sharing if the provider were in-network. (Maine also prohibits charging out-of-network amounts for emergency services; see ME Insurance Code § 4320-C.)

New Hampshire passed a bill (2018 NH HB 1809/Chapter 356) which prohibits specialty providers from balance billing enrolled patients serviced at in-network facilities for charges beyond copayment, deductibles, or coinsurance. This prohibition applies regardless of the provider's network status.

New Mexico's Surprise Billing Protection Act (2019 NM SB 337/Chapter 227) broadly prohibits service providers from surprise billing covered patients for more than the cost sharing amount enrolled patients would pay if the service were rendered by an in-network provider. The act also requires out-of-network providers to compensate patients for any amount the patient pays over the in-network cost sharing amount. If the provider does not refund patients within 45 days, the refund begins to accrue interest.

Oregon enacted legislation (2017 OR HB 2339) that prohibits balance billing from out-of-network providers for emergency services and for non-emergency services when the patient did not knowingly choose an out-of-network provider. And for patients who choose an out-of-network provider, the provider is required to disclose to the patient the added expenses (coinsurance, copayments, or deductibles) of choosing an out-of-network provider.

Texas passed a consumer protection bill (2019 TX SB 1264) that prohibits a non-network facility-based provider from billing an enrolled patient for more than the in-network cost sharing amount the enrolled patient would pay for the same service. A non-network facility-based provider may charge an enrolled patient additional bills only if the patient knowingly elects to receive non-emergency service after receiving full disclosure of the provider's status and projected costs.

Washington passed the "Balance Billing Protection Act" (2019 WA HB 1065/Chapter 427), which prohibits out-of-network providers and facilities from balance billing enrolled patients for emergency or non-emergency services provided at in-network facilities. Similarly, a patient must be "held harmless" from paying additional charges, beyond the cost-sharing amount, when the patient receives emergency services from a hospital in a bordering state (i.e., Oregon or Idaho). The Act also requires out-of-network providers and facilities to reimburse patients who pay more than the in-network cost-sharing amount for their services plus interest, at a rate of 12%, if they fail to reimburse the patient within 30 days.

AMBULANCE AND EMERGENCY TRANSPORTATION CHARGES

The following are examples of state laws that affect how ambulance charges, particularly those out-of-network, are covered. Though ground ambulance rides are a frequent source of surprise bills, most state laws addressing emergency transportation focus on air ambulances because air ambulances are managed by private companies and ground ambulances were, until very recently, often managed by local and municipal governments. However, the Airline Deregulation Act of 1978 prohibits states from regulating the price, route, and service of air carriers, which various courts have interpreted to include air ambulance providers. State laws range from estimated cost disclosure requirements to prohibitions on balance billing.

California passed a bill (2019 CA AB 651/Chapter 537) which requires a health insurance contract or policy to guarantee that an enrollee receiving covered services from a noncontracting air ambulance provider will not owe more than the expected cost sharing amount if the enrollee were receiving covered services from a contracting air ambulance provider. [NOTE: Advocates have claimed that this bill was able to pass only because it does not set a payment rate.]

Connecticut state law (CT Gen Stat § 19a-193b) prohibits ground ambulance services from trying to collect more than the coinsurance, copayment, or deductible from an enrolled patient. Ground ambulance services may try to collect payment from individual patients only after they confirm that the health insurance will not pay for the emergency transportation service.

Montana passed legislation (2017 MT SB 44) which requires a health insurance provider or plan, instead of the patient, to cover the additional cost of out-of-network air ambulance transportation. The air ambulance provider may not bill or collect from the enrolled patient beyond what the patient would pay in cost sharing if the air ambulance provider were in-network. Montana also passed a bill (2017 MT SB 292) prohibiting ground ambulance providers from harming a patient's credit report if that patient has not fully paid for the ambulance services because the patient's health insurer has paid for the ambulance service according to the patient's insurance plan. SB 292 similarly bans ground ambulance providers from harming a patient's credit report if the patient is uninsured, has paid part of the bill, and has filed a complaint that the bill is excessive.

North Dakota passed legislation (2017 ND SB 2231) which requires health care insurers to develop out-of-network air ambulance bill payment programs before a health benefit plan may be issued. Health care insurers can pay the out-of-network bill, request mediation, or reach a separate payment agreement with the out-of-network air ambulance provider.

Virginia passed a bill (2018 VA SB 663/Chapter 682) that empowers the Office of Emergency Medical Services to develop and implement a system for disclosing estimated costs for patients before they use air transportation. Virginia also passed legislation (2018 VA HB 778/Chapter 271) which requires hospitals to disclose to patients that they may be responsible for additional charges incurred by out-of-network transport providers. HB 778 also requires the hospital to notify patients that they can opt for ground or air transport.

DISPUTE RESOLUTION AND COMPLIANCE STANDARDS

Dispute resolution and compliance standards are necessary to enforce the protections and billing standards. As exemplified by Mississippi, health care insurers and providers are disinclined to follow bill standards that are neither enforced nor disseminated. Effective dispute resolution systems and compliance/enforcement standards include arbitration, mediation, independent dispute resolutions (IDRs), audits, investigations, fines, penalties, and formal complaint channels.

California passed a bill (2016 CA AB 72/Chapter 492) which establishes that, in the event of a disagreement over billing and payment, either the health care plan or the noncontracting provider may appeal a claim to the insurance department's independent dispute resolutions (IDR) office. The decision of the IDR organization is binding on both parties.

Delaware law (76 Del. Laws, c. 64, §1 and 80 Del. Laws, c. 339, § 2) empowers the insurance commissioner to create a panel of arbitrators tasked with arbitrating any dispute between a health care provider and insurance carrier regarding claim reimbursement, procedures, or services. Arbitration occurs if the health care provider requests it within 60 days of receiving the insurance carrier's decision, cannot settle informally with the insurance carrier, and/or balance bills a patient in violation of the out-of-network disclosure requirements of HB 439/Chapter 339.

Maryland's "Patient Bill of Rights" (2019 MD SB 301/Chapter 286) protects patients from retaliation for filing complaints and empowers the Office of Health Care Quality to review hospital compliance.

Montana passed legislation (2017 MT SB 44) which requires health insurers and air ambulance providers, in the event of disagreement, to enter into independent dispute resolution (IDR) to calculate the fair market price, which becomes the full payment necessary. The determination is not binding and the insurance commissioner selects an independent reviewer to recalculate the fair market price if disagreement persists.

Nevada passed a bill (2019 NV AB 469/ Chapter 62) which specifies the process of dispute resolution between an out-of-network provider and third-party insurer through counteroffers and binding arbitration.

New Hampshire passed a bill (2018 NH HB 1809/Chapter 356) which empowers the insurance commissioner to determine if a fee is commercially reasonable when the provider and insurance carrier cannot reach a settlement themselves.

New Jersey's "Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act" (2018 NJ AB 2039/Chapter 32) establishes binding arbitration for disputes and financial penalties for violations of the Act. Binding arbitration factors in whether the carrier's payments were conducted in good faith.

New Mexico's Surprise Billing Protection Act (2019 NM SB 337/Chapter 227) authorizes the superintendent of insurance to annually review the reimbursement rate for surprise bills at a stakeholder meeting and calculate compliance for prompt payment requirements. The legislation also empowers patients who are not fully refunded within 45 calendar days to file an appeal with the office of the superintendent of insurance to receive their refund and accrued interest. The law also empowers the superintendent of insurance to annually review the reimbursement rate for surprise bills at a stakeholder meeting and calculate compliance for prompt payment requirements.

New York passed a bill (2019 NY SB 6544A/Chapter 377) that allows non-participating providers to submit a dispute regarding payment for emergency services. If the provider and health care plan do not reach a settlement after 10 days of negotiations, SB 6544A empowers an independent dispute resolution (IDR) entity to determine a reasonable fee. The IDR entity's decision is binding.

Texas's enacted consumer protection bill (2019 TX SB 1264) requires mandatory mediation to resolve disputes between the health benefit plan issuer and the out-of-network facility, and requires mandatory binding arbitration to resolve disputes between the health benefit plan issuer and the out-of-network provider (that is not a facility). If mediation doesn't produce an agreement between the out-of-network facility and the health benefit plan issuer, then either party may file a civil action within 45 days of the mediator's report. This legislation empowers the attorney general to bring a civil action against a person or entity that repeatedly and intentionally bills an enrolled patient more than they should owe under their managed care plan. A relevant regulatory agency that licenses, certifies, or otherwise authorizes a health service provider or facility may take disciplinary action against a provider or facility that repeatedly and intentionally bills an enrolled patient more than they should owe under their managed care plan.

Washington's recent Balance Billing Protection Act (2019 WA HB 1065/Chapter 427) empowers the insurance commissioner to provide arbitrators in the event that a carrier and out-of-network provider cannot settle on an agreed fee after 30 days of good faith negotiating. The Act classifies a health carrier constantly filing for arbitration as an unfair or deceptive business practice. The insurance commissioner is required to annually report the dispute resolution information through both posting the results online and submitting the report to relevant legislative committees.

NETWORK ADEQUACY STANDARDS

Network adequacy standards ensure that health care insurance entities provide both participant networks and benefit plans that are large enough to reasonably cover the range of enrollees' medical needs. Though all states establish network adequacy standards, some states include more stringent regulations than others. Robust network adequacy standards can limit the "narrow network" health insurance systems that increase the frequency of out-of-network billing. The two state laws listed below include audit and mediation passages recommended in the guidelines of the National Association of Insurance Providers (NAIC) Network Adequacy Model.

New Hampshire passed a bill (2018 NH HB 1809/Chapter 356) that mandates standards for addressing in-network specialty providers and empowers the insurance commissioner to annually report network adequacy compliance findings to the relevant House and Senate committees.

New Jersey's "Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act" (2018 NJ AB 2039/Chapter 32) requires health insurance entities ("carriers") to annually audit their networks and empowers the commissioner of insurance to both publish results and penalize noncompliant carriers.

ACCESSIBLE NETWORK DIRECTORIES

While not sufficient on their own, laws that require health insurance entities to publish and regularly update their directories of contracting providers can help enrollees avoid potential out-of-network costs. The following are some examples of state laws that require health insurance providers to publish comprehensive directories of in-network providers. Techniques broadly fall under the categories of accessibility (online, options for patients with low proficiency in English, etc.), accountability (regular updates, audits, and reimbursement systems for misinformation), and specificity (provider specialties, new patient admissions, etc.).

California enacted legislation (2015 CA SB 137/Chapter 649) which requires health insurance entities that contract with providers to publish and regularly update directories of contracting providers both online and in print. SB 137 similarly requires health insurance entities to compensate enrollees for out-of-network services if the published directories misinformed enrollees about which providers were in-network at the time of services.

Connecticut enacted legislation (2016 CT SB 433/Act 205) which specifies that health carriers must publish their provider directories in plain writing both electronically and in print. SB 433 similarly requires that health carriers update their provider directories monthly and publish information regarding available assistance for individuals with limited English proficiency. In 2017, Connecticut amended its provider directories laws through the passage of a bill (2017 CT SB 546/Act 154) which requires directories to list whether participating providers are accepting new patients on an outpatient service basis.

Georgia passed a bill (2016 GA SB 302/Act 341) that directs health insurers to post online provider directories that are fully public and are updated at least every 30 days. This law also requires insurers to provide telephone and online methods for the public to report inaccurate information, which the insurer is required to investigate no later than 30 days after receiving this report. These reports of inaccuracies are also added to an audit by the state's commissioner of health, and the commissioner may require that any out-of-network charges based on an inaccurate provider directory be reimbursed to the consumer.

Louisiana enacted legislation (2018 LA HB 875/Act 290) which requires health insurance entities to make provider directories publicly accessible, electronically searchable, and updated within 10 days of notified contract changes. HB 875 similarly empowers the commissioner of insurance to fine health insurance entities a maximum of $500 per violation (not exceeding a total of $50,000) if enrollees file three or more complaints of a directory inaccuracy within a 30-day period.

Maine passed a bill (2017 ME LD 1557/Chapter 218) that requires carriers to publish provider directories that are electronically searchable, update the provider directories at least monthly, and periodically audit a reasonable sample size for accuracy.

Maryland enacted legislation (2016 MD HB 1318/Chapter 309) which requires that health insurance entities publish contractor directories which are publicly accessible online, annually updated, and corrected within 15 days of a filed complaint of inaccuracy. HB 1318 similarly requires health insurance entities to cover enrollees for any additional charges the enrollees may incur for out-of-network services if the published directories misinformed enrollees about the contract status of a provider at the time of services.

New Jersey's "Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act" (2018 NJ AB 2039/Chapter 32) requires health insurers ("carriers") to maintain, online and over the phone, not only an updated directory of in-network providers but also the health care plan's reimbursement methodology for out-of-network costs and examples of common out-of-network costs enrollees must pay themselves.

Texas passed a bill (2019 TX SB 1742) specifying that the directories of contracting providers published by health insurance entities must be easily accessible to the public and electronically searchable. SB 1742 similarly requires that, when a listed health care provider is a facility, the health insurance entity also records which specialists (radiologists, anesthesiologists, pathologists, emergency department physicians, neonatologists, assistant surgeons, etc.) are contracted in-network at the facility.

Virginia passed a bill (2019 VA HB 2538/Chapter 432) which partially puts the responsibility of provider directory disclosure on health care facilities. HB 2538 requires facilities to list all provider groups offering services at the facility along with the recommendation that the patient check their health care plan for which provider groups are in-network.

TRANSPARENCY AND COST DISCLOSURE LAWS

Because comprehensive lists of a hospital's products, procedures, and services, also known as chargemasters, published online are difficult for patients to comprehend, comprehensive cost disclosure laws become all the more important for combating surprise medical bills. State laws revolve around three broad categories, which form the three subcategories of this section: Automatic Disclosure, Disclosure of Common Health Care Procedure Costs, and Good Faith Estimates. While transparency can be a vital component, it should ideally be part of a broader reform package. Altarum's Health Care Value Hub summarized research finding that only 7% of national health care spending is both "shoppable and paid out-of-pocket" and health care consumers "may not believe that price is the most important factor in making healthcare decisions." And Georgetown's CHIR states that "[a]dditional transparency requirements, without additional patient protections, will not ensure use of network providers nor solve all surprise bills (such as emergency care, when the patient does not have the option to search for and select an in-network provider). However, policymakers can consider additional ways to improve access to accurate information for patients, insurers, and providers."

AUTOMATIC DISCLOSURES RELATED TO PATIENT COSTS

While no laws require automatic (i.e., without a request first) cost disclosures directly to patients, the following includes examples of state laws where a health care facility is required to automatically notify patients of their rights, including their rights to receive cost estimates or cost estimates shared with a patient's physician/health care provider.

Colorado enacted legislation (2003 CO SB 15/CO Statutes § 6-20-101) to require hospitals and other health care facilities to disclose to a patient their right to receive the "average facility charge" for a treatment prior to admission for that procedure (unless it is for emergency care).

Delaware enacted legislation (2016 DE HB 439/Chapter 339) that, in the case of non-emergency services offered by out-of-network providers, facility-based providers and out-of-network health providers must present patients with an out-of-network disclosure specifying whether the facility and facility-based providers are out-of-network for the patients' health insurance. The disclosure also specifies that patients may be responsible for out-of-network charges and that patients may request an estimate for the range of out-of-network charges they could be responsible for.

Maryland's recent Patient Bill of Rights (2019 MD SB 301/Chapter 286) recognizes patients' rights to receive an estimation of hospital charges before care is provided in a way that is accessible for a variety of patients. SB 301 requires hospitals to provide paper copies of the Patient Bill of Rights to patients as well as posting the Patient Bill of Rights online and in areas in plain view of both patients and visitors.

New Jersey passed a bill (2018 NJ AB 2039/Chapter 32) that requires a health care facility to inform a patient if the health care professional is out-of-network with respect to the covered person's health benefits plan and of the right to receive an estimate of the cost.

Tennessee law (TN Code § 56-7-120) prohibits health care providers from collecting out-of-network charges from an insured patient if the written notice required by this bill has not been provided and signed by the insured. This bill adds a similar prohibition to the provisions governing health care providers and facilities, specifying that they are prohibited from collecting out-of-network charges from an insured, or the insurer on behalf of the insured, unless they provide written notice, prior to treatment or service, regarding being out-of-network and the consequences of that on the insured, such as a statement that the insured agrees to receive service from the provider and an estimate of the amount to be charged.

Virginia passed a bill (2019 VA HB 2750/Chapter 670) to amend its procedure payment estimate law (VA Code § 32.1 – 137.05) such that hospitals must notify patients of their right to request an estimate of payment. HB 2750 similarly requires hospitals to post the written notifications in public areas and online.

Washington law (WA Code § 70.41.250) provides that a hospital shall disclose to physicians and other health care providers all health care service charges ordered for their patients for review. The law allows these health care providers to discuss these charges with the patient. The law also directs hospitals to study methods for making daily charges available electronically to prescribing physicians for them to consider the cost of past services and the future cost of additional diagnostic studies and therapeutic medications.

DISCLOSURES OF COMMON HEALTH CARE PROCEDURE COSTS

The following are examples of state laws that require disclosure of the average costs of common procedures. These can be thought of as disclosures before a patient undergoes a non-emergency procedure, but they are not specific to the patient's course of care.

Alaska passed a bill (2017 AK SB 105/Chapter 75) that requires health care facilities to publicly disclose the undiscounted price for a range of commonly performed procedures.

Arizona law (AZ Statutes § 36-437) directs health care facilities to make the direct pay price (the entire price for health care services if paid in full directly to the health care facility by the person receiving the service) for the most used diagnosis-related group codes (DRGs) available on request or online. The service prices must be updated at least annually. The direct pay price may include the cost of treatment for complications or exceptional treatment. A facility must give the required notice and disclaimer to an insured in-network patient attempting to pay directly that, among other things, the patient may not be required to pay the facility directly for the services covered by their plan over and above the cost-sharing amount.

California passed a law (CA Health & Safety Code §§ 1339.50-59), also known as the "Payers' Bill of Rights," that seeks to prevent hospitals from "gouging patients" and to help inform patients of the cost of health care procedures. It requires each hospital to make available to the public its average billed charges for the 25 most common inpatient and outpatient procedures, and also to disclose the charges to the Office of Statewide Health Planning and Development (OSHPD) for publication on a website. The Payers' Bill of Rights

also requires every hospital to make its chargemaster, a list of the hospital's gross billed charges for specific services or items (which may vary significantly from contracted rates), publicly available.

Colorado law (CO Statutes Title 25 Article 49; 2017 CO SB 65) requires health care providers to post on their website and in patient waiting areas the health care prices of at least the 15 most common health care services provided.

Illinois law (IL Statutes § 2215/4-4) requires that hospitals make price information on the normal charge incurred for any procedure available to a prospective patient. Further, the Department of Public Health shall require by regulation that hospitals post the established charges for specified services (including room charges and certain common procedures).

Minnesota enacted legislation (2018 MN SF 3480/Chapter 168) that requires each health care provider to "maintain a list of the services over $25 that correspond with the provider's 25 most frequently billed current" procedures and "disclose the provider's charge, the average reimbursement rate received for the service from the provider's health plan payers in the commercial insurance market, and, if applicable, the Medicare allowable payment rate and the medical assistance fee-for-service payment rate."

Nevada law (NV Statutes § 439B.400) requires that hospitals maintain a uniform list of billed charges for goods and services provided to all inpatients. Generally, a hospital may not use a billed charge for an inpatient that is different than the billed charge used for another inpatient for the same good or service; however, a hospital or other person may negotiate a discounted rate from the billed charges.

North Carolina enacted a law (NC Statutes §§ 131E-214.11 – 214.14), the "Health Care Cost Reduction and Transparency Act of 2013," that aims to improve transparency in health care costs by mandating that the Department of Health and Human Services publish on the internet the most current price information it receives from facilities on the cost of the most common surgical and imaging procedures.

Utah law (Utah Code § 26-21-27) requires that a licensed health care facility must provide to a consumer upon request a list of prices charged by the facility, to include the following: inpatient procedures; outpatient procedures; the 50 most commonly prescribed drugs in the facility; imaging services; implants; and information on discounts the facility provides for charges not covered by insurance or for prompt payment of billed charges.

Wisconsin law (WI Statutes § 146.903) requires disclosures respecting cost and quality of a health care provider. Upon the request of a consumer, a health care provider must disclose at no cost to the consumer the median billed charge for a health care service, diagnostic test, or procedure. Additionally, a provider that submits data to a health care information organization must also make comparative quality information available to the consumer concurrently with the median billed charge information. Providers must post a notice that consumers have the right to request charge information at no cost. Providers must also maintain a document that lists charge information for the 25 most common presenting conditions identified for the health care provider's provider type.

Similarly, a hospital must maintain a single document that lists charge information for each of the 75 diagnosis-related groups for inpatient care and outpatient surgical care identified in the code, including the median billed charge, the average allowable payment under Medicare, and the average allowable payment from private third-party payers. Consumers shall be provided a copy of the document at no charge upon request.

GOOD FAITH ESTIMATES OF PATIENT COSTS UPON REQUEST

The following are examples of state laws that include additional provisions worth considering, such as civil penalties for noncompliance, a "bill of rights" from a health care facility, good faith estimates from health insurance companies, specific procedure codes, a maximum amount of time to provide the estimate, etc.

Alaska enacted a law (2017 AK SB 105) that requires health care facilities to provide patients with a detailed good faith estimate of the cost of a non-emergency procedure (if requested by the patient). This good faith

estimate must be provided within 10 business days of the request and include a plain language description of the services, products, and procedures; a notice regarding network status for the patient's health insurance plan; procedure codes; facility fees; and information on the health care professionals who may charge the patient for related health care services. Different from many of the other related bills is that this new law includes a civil penalty of no more than $10,000 for each violation or $100 per day of noncompliance.

Florida has a law (FL Statutes § 381.026; 2012 FL HB 7007), the "Florida Patient's Bill of Rights and Responsibilities," which provides that a patient has the right to request a reasonable estimate of charges for care before the treatment; that he/she receive an itemized bill which is clear and understandable, and should be explained upon request; and that the patient is responsible for ensuring that his/her financial obligations to the provider are fulfilled as promptly as possible, among other things. A patient may request the Bill of Rights and Responsibilities from a facility.

Minnesota law (MN Statutes § 62J.81) provides that upon request, a health care provider must give a consumer a good faith estimate of the allowable payment the provider has agreed to accept from the consumer's health plan company for the service specified by the consumer. If the consumer does not have health insurance, the provider must give a good faith estimate of the average allowable reimbursement the provider accepts as payment from private third-party payers for the service specified and the estimated amount the non-covered consumer will be expected to pay. Furthermore, a health insurance company must provide an enrollee with a good faith estimate of total out-of-pocket costs for a specified health care service.

Minnesota's "Hospital Pricing Transparency Act" (MN Statutes § 62J.823) obligates hospitals to provide to a patient (upon request), free of charge, a written estimate of the cost of a specific service or stay, including the method used to calculate the estimate, the specific diagnostic-related group or procedure code, and a statement indicating that the estimate may not reflect the actual billed charges.

An enacted bill in **Minnesota** (2018 MN SF 3480/Chapter 168) requires a health care provider to provide consumers with "information regarding other types of fees or charges that the consumer may be required to pay … including but not limited to any applicable facility fees." This new law also requires health plan companies to provide, within 10 business days, "patient and service information the health plan company requires to provide a good faith estimate."

Nebraska law (NE Statutes § 71-2075) requires that hospitals provide a written estimate of the average charges for health services relating to a particular condition or medical procedure upon the written request of a prospective patient or his/her attending physician. The prospective patient or his/her agent may provide the hospital with additional medical history in order that the hospital provide a more accurate estimate of the charges, which in any case must be provided within seven working days from the date of the original submission. Hospitals and ambulatory surgical centers must give notice to the public of their ability to seek an estimate of charges.

New Jersey passed a bill (2018 NJ AB 2039/Chapter 32) that requires a health care facility, upon request, to provide an estimate of the cost.

Ohio law (OH Statutes § 5162.80; 2015 OH HB 52 (p. 54)) requires a health care provider to provide a good-faith estimate of the amount the provider will charge, the amount the health plan issuer intends to pay, and the difference that the consumer would be responsible to pay.

Rhode Island law (RI Statutes § 23-17-61) requires that a hospital provide a prospective patient the requested cost estimate of their requested anticipated hospital services within five business days of request and the cost of any facility fee.

Texas law (TX Insurance Code § 1456.007) allows consumers to request a health care cost estimate from their health insurance company before receiving care.

ANNOTATED LEGISLATION

The following section takes a closer look at how states have addressed surprise medical billing. Besides the providers or medical service included, there are a number of other policy options baked into these legislative reforms, including what insurance plan protections apply (e.g., PPOs, HMOs, all plans); what triggers protection (e.g., in all cases, only upon failure to notify the patient, if a bill exceeds some dollar threshold); and how to resolve reimbursements from insurers to out-of-network providers (e.g., payment standards, dispute resolutions, or a blended approach).

NEW MEXICO EXAMPLE

The following selection from New Mexico's Surprise Billing Protection Act (2019 NM SB 337/Chapter 227) provides an example of how surprise medical bill reform components have been translated into statutory language. Please note that this is not an endorsement of this specific legislative language, and is included here for informational purposes only.

Section 2. A new section of the New Mexico Insurance Code is enacted to read: "DEFINITIONS.--As used in the Surprise Billing Protection Act:

O. "health insurance carrier" means an entity subject to state insurance laws, including a health insurance company, a health maintenance organization, a hospital and health service corporation, a provider service network, a nonprofit health care plan or any other entity that contracts or offers to contract, or enters into agreements to provide, deliver, arrange for, pay for or reimburse any costs of health care services or that provides, offers or administers a health benefit policy or managed health care plan in the state;

Insurance Plans: law applies to all health insurance carriers in the state.

[...]

Y. "surprise bill":

(1) means a bill that a nonparticipating provider issues to a covered person for health care services rendered in the following circumstances, in an amount that exceeds the covered person's cost-sharing obligation that would apply for the same health care services if these services had been provided by a participating provider:

Triggers: when a bill from an out-of-network provider is greater than what would have been charged by an in-network provider.

(a) emergency care provided by the nonparticipating provider; or

(b) health care services, that are not emergency care, rendered by a nonparticipating provider at a participating facility where 1): participating provider is unavailable; 2) nonparticipating provider renders unforeseen services; or 3) a nonparticipating provider renders services for which the covered person has not given specific consent for that nonparticipating provider to render the particular services rendered; and

Providers: emergency and non-emergency care providers.

(2) does not mean a bill:

(a) for health care services received by a covered person when a participating provider was available to render the health care services and the covered person knowingly elected to obtain the services from a nonparticipating provider without prior authorization; or

(b) received for health care services rendered by a nonparticipating provider to a covered person whose coverage is provided pursuant to a preferred provider plan; provided that the health care services are not provided as emergency care or for services

Triggers: exemption from protection when patient authorization is obtained for out-of-network care when an in-network provider was an available option.

rendered pursuant to Subparagraph (b) of Paragraph (1) of this subsection.

[...]

SECTION 8. A new section of the New Mexico Insurance Code is enacted to read: "HEALTH CARE PROVIDER REIMBURSEMENT RATES--SURPRISE BILLING.-- A. The superintendent shall convene appropriate stakeholders, including rural providers, insurers and consumer advocates, and review the reimbursement rate for surprise bills annually to ensure fairness to providers and to evaluate the impact on health insurance premiums and health benefits plan networks.

B. Calculation of the date of health insurance carrier receipt of a claim shall align with requirements for prompt payment established pursuant to Section 59A-16-21.1 NMSA 1978.

C. A health insurance carrier shall make available to providers access to claims status information."

Reimbursements: benchmark rates for payments to out-of-network providers are to be reviewed annually by a stakeholder panel made up of at least rural providers, insurers, and consumer advocates.

[...]

SECTION 13. A new section of the New Mexico Insurance Code is enacted to read: "PROVIDERS--REIMBURSEMENT FOR A SURPRISE BILL.-- A. For services provided pursuant to Section 3 or 4 of the Surprise Billing Protection Act, a health insurance carrier shall directly reimburse a nonparticipating provider for care rendered the surprise bill reimbursement rate for services.

B. The surprise bill reimbursement rate shall be calculated using claims data reflecting the allowed amounts paid for claims paid in the 2017 plan year.

C. As used in this section, "surprise bill reimbursement rate" means the 60th percentile of the allowed commercial reimbursement rate for the particular health care service performed by a provider in the same or similar specialty in the same geographic area, as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent after consultation with health care sector stakeholders; provided that no surprise bill reimbursement rate shall be paid at less than 150% of the 2017 Medicare reimbursement rate for the applicable health care service provided.

D. The nonprofit organization shall be conflict-free and unaffiliated with any stakeholder in the health care sector.

Reimbursements: the New Mexico law established a benchmark rate at the 60th percentile of allowed rates for the same medical service in a similar geographic area, but at least 150% of the Medicare reimbursement rate.

When Is Choice Not a Choice?

The Texas legislation highlighted in this section (2019 TX SB 1264) provides an exemption for those who elect to receive services from an out-of-network provider:

TX Insurance Code § 1271.157

(d) This section does not apply to a nonemergency health care or medical service:

(1) that an enrollee elects to receive in writing in advance of the service with respect to each non-network physician or provider providing the service; …

While this appears to be a standard exemption, the vagueness of this language provided an implementation loophole that could have led to patients signing waivers even if there were no alternative in-network providers available. Advocates pushed back and the Texas Medical Board changed their rules to provide that a patient must have a "meaningful choice" in order to opt out:

TX Dept. of Insurance Rule § 21.4903

(b) An out-of-network provider may not balance bill an enrollee receiving a nonemergency health care or medical service or supply, and the enrollee does not have financial responsibility for a balance bill, unless the enrollee elects to obtain the service or supply from the out-of-network provider knowing that the provider is out-of-network and the enrollee may be financially responsible for a balance bill. For purposes of this subsection, an enrollee elects to obtain a service or supply only if:

(1) the enrollee has a meaningful choice between a participating provider for a health benefit plan issuer or administrator and an out-of-network provider. No meaningful choice exists if an out-of-network provider was selected for or assigned to an enrollee by another provider or health benefit plan issuer or administrator;

(2) the enrollee is not coerced by a provider or health benefit plan issuer or administrator when making the election. A provider engages in coercion if the provider charges or attempts to charge a nonrefundable fee, deposit, or cancellation fee for the service or supply prior to the enrollee's election; ….

LESSONS LEARNED

A Community Catalyst report includes important tips for understanding 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% of the Medicare rate. 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's first legislative attempt to prohibit balance billing stalled because of powerful lobbying from provider groups who were unhappy with the bill's cap for an out-of-network payment rate, which was set at 100% of the Medicare rate. After months of negotiations among stakeholders, **California was able to pass revised legislation (AB 72) that sets the minimum out-of-network payment at 125% of Medicare or the average contracted rate**. This provides a guarantee of a minimum payment floor for providers. Providers can seek higher rates for their out-of-network services, but they need to make their case through an independent dispute resolution process. **Despite the lack of a hard rate cap, the independent dispute resolution mechanism is intended to limit excessive or unjustified payments.**

The following are selected recommendations for advocates from Community Catalyst that may also be helpful for state policymakers:

If a federal standard is created, states that have already enacted balance billing protections will need to understand how federal proposals will interact with state laws.

- If state protections are in place, will consumers have different protections depending on whether they have coverage under a state regulated plan or an ERISA-governed plan?
- Will federal protections allow for states to enact more consumer protective laws?

States may also want to consider where any federal law leaves consumers without protections. For example, no federal bill currently under consideration addresses balance billing by ground ambulance service providers, which have been a major source of out-of-network bills for consumers.

[...]

Too often, cost containment comes in a form that is harmful to consumers, such as benefit cuts, increased cost sharing, or network restrictions. Providers who oppose any benchmark rate, regardless of where it is set, may use misleading information or unfounded claims to push back against that approach. It may be difficult to know how any given approach or benchmark will affect cost and network incentives, so at a minimum advocates should ask for a study of the effects of the adopted approach on networks, provider charges, and premiums. **Beyond their advocacy on the best way to address payment disputes, advocates must work to ensure that key consumer protections are defined as broadly as possible—defining the providers and facilities to which protections apply and ensuring that protections apply regardless of whether notice of out-of-network costs was provided to a patient in advance of their care.**

ADDITIONAL RESOURCES

- Protecting Patients from Surprise Medical Bills (Center on Health Insurance Reforms) https://surprisemedicalbills.chir.georgetown.edu/
- Addressing Payment in Balance Billing Legislation (September 2019), Community Catalyst https://www.communitycatalyst.org/resources/tools/resources/Advocates-Guide-to-Balance-Billing.pdf
- Ending Surprise Balance Billing: Steps to Protect Patients and Reduce Excessive Health Care Costs (February 2019), Community Catalyst https://www.communitycatalyst.org/resources/publications/document/2019/balance-billing/CC-BalancedBilling-Report-FINAL.pdf
- State Action Counteracting Surprise Medical Bills: National Conference of State Legislators publication http://www.ncsl.org/research/health/counteracting-surprise-medical-billing.aspx
- Protecting Consumers from Surprise Medical Bills: Considerations for Governors by the National Governors Association (NGA) https://www.nga.org/wp-content/uploads/2019/05/NGA-Surprise-Medical-Bills-Brief-July-2019.pdf
- State Approaches to Mitigating Surprise Network Billing (USC-Brookings Schaeffer White Paper) https://www.brookings.edu/wp-content/uploads/2019/02/State-Approaches-to-Mitigate-Surprise-Billing-February-2019.pdf
- Teasing Apart the Threads to the Surprise Billing Debate: Understanding Policy Choices through the Lens of Independent Data (FAIR Health Brief): https://www.fairhealth.org/article/fair-health-serves-as-a-resource-on-surprise-billing
- State and Federal Resources to Address Surprise Medical Balance Billing (National Academy for State Health Policy (NASHP)): https://nashp.org/state-and-federal-resources-to-address-surprise-medical-balance-billing/

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