State Approaches to Protecting Consumers from Surprise Medical Bills

Statement of
Jack Hoadley, Ph.D.

Research Professor Emeritus
Health Policy Institute, McCourt School of Public Policy
Georgetown University

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Subcommittee on Health, Education, Labor, and Pensions
Examining Surprise Billing: Protecting Patients from Financial Pain

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Good morning, Madam Chairwoman, Ranking Member, and Members of the Subcommittee. My name is Jack Hoadley, and I am a Research Professor Emeritus at Georgetown University's McCourt School of Public Policy. Together with Kevin Lucia and other Georgetown colleagues, I have been studying for ten years the ways states address surprise medical bills. Our most recent analysis of state legislation was conducted with the support of the Commonwealth Fund, resulting in a June 2017 report[1] and an update published in the "To the Point" blog in January of this year.[2] I am pleased to have the opportunity to share the findings of this research and my perspectives on this policy issue with the Subcommittee.

What Are Surprise Medical Bills?

A surprise medical bill is any bill sent by a medical provider to a patient for an amount larger than expected. A surprise bill can happen when you did not expect that a medical procedure would be so expensive or when you did not understand the consequences of a cost-sharing requirement, such as a deductible, included in your insurance policy. These are unfortunate circumstances, but they are not the type of surprise billing that are the current focus for your Committee. Our concern today is about those surprise medical bills that result from interactions with the medical system in situations where patients reasonably assumed that they were being treated by providers in their health plan's insurance network or where patients had no real ability to select their medical provider.

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[1] K. Lucia, J. Hoadley, and A. Williams, Balance Billing by Health Care Providers: Assessing Consumer Protections Across States, Issue Brief, The Commonwealth Fund, June 2017. https://www.commonwealthfund.org/publications/issue-briefs/2017/jun/balance-billing-health-care-providers-assessing-consumer.

[2] J. Hoadley, K. Lucia, and M. Kona, State Efforts to Protect Consumers from Balance Billing, To the Point, The Commonwealth Fund, January 18, 2019. https://www.commonwealthfund.org/blog/2019/state-efforts-protect-consumers-balance-billing.

In these situations, surprise bills arise when insurance makes a payment for out-of-network care based on in-network rates, but the provider bills the consumer for the balance of their charges beyond what the insurer pays and beyond the consumer's cost sharing.

These surprise bills, sometimes referred to as balance bills, may occur in emergency situations where a consumer has no effective way to choose their provider. The bill may come from an air or ground ambulance service, from an emergency department physician, or from any physician or other clinician who provides treatment in the case of this emergency. It may also be a bill from the facility in cases where the closest emergency facility is out of network.

Surprise bills also occur for consumers who do their due diligence by selecting an in-network facility and an in-network surgeon for an elective procedure such as a joint replacement. But on the day of surgery, the anesthesiologist assigned by the hospital to provide care or the radiologist who reads an MRI or CT scan is out of network. This is another situation where consumers typically assume these health care professionals are in network or have no forewarning that an out-of-network clinician will be providing care. The balance bill is therefore unexpected. Unexpected bills may also occur when a consumer relies in good faith on an inaccurate provider directory or misinformation from a doctor's office.

All these situations are different from those where consumers make an informed and voluntary choice to receive services from an out-of-network obstetrician or oncologist and understands and accepts that their costs will be greater than if they chose an in-network physician.

We lack good data on how often unanticipated surprise medical bills from out-of-network providers occur, but insurance claims data suggest that about 20 percent of inpatient emergency department encounters have the potential for a surprise out-of-network bill. This is twice the rate of out-of-network encounters for elective inpatient care.[3]

These unexpected medical bills are a major concern for Americans, with two-thirds saying they are "very worried" or "somewhat worried" that they or a family member will receive a surprise bill. In fact, these bills are the most-cited concern related to health care costs and other household expenses.[4]

Most public-sector insurance programs—including Medicare, Medicaid, Tricare, and VA care—protect their beneficiaries fully or in large part from balance bills. But the same protections do not exist for most private insurance. The Affordable Care Act requires that insurers under its jurisdiction make payments for emergency services that are out of network comparable to what they would pay for those services when they are in network. But the ACA does not restrict health care providers from asking patients to pay the balance of the bill.[5]

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[3] C. Garman and B. Chartock, One in Five Inpatient Emergency Department Cases May Lead to Surprise Billing, Health Affairs 36(1); 177-181, January 2017

[4] A. Kirzinger, B. Wu, C. Muñana, and M. Brodie, Kaiser Health Tracking Poll – Late Summer 2018: The Election, Pre-Existing Conditions, and Surprises on Medical Bills, Kaiser Family Foundation, September 5, 2018. https://www.kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-late-summer-2018-the-election-pre-existing-conditions-and-surprises-on-medical-bills/

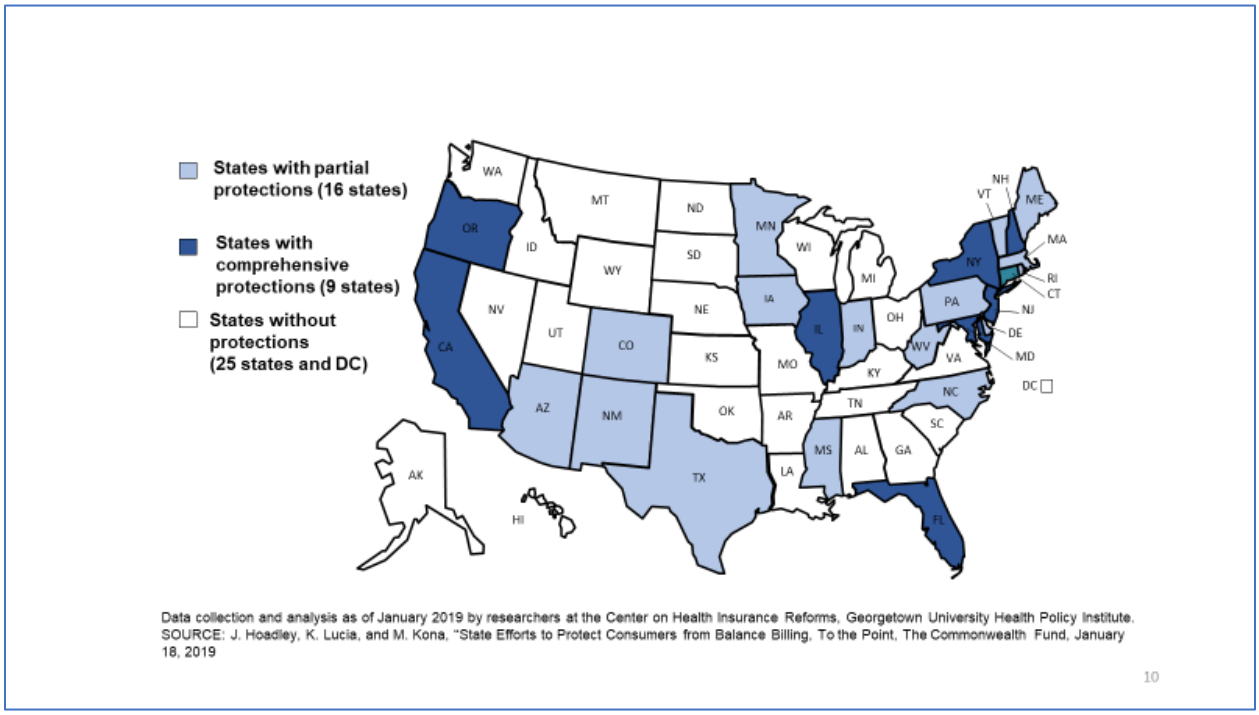
[5] K. Keith, New Regulation Justifies Previous Position On Emergency Room Balance Billing, Health Affairs Blog, May 9, 2018. https://www.healthaffairs.org/do/10.1377/hblog20180509.247998/full/.

Employers and insurers may voluntarily protect their employees or enrollees from these balance bills in some situations. And as I will describe here, some states have acted to protect consumers from surprise bills in some circumstances. However, state protections are limited by federal law (ERISA), which exempts self-insured employer-sponsored plans, covering 61 percent of privately insured employees, from state regulation.[6] As a result, state laws do not apply to the majority of Americans covered under employer-sponsored health plans.

The Scope of State Protections

At Georgetown, we conducted a study, most recently updated in January 2019, that found that 25 states today have laws offering consumers at least some protections in a balance billing situation (Figure).[7] The key element in all these state laws is that they take the consumer out of the equation and make sure that they are only obligated to pay normal cost sharing.

Figure. State Laws Protecting Consumers Against Balance Billing



Although 25 states have created some protections, only nine—California, Connecticut, Florida, Illinois, Maryland, and New Hampshire, New Jersey, New York, and Oregon—have laws meeting our standard for "comprehensive" protections.

To qualify as offering comprehensive protection for consumers, we look for a state to meet four conditions:

- Extend protections to both emergency department and in-network hospital settings;

[6] 2018 Employer Health Benefits Survey (Section 10), Kaiser Family Foundation, October 3, 2018. https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-10-plan-funding/.
[7] J. Hoadley, K. Lucia, and M. Kona, State Efforts to Protect Consumers from Balance Billing.

- Apply balance billing laws to all types of insurance that are subject to state regulation, including both HMOs and PPOs;
- Protect consumers both by requiring that insurers hold them harmless from extra provider charges—meaning they are not responsible for the charges—and by prohibiting providers from balance billing; and
- Adopt an adequate payment standard—a rule to determine how much the insurer pays the provider—or an arbitration process to resolve payment disputes between providers and insurers.

Collectively, these conditions do not necessarily constitute total protection for consumers with no gaps. But they combine to protect consumers in most emergency room and network hospital settings.

We have seen considerable state activity in recent years. In 2017 and 2018, four states—Arizona, Maine, Minnesota, and Oregon—created balance-billing consumer protections for the first time, and two—New Hampshire and New Jersey—substantially expanded existing protections. Many states in their current legislative sessions are considering new bills. Several states—Colorado, Georgia, New Mexico, Oklahoma and Washington—have seen action in at least one chamber of their legislatures. It remains to be seen what new laws will be enacted or which ones will meet our standard for comprehensive protections.

The approaches taken by states in recent years has varied. For example, New Jersey has met our criteria for comprehensive protection by creating a dispute-resolution process to establish a payment amount for the out-of-network service. Other states have recently acted to protect consumers from balance billing in a more limited way. For example, Missouri's new protections apply only if the provider and insurer voluntarily agree to participate in the process. Such laws mark a starting point; many states have built up their protections over several years.

Lessons from the States

In many cases, state laws have been in effect only a short time so it is premature to understand fully how effective they may be. But we can still take away some key lessons from the state experiences.

Scope of State Protections

One issue has been the scope of laws passed in different states. Some states apply protections only to bills coming from certain types of providers. For example, a state may otherwise have a comprehensive approach to balance billing, but only applies the protection to certain hospital-based physicians—radiologists, anesthesiologists, pathologists, neonatologists, or emergency department physicians when those services are provided in a network hospital or ambulatory surgical treatment center. Thus, the law would not apply to surprise bills for services by a consulting cardiologist or orthopedist called in to treat the patient. This law also fails to protect patients who are taken in an emergency to a non-network hospital.

In addition, most state laws do not apply to ground ambulance services. Furthermore, states are prohibited by federal law from addressing bills arising from air ambulance services.[8]

Types of Insurance to Which Laws Apply

A second issue is the range of insurance products to which state laws apply. Laws in several states apply balance billing protections only apply to HMO enrollees and not to PPO enrollees.

Furthermore, as I pointed out earlier, states are prohibited by ERISA from applying protections to self-funded arrangements. New Jersey has included in its law a provision allowing self-funded plans to participate in the state protections on a voluntary basis. Because this law was just enacted in 2018, it is too early to know whether any ERISA plans will opt to participate.

Gaps in State Protections

A third issue is whether there are gaps in how well consumers are protected. Some states have made protections contingent on disclosure to the consumer that they may be subject to balance bills if they are treated by out-of-network providers. Protections, at least in nonemergency situations, only apply if the required disclosure does not occur. Disclosure can be helpful to consumers but making protection contingent on this disclosure seems inadequate given the challenges that consumers face in understanding the many disclosures handed to them when receiving medical services.

California's law goes a step beyond most other states in one regard. It explicitly forbids providers from sending their patients balance bills. It further requires providers to refund any amounts consumers pay that should not have been paid.

Determining a Payment Amount for Non-Network Services

A fourth issue is how to set a payment amount for the services delivered by a non-network provider. For in-network services, insurers pay based on the contracts established for network participation. In the absence of a contract, it is important to have a mechanism to establish a payment amount. Without any such mechanism, insurers and providers may be at odds over the payment, and payment disputes can leave the patient at risk.

Some states—for example, California, Maryland, and Oregon—have opted to set a payment standard in law to determine what the insurer must pay, while also requiring that the provider accept this amount as payment in full. Payments vary in how they are structured and in the level of payment. Standards can be structured as a percentage of Medicare rates, or they can be based on a percentage of average network payments or based on a percentage of provider charges. The different approaches matter; for example, a charge-based standard is more likely to be inflationary. Political and market considerations in a state have led to setting standards in different ways and at different levels.

Other states—for example, Florida, New Jersey, and New York—have opted instead for an arbitration process to determine a reasonable reimbursement rate for a particular case. The expectation is that in most cases, providers and insurers will agree on an appropriate amount

[8] S. Corlette and M. Kona, Lawmakers had a Chance to Provide Relief from Surprise Medical Bills – and Whiffed It, CHIRBlog, September 27, 2018. http://chirblog.org/lawmakers-blow-chance-to-curb-surprise-medical-billing/.

voluntarily. But where no agreement can be reached within a reasonable time, the parties go to binding arbitration. New Jersey and New York use "final offer" or "baseball-style" arbitration, where each party elects a payment amount. The arbitrator then selects one amount or the other but cannot select any other amount. This system is designed to create an incentive for the sides to submit reasonable amounts, thus making it easier to reach a voluntary settlement. One consideration is whether to provide the arbitrator any sort of guidance; if this is done, it raises similar considerations to those in setting a payment standard.

States have typically found designing a payment standard or arbitration process to be the most challenging issue in gaining consensus among all stakeholders. When all stakeholders come to the table, it often proves possible to reach agreement on a solution that fits the particular needs and market conditions of that state.

Enforcement

A final consideration raised by the states that have acted on balance billing is how to enforce the protections they write into their laws. State insurance departments have jurisdiction over insurers, so enforcing rules on their insurers is a normal part of doing business. But they generally have no jurisdiction over providers. Prohibitions against balance billing by providers are sometimes defined as an unfair business practice, an established area for state regulation. But enforcement remains a challenge. A critical consideration is to avoid placing the onus on the consumer to protest a surprise bill.

The Role for Federal Legislation

Although states continue to make considerable progress in protecting consumers from surprise medical bills, they are looking to the federal government to address the self-insured ERISA arrangements they have no jurisdiction to regulate. In addition, protections are still lacking in half the states, meaning that federal legislation could make these consumer protections universal.

Federal policymakers also face decisions on the degree to which they allow a continuing state role in these protections. Federal policy could defer to state laws that meet a standard for adequate consumer protection. Federal policy could also leave a role for states in adapting payment standards or arbitration processes to their market environments.

Throughout the state actions to date, the unifying principle has been that consumers should not be liable for surprise medical bills in circumstances where they have little or no control over whether their medical providers are in network. Protecting consumers in these situations will offer some relief from worry about their health costs.