



GETTING STARTED ON SURPRISE MEDICAL BILLS:

AN ADVOCATE'S GUIDE



ConsumersUnion®

POLICY & ACTION FROM CONSUMER REPORTS

A photograph of an operating room with two large surgical lights hanging from the ceiling. In the foreground, there is a piece of medical equipment, possibly a ventilator or anesthesia machine, with various tubes and a blue and white unit. The room has white walls and a tiled floor.

ABOUT THIS GUIDE

The authors of this guide surveyed the literature on surprise medical bills and spoke to a variety of expert stakeholders in eight states to understand the problem and, more importantly, to assess potential solutions. The guide also relies heavily on Consumer Reports National Research Center's ground-breaking 2015 nationally representative survey of adults enrolled in private health coverage to describe the dimensions of the problem. Consultants Nancy Metcalf and Ronni Sandroff conducted the interviews, did the analysis, and drafted the report. Consumers Union staff provided review and input into the final report. We wish to thank the advocates, policymakers, and other stakeholders who gave us their time and insight to share information about the work going on in their states. Consumers Union takes responsibility for any errors. You can find out more about our surprise medical bill work at <http://consumersunion.org/surprise-medical-bills/surprise-medical-bills-resources/>, join our campaign EndSurpriseMedicalBills.org and/or contact us at healthcare@consumersunion.org.

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Executive Summary

Surprise doctor bills, sometimes exorbitant ones, are blindsiding many consumers. In one frequent scenario, patients are treated without their knowledge or consent by practitioners who do not participate in their health plan, even though they have sought care at an emergency room or hospital that is in their insurance network. Another cause of surprise bills: patients pay cost-sharing for a procedure and then discover later that they owe the whole bill because they haven't met their deductible.

These surprise bills are quite common, as a 2015 nationally representative Consumer Reports survey revealed for the first time. In the online survey of 2,200 adult U.S. residents with private health insurance, one-third of respondents reported receiving a surprise bill where their health insurance paid less than they expected or not at all.¹

For consumers, resolving surprise medical bill disputes is not easy. Only 28 percent of survey respondents with billing issues were satisfied with how the issue was resolved. More than half (53 percent) reported that their surprise bill issue was either not resolved as they liked or not resolved at all.

While patients can be surprised by bills from both in-network and out-of-network providers, surprise bills from out-of-network providers can be particularly large. One in four people surveyed had received a surprise bill from an out-of-network provider. More than 60 percent of survey respondents mistakenly assumed that if they went to an in-network hospital, all the doctors at the hospital would also be in-network. Of the one third of survey respondents who had received a surprise medical bill, 14 percent said they were charged at the out-of-network rate for a provider they thought was in network, and



another 23 percent got a bill from a doctor they did not expect to get a bill from.

This report focuses on surprise bills from out-of-network providers and is intended as a guide for advocates and legislators interested in practical steps to address this problem. It discusses the reasons for surprise out-of-network bills and the existing and proposed state laws and federal approaches that have attempted to mitigate this problem. Drawing on interviews with advocates, regulators, and stakeholders, the guide identifies five essential consumer protections:

1. An obligation for insurers to maintain accurate and up-to-date provider directories, with auditing and consequences for non-compliance;
2. A requirement that providers inform consumers whether they are in-network or out-of-network in a way that preserves meaningful consumer choice;
3. A ban on “balance billing” that explicitly protects the consumer from receiving or having to pay unavoidable or inadvertent out-of-network charges, known as balance bills;
4. A well-defined process for determining payment of surprise bills, including some type of independent dispute resolution process; and
5. An effective way of informing consumers of their surprise bill rights.

¹ Consumer Reports National Research Center, Surprise Medical Bills Survey, May 5, 2015. Available at <http://consumersunion.org/research/surprise-bills-survey/>

Introduction

For most Americans, health insurance consists of some type of managed care plan that requires them to obtain their care from doctors, hospitals, labs and other providers in the plan’s provider network who have contracted to accept the plan’s reimbursement as payment in full. Network providers may not bill patients for more than their specified level of cost-sharing (deductibles, copays, and coinsurance).

But if patients seek care out of network, these protections do not apply. Health Maintenance Organizations (HMOs) and Exclusive Provider Organizations (EPOs) typically do not cover out-of-network care at all. Patients must pay the entire bill except for some emergency coverage. Preferred Provider Organizations (PPOs) and Point of Service (POS) plans usually do cover out-of-network care, but require more patient cost-sharing than for in-network services and, beyond that, out-of-network providers are

permitted to send patients the balance of bills over and above what the insurance company decides to pay them.

Patients thus have a strong financial incentive to get their health care from network providers. But even if they conscientiously try to do so, patients can find themselves hit with unexpected bills for out-of-network care.

Even when patients seek emergency or elective care at an in-network hospital, they may end up with surprise out-of-network bills from physicians and other providers who work within the hospital but have not contracted with their insurance plan. This can happen without the patient’s consent or even awareness—for example, when an out-of-network doctor assists during surgery, or when the doctor on duty in the emergency room turns out not to work for the hospital, but rather as a consultant or for an independent medical group that contracts to provide emergency room staffing.

WHAT IS A BALANCE BILL?

In-network providers have signed contracts with insurance companies that prohibit them from collecting anything from the patient beyond what s/he owes based on the plan’s deductibles, coinsurance, or copays. But out-of-network doctors can bill as much as they want. Even if the health plan pays a portion of the bill, the patient may be stuck paying the out-of-network cost-sharing obligation AND any amount that is over and above the plan’s “allowed amount”—see the example below.

	OUT-OF-NETWORK PROVIDER CHARGE	PLAN ALLOWED AMOUNT	PATIENT PAYS BALANCE
BILL TOTAL	\$500	\$300	\$200
PLAN PAYS		\$150 (50%)	\$0
PATIENT’S RESPONSIBILITY		\$150	\$150
TOTAL PATIENT PAYS:			\$350 of \$500

EXAMPLE

Hospital-based specialists who are out-of-network.

Lisa N. of Santa Cruz, California, checked in to her local in-network hospital to have her baby, using her in-network obstetrician and neonatologist. Though she hadn’t planned on getting an epidural, she needed one, and the out-of-network anesthesiologist who administered it billed her \$3,000. She later found out that there were no in-network anesthesiologists practicing at the hospital.

Depending on the type of plan the patient has, the insurer may not cover any of the surprise bill, or reimburse only part of it. Not bound by a network contract, the provider can then present the patient with a balance bill for the amount s/he charges for the service, often much more than the insurance company's allowed amount.

An analysis by America's Health Insurance Plans (AHIP), an industry trade group, showed that out-of-network doctors can submit bills that are 10, 20, or sometimes nearly 100 times higher than the fees paid by Medicare for the same service.² Economists and advocates estimate that consumers routinely pay almost \$1 billion a year due to balance billing.³

Most consumers are not fully aware of this potential problem. The 2015 Consumer Reports National Research Center found that 63 percent of respondents assumed that if they went to an in-network hospital, all the doctors at the hospital would also be in-network.⁴

Inaccurate provider directories can result in surprise bills when patients rely on them to seek care from doctors incorrectly listed as being in their plan's network. In some cases, doctors themselves may be uncertain about which plans they participate in.

EXAMPLE

Inaccurate provider directories.

Cesia from Katy, Texas, changed health insurance plans. Prior to taking her son to his pediatrician, she called the insurance plan and spoke to a customer representative who verified and assured her that the doctor was in-network. After a few months of taking her son for checkups and sick visits, she received bills from his pediatrician stating that her insurance didn't cover them. She called the plan and was told that the doctor was out-of-network and they couldn't do anything. She tried twice, unsuccessfully, to appeal the case.

After receiving many consumer complaints, the California Department of Managed Health Care (DMHC) conducted a study of two of the largest insurers in the state, Blue Shield of California and Anthem Blue Cross. DMHC found that both plans' provider directories had significant errors in the providers listed as accepting new patients, and listed providers in the directory who were not practicing at the listed locations.⁵

² America's Health Insurance Plans. Survey of Charges Billed by Out-of-Network Providers: A Hidden Threat to Affordability, January 2013. Available at <https://www.ahip.org/Value-of-Provider-Networks-Report-2012/>

³ Texas Association of Health Plans press release, TAHP Supports SB 481 To Empower Consumers & Take Surprise Out of "Balance Billing." March 24, 2015. Available at <http://tahp.org/en/press-releases/341-tahp-supports-sb-481-to-empower-consumers-take-surprise-out-of-balance-billing>

⁴ Consumer Reports National Research Center, Ibid.

⁵ California Department of Managed Health Care, Final Report: Non-routine Survey of Blue Shield of California, a Full Service Health Plan. November 18, 2014. Available at <http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/043fsnr111814.pdf> and Final Report: Non-routine Survey of Anthem Blue Cross, a Full Service Health Plan. Available at <https://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/303fsnr111814.pdf>

The scope of the out-of-network surprise bill problem

Consumer Reports recently found that nearly one in four privately insured Americans surveyed received a surprise out-of-network medical bill.⁶

Based on interviews we conducted for this guide,⁷ as well as media stories in both national and local media, the problem of surprise medical bills appears to be particularly widespread with doctors who practice in hospitals. These include emergency room doctors and in-hospital “ologists” (anesthesiologists, pathologists, and radiologists), as well as community-based specialists who agree to take emergency room calls, such as dermatologists, orthopedists, and plastic surgeons. Unlike scheduled office visits to internists or pediatricians, situations involving hospital-based, out-of-network providers virtually eliminate consumers’ power to make an informed choice, leaving them vulnerable to unexpected bills.

A 2013 report revealed that many hospitals in Texas have no in-network doctor option at all.⁸ United Healthcare, the state’s largest insurer, reported that 45 percent of its in-network hospitals had no in-network emergency room physicians whatsoever. Not surprisingly, 68 percent of billings from emergency room physicians at its in-network hospitals were out of network. The insurer also reported that 25 percent of its anesthesiology claims for in-network hospitals were billed out of network, as were 24 percent of pathology bills and 15 percent of radiology bills.

Federal protections and gaps

Medicare—our nation’s health coverage program for seniors and those with disabilities—provides beneficiaries with strong protections from surprise

balance bills. Physicians who participate in Medicare, about 96 percent of the total, may not balance bill for any amount beyond the standard Medicare cost-sharing. Providers who don’t accept assignment, about 4 percent of the total, collect a slightly reduced amount from Medicare, but may balance bill patients up to a maximum of 115 percent of the Medicare fee schedule.⁹

But more than a hundred million privately insured Americans have no such comprehensive protection.¹⁰ Some of these enrollees are governed by state rules if they buy on their own or are offered coverage by a small employer. But larger employers tend to “self-insure,” which means the coverage is not regulated by states and instead is overseen by the U.S. Department of Labor (DOL). DOL has not enacted any protections against balance bills for self-insured plans, such as those described in the next section.

The Affordable Care Act (ACA) offers very limited protection from surprise bills that result from emergency services. It specifies that health plans must cover emergency services, whether at an in-network or out-of-network facility, at the in-network cost-sharing level—even if obtained from out-of-network providers. But non-network providers are still allowed to balance bill. In implementing the ACA, for example, Department of Labor regulations for group insurers state that insurers are deemed in compliance with the regulations so long as they provide benefits in an amount equal to the greatest of the: 1) median in-network rate, 2) the “usual, customary, and reasonable” (UCR) rate, or 3) the Medicare rate for the emergency service—unless a state law prohibits balance billing outright.¹¹ There is no protection at all from surprise bills resulting from non-emergency services.

⁶ Consumer Reports National Research Center, Ibid.

⁷ See “About this report.”

⁸ Center for Public Policy Priorities. Surprise Medical Bills Take Advantage of Texans: Little-known practice creates a “second emergency” for ER patients. September 15, 2014. Available at http://forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf

⁹ Kaiser Family Foundation. Paying a visit to the Doctor: Current Financial Protections for Medicare Patients When Receiving Physician Services. April 2014. Available at <http://kff.org/medicare/issue-brief/paying-a-visit-to-the-doctor-current-financial-protections-for-medicare-patients-when-receiving-physician-services/> See also, Kaiser Family Foundation. Health Insurance Coverage of the Total Population. Available at <http://kff.org/other/state-indicator/total-population/>.

¹⁰ Public Citizen. Out of Control: Patients are Unwittingly Subjected to Enormous, Unfair, Out-of-Network “Balance Bills”. Public Citizen, 2014. Available at <http://www.citizen.org/documents/out-of-network-balance-billing-report.pdf>

¹¹ Department of Labor regulations, 29 C.F.R. Section 2590-715-2719a(b)(3).

LESSONS FROM THE STATES: Five Essential Consumer Protections

A number of states have adopted laws or regulations that attempt to provide some degree of protection from surprise out-of-network bills for privately-insured consumers.

These laws—as well as legislation that has failed or is pending—have yielded important lessons on legal approaches and their real-world results.

Five elements are key to any plan to adequately protect consumers from surprise out-of-network medical bills.

1. An obligation for insurers to maintain accurate and up-to-date provider directories, with auditing and consequences for non-compliance;
2. A requirement that providers inform consumers whether they are in-network or out-of-network in a way that preserves meaningful consumer choice;
3. A “ban on balance billing” that explicitly protects the consumer from receiving or having to pay unavoidable or inadvertent out-of-network charges, known as balance bills;
4. A well-defined process for determining payment of surprise bills, including some type of independent dispute resolution process; and.
5. An effective way of informing consumers of their surprise bill rights.

These protections are discussed further below, along with policies that have been implemented in particular states. There are many nuances and pitfalls that activists and legislators should be aware of as they engage with other stakeholders around these issues.

1. ACCURATE AND UP-TO-DATE PROVIDER DIRECTORIES

While health plans all maintain some sort of provider directory, consumers don’t always find them easy to locate or understand. Moreover, if the directories aren’t up-to-date, consumers may get the wrong information, even from the insurer’s own representatives. When consumers rely on an out-of-date directory and see a provider who has left the network but is still listed in the directory—they often end up stuck with a balance bill.

Looking up providers can be a challenge. A single insurer may have dozens of network configurations for its different products. And there have been no uniform standards for how companies must present their directories. HealthCare.gov and several state-run Marketplaces, for instance, send consumers to insurers’ websites to view provider directories. But once there, confusing links or inconsistent plan names can make it difficult for consumers to identify the directory of the plan they’re considering.¹²

This situation will change somewhat in late 2015. This year, for the first time, HealthCare.gov, which runs ACA Marketplaces in 34 states, will require all insurers to provide direct links from a plan’s online listing to its specific provider directory, updated monthly. The directories must also be provided in a standardized, downloadable, machine-readable format to enable third-party developers to create apps to help consumers select plans based on their personalized preferences.

Yet at the state level, regulation of provider directory accuracy is not uniform. A 2014 survey of state insurance departments commissioned by the consumer representatives to the National Association of Insurance Commissioners found that two-thirds had no requirements for how often insurers must update their directories.¹³

¹² Blumberg LJ et al. Physician Network Transparency: How Easy Is It for Consumers to Know What They Are Buying? Urban Institute, August 2014. Available at <http://www.rwjf.org/en/library/research/2014/08/physician-network-transparency.html>

¹³ NAIC Consumer Representatives. Ensuring Consumers’ Access to Care: Network Adequacy State Insurance Survey Findings and Recommendations for Regulatory Reforms in a Changing Insurance Market, November 2014. Available at http://www.naic.org/documents/committees_conliaison_network_adequacy_report.pdf

Among those with update requirements, the required frequency varies significantly from state to state. Arizona and Vermont require updates only twice per year. New York requires changes to provider lists to be added to directories within 15 days.¹⁴ A **California** bill that was signed into law in October 2015 requires weekly updates of online provider directories,¹⁵ while newly proposed federal rules for the Medicaid program would require updates of online directories within three days of the plan being notified of a change.¹⁶

A new law in **New York** seeks to assist consumers in obtaining accurate information on provider participation through multiple channels. It requires physicians and hospitals to disclose their network participation in writing or through a website. Physicians must disclose the hospitals with which they are affiliated and hospitals must provide a list of the physician groups who practice in the hospital.

Another important consumer protection would be to pass laws that require insurers to protect patients from balance billing if they rely on inaccurate directory information when selecting a provider. Of the 21 states that responded to the NAIC survey question on network directory requirements, only nine said they had such a requirement.¹⁷ The Attorney General in New York State in 2012, however, entered into a settlement agreement with eight health insurers, requiring restitution to consumers who relied on an inaccurate provider directory representation that a provider was in-network.¹⁸

Advocates addressing the issue of surprise bills should push for broad consumer protections, such as restitution, similar to the ones that Consumers Union has developed,

including weekly updates and information on credentials, hours of operation, email availability, and hospital affiliations.¹⁹

2. DISCLOSURE OF IN-NETWORK OR OUT-OF-NETWORK STATUS

Lack of meaningful disclosure by both out-of-network providers and insurers blindsides consumers when they are seeking care. Meaningful disclosure provides the consumer with the opportunity to avoid a surprise bill.

The challenge for regulators and advocates is to distinguish between situations where disclosure gives the consumer an opportunity to avoid a surprise bill, and where it doesn't. For instance, asking patients, upon hospital admission, to sign a blanket acknowledgement that they might be treated and balance billed by an out-of-network provider at some unspecified point is not a meaningful protection.

New York's new surprise bill law takes a dual approach. The law only permits balance billing for office-based out-of-network services if the patient has signed a written consent form acknowledging the services would be out-of-network and would result in costs not covered by the patient's health plan. The law also requires, upon the consumer's request, that providers present an estimate of the reasonable anticipated charges to be incurred.

The law is more restrictive when it comes to hospital-based balance bills. It presumes that all out-of-network hospital-based provider bills are surprise bills and subject to the new surprise bills law, unless the patient knowingly chose an out-of-network physician over an available in-network physician.²⁰ New York regulators say that the enforcement of this protection will depend upon whether

¹⁴ Giovannelli et al. Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks. The Commonwealth Fund, May 2015. Available at <http://www.commonwealthfund.org/publications/issue-briefs/2015/may/state-regulation-of-marketplace-plan-provider-networks>

¹⁵ California Senate Bill 137, authored by Senator Ed Hernandez. Available at http://leginfo.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB137

¹⁶ 42 CFR section 438.10(h)(3), Federal Register, Vol. 80, No. 4, Proposed Rules, June 1, 2015.

¹⁷ NAIC Consumer Representatives, p. 27. California Senate Bill 137 also provides this protection.

¹⁸ New York Attorney General's office press release, A.G. Schneiderman Announces Settlements Requiring Health Insurers To Publish Accurate Provider Directories, January 2012. Available at: <http://www.ag.ny.gov/press-release/ag-schneiderman-announces-settlements-requiring-health-insurers-publish-accurate>. The California bill incorporates this consumer protection, as well.

¹⁹ Consumers Union, Making Provider Directories Meaningful to Consumers. December 2014. Available at http://consumersunion.org/wp-content/uploads/2014/12/Provider_Directories_principles_1214.pdf

²⁰ New York Department of Financial Services. Protection from Surprise Bills and Emergency Services. Available at <http://www.dfs.ny.gov/consumer/hprotection.htm>

the patient has a “meaningful opportunity” to choose the provider. “Meeting an out-of-network anesthesiologist five minutes before your procedure is not a meaningful choice for consumers,” said one regulator. Protection for emergency room care is more robust still: *any* out-of-network emergency care is considered a surprise bill.

The New York law took effect in April, 2015, so it’s too soon to tell how effective it will be in protecting consumers.

In **Maryland**, pre-service disclosure of potential costs is required for all out-of-network care, including when patients voluntarily choose an out-of-network provider. Providers can agree to accept a patient’s assignment of insurance benefits as total payment, even if they are not part of the patient’s insurance network. The law does not adequately protect consumers, however, because providers can choose not to accept assignment of benefits. But, in practice, most of them do.²¹

Texas moves disclosure upstream by requiring in-network hospitals to disclose the percentage of emergency room and other selected hospital-based specialists that are out-of-network at the point of health plan shopping. The requirement enables patients to avoid plans with poor network designs and/or avoid scheduling elective procedures at hospitals with few or no in-hospital “ologists.”

The Texas law also says that to avoid mediation for surprise bills, hospital-based providers must not only disclose their out-of-network status in advance of providing services, but also must provide the patient with a written estimate of the bill. Advocates say that in practice, it appears the latter requirement is rarely followed, which preserves the patient’s right to challenge the bill.

3. A BAN ON OUT-OF-NETWORK SURPRISE BALANCE BILLING

While protecting consumers from paying surprise bills is, of course, the overriding goal of surprise bills policies, legislation must set forth an explicit process by which a consumer never gets a surprise balance bill in the first place.

“Hold harmless” clauses are helpful but not sufficient unless they are accompanied by a ban on balance billing. By themselves, hold harmless clauses do not prevent providers from actually sending bills to consumers. State experience has shown that consumers often end up paying such bills because they are unaware that they don’t have to. Hold harmless clauses also leave insurers at risk for paying whatever the provider charges, a worry for upward spiraling health system costs. A better approach is to couple hold harmless clauses with a ban on balance billing for surprise medical bills. Further, if a consumer gets and erroneously pays an unauthorized balance bill, the law should provide that she gets her money back from the provider, plus interest.

Colorado’s law illustrates the pitfalls of a bare-bones approach. The law says that insurers must hold consumers harmless for any balance bill for surprise out-of-network services received when admitted by an in-network provider to an in-network facility. But the law does nothing to prevent providers from sending consumers a surprise bill, nor does it provide any way for consumers to learn that they don’t have to pay the bill.

In 2010 the state Insurance Commissioner’s office surveyed 52 carriers on their experiences with the Colorado law.²² The report was required by the Legislature to determine if the law should be repealed or continue in force. The findings are difficult to interpret, because there are no statistics on how many consumers simply paid their surprise medical bills because they didn’t realize they didn’t have to. Even more worrisome, advocates working to strengthen the law said that they had seen evidence that some providers were setting up business models, such as special practice groups created to take emergency

²¹ Maryland Health Care Commission Report. Re: Health Insurance- Assignment of Benefits and Reimbursement of Nonpreferred Providers. January 15, 2015. Available at http://mhcc.maryland.gov/mhcc/pages/plr/plr/documents/LGSPT_AOB_rpt_20150115.pdf

²² Colorado Department of Regulatory Agencies. Report of the Commissioner of Insurance to the Colorado General Assembly on §10-16-704(3), C.R.S. Consumer Protections Against Balance Billing. Jan. 21, 2010. Available at <http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheadname1=Content-Disposition&blobheadname2=Content-Type&blobheadvalue1=inline%3B+filename%3D%22Consumer+Protections+Against+Balance+Billing+2010.pdf%22&blobheadvalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251822199740&ssbinary=true>

rotations, designed specifically to get around Colorado's surprise medical bill law. Despite the law's shortcomings, after reviewing the survey results, the Commissioner found that the law protects consumers who get services at an in-network facility and that " [r]epealing the statute will harm consumers in situations where they have followed the rules of their managed care plan."²³

In **New Jersey**, HMO and PPO enrollees are held harmless for emergency care or involuntary out-of-network treatment at in-network hospitals— they are only responsible for the cost-sharing amounts they would pay had the physician been in-network. Enforcement of the hold harmless provisions, however, seems to be a significant problem, because advocates indicate that many patients report that they do, in fact, receive such bills.

The **New York** law is designed to remove patients from the process as soon as possible. The bill requires that consumers be given an assignment of benefits form that leaves it up to the provider and plan to work out the payment amount regarding a surprise bill. A patient can only be charged the cost-sharing that would have applied had the physician been in-network. The law goes further to require both the insurer and the physician to notify the consumer of her rights and cost-sharing obligations. "The important thing was to take the consumer out of the mix," said one stakeholder. "We wanted to make it a fight between the doctors and the health plans."

In 2015, **Connecticut** enacted an omnibus health bill²⁴ that includes protections against surprise bills for non-emergency out-of-network services provided at an in-network facility if the patient did not knowingly select that provider over an available in-network one. The same provision applies to all out-of-network emergency services. Consumers in both situations can only be charged cost-sharing (copays, coinsurance, deductibles and other out-of-pocket costs) that is equivalent to what they would pay for in-network care. Connecticut also prohibits out-of-network providers from directly billing

consumers at all, except for standard in-network cost-sharing. These provisions of Connecticut's new law do not take effect until July 2016 and enabling regulations have yet to be written.

While the New York and Connecticut laws are new, protection against surprise balance billing in Maryland has a longer history. HMO members in Maryland have a long-running and extensive protection against balance billing. In 2010, after a contentious legislative battle, **Maryland** extended some protections against balance billing to consumers in other types of managed care plans, not just HMOs.²⁵ The law requires insurance carriers to recognize a patient's assignment of benefits to an on-call or hospital-based physician who does not participate in the insurer's provider network, if the physician agrees to accept the insurer's payment as full reimbursement for the service. While physicians cannot balance bill patients, they still can collect out-of-network cost-sharing, such as copays, coinsurance, or a separate out-of-network deductible.

How well has Maryland's law worked? The Maryland Health Care Commission studied the law's impact in a report released in January 2015.²⁶ After analyzing privately insured medical claims for PPO and POS plans from the 2010 and the 2013 Medical Care Data Base, the Maryland Healthcare Commission found that the legislation had achieved its purpose of reducing "...the financial burden on patients by discouraging reliance on balance billing, without reducing payments to out-of-network physicians."²⁷

The Commission not only found that the law protected payment levels for out-of-network physicians, but also that it provided those same physicians with "increased predictability of payments." Moreover, while impact varied by payer, the Commission "found no evidence that provider participation rates in commercial networks systematically declined between 2010 and 2013."²⁸

²³ Id.

²⁴ State of Connecticut, Public Act No. 15-146: An Act Concerning Hospitals, Insurers and Health Care Consumers. Available at: <https://www.cga.ct.gov/2015/ACT/PA/2015PA-00146-R00SB-00811-PA.htm>

²⁵ 2013 Maryland Insurance Code, Benefits for health care services; payments to and rates for providers. Section 14.205.

²⁶ Maryland Health Care Commission Report. Ibid.

²⁷ Id.

²⁸ Id.

Following the Commission's recommendation, the Maryland legislature updated the law by removing the provision that would require it to expire at the end of September 2015, effectively making the law permanent.

In 2009, the Supreme Court of **California** prohibited balance billing for in-network and out-of-network emergency care under the state's Knox-Keene Act, which protects the majority of policyholders in the state and is enforced by the Department of Managed Health Care.²⁹ Health plans licensed by the state's other regulator, the California Department of Insurance, are not covered by the decision on emergency care.

For non-emergency care, if no in-network providers are available for medically appropriate services, such as in a particular specialty, both regulators require the plan to provide consumer access at in-network cost sharing, even if that means using an out-of-network provider. If the plan arranges the out-of-network care, there should be no balance billing.³⁰ Neither regulator, however, has a prohibition against balance billing if the consumer goes to an in-network hospital for non-emergency care and ends up with services from an out-of-network provider.

Texas is the only state in which some balance bills must count toward in-network deductibles and in-network out-of-pocket limits, which applies to services that would otherwise not be reasonably available to the consumer.³¹ The state also requires mediation for patients who receive surprise balance bills from out-of-network radiologists, pathologists, anesthesiologists, neonatologists and emergency physicians working at network hospitals. Originally, to take advantage of this protection, consumers could challenge any individual surprise bill that was over \$1,000. Legislation that took effect September 1, 2015, however, lowered the threshold to \$500 and adds assistant

surgeons to the list of specialists to which the protection applies. But multiple bills below \$500 cannot be aggregated, even if together they exceed the threshold.³²

4. A WELL-DEFINED PROCESS FOR DETERMINING PAYMENT OF SURPRISE BILLS

An explicit process for how providers and insurers settle on payment for out-of-network services is a corollary desired by physicians to a ban on balance billing. Often called "independent dispute resolution," when patients are taken out of the puzzle, insurers and providers require some sort of formal or informal way to resolve payment for out-of-network care.

New York's new law sets up a two-step process for settling non-emergency surprise out-of-network bills. In the first step, the provider bills the insurer, who has the choice of either paying the bill in full or attempting to negotiate reimbursement with the provider. If the insurer and provider can't agree on a price, the insurer pays the provider an amount it deems reasonable and then one of the parties or an uninsured patient can initiate the independent dispute resolution process (IDRP). A decision through the IDRP must be made within 30 days. The independent IDRP reviewer can consider all relevant information, request additional information—including information about "usual and customary charges"—and even require that the parties make a good faith effort to settle. When applicable, the parties are given up to 10 days (of the 30 allotted) to try to come to a settlement agreement. If no settlement can be reached, the reviewer will resolve the dispute in favor of one of the parties, and the decision is additionally reviewed by an independent physician reviewer. Generally, the costs of IDRP are the responsibility of the losing party, unless there is a settlement, in which case both parties share the costs.³³

²⁹ Prospect Medical Group, Inc., et al. v. Northridge Emergency Medical Group, 45 Cal. 4th 497 (2009).

³⁰ The California Department of Insurance regulations provide that, "Networks must provide access to medically appropriate care from a qualified provider. If medically appropriate care cannot be provided within the network, the insurer shall arrange for the required care with available and accessible providers outside the network, with the patient responsible for paying only the in-network cost sharing for the service." 10 California Code of Regulations §2240.1(e). See similar Department of Managed Health Care regulations at 28 California Code of Regulations §1300.67.2.2 (c) (7) (B).

³¹ Texas Administrative Code Title 28, Rule §3.3708. The rule is challenging to enforce, given that insurers do not track consumer balance billing payments, so are only aware of these payments if consumers alert the insurer to their existence. Furthermore, there is nothing in the current Texas law that requires insurers and/or providers to inform consumers of these rights.

³² Texas Senate Bill No. 481.

³³ If an alternative good faith negotiation is directed by the reviewer and a settlement is reached, both parties share the cost. If an individual uninsured patient brings a case through the IDRP, the patient could be assessed fees if the claim is unsuccessful, but there is a waiver of fees for financial hardship. 23 NYCRR 400. Independent Dispute Resolution for Emergency Services Bills and Surprise Bills, proposed full text version. Available at <http://www.dfs.ny.gov/legal/regulations/emergency/np400t.pdf>

The information before the IDR review is either based on charges—what the out-of-network physician charges or the “usual and customary charges” determined by physicians—or the reasonable amount an insurer would pay—likely based on in-network contracts. Stakeholders involved in the development of the New York law expect that providers who charge multiple times the “usual and customary” rate for a service are likely to find themselves on the losing end of the dispute resolution, as are insurers who lowball their reimbursement rates. Yet, if many of these cases go to IDR, it’s not yet clear how effective the process will be in ensuring that the health plan and provider rate proposals are fair, reasonable, and proposed to keep health costs at bay. The decision is binding on the parties and can be reviewed in court.³⁴

Other states have less sweeping or prescriptive dispute resolution requirements. For example, **Florida’s** balance billing law, which protects only HMO members, is silent on dispute resolution.³⁵ Doctors or plans wishing to obtain help with dispute resolution can avail themselves of the Florida Agency for Health Care Administration’s Statewide Provider Health Plan Claim Dispute Resolution Program.³⁶ However, few providers use the process (although it appears that insurers and providers work out their differences informally).³⁷ Occasionally, emergency providers balance bill the patient, but when patients call the Department of Insurance’s consumer help line, they find out they aren’t obligated to pay the charges. Sometimes it’s a provider error, other times it is an inadvertent billing. Meanwhile, those

patients who aren’t aware that they are not responsible for the charges are left paying the balance bills. The Florida Department of Insurance does get many calls from PPO subscribers, who by the definition of the bill, are not protected under the law.

New Jersey laws require insurers to hold patients harmless for bills for out-of-network services at in-network facilities. In 2007, the NJ Department of Banking and Insurance issued a 2007 decision against Aetna, ordering the insurer to pay the full, *billed* charges for out-of-network services provided at an in-network facility.³⁸

That same year, the state implemented a voluntary dispute resolution program. The New Jersey program is underutilized. The process requires providers to exhaust their appeals through the insurer’s claims payment appeal system, before initiating an action through the dispute resolution process, which involves arbitration. Providers and insurers split the costs both of the review and the arbitration. Arbitration disputes are resolved based on the written record. Insurers and providers may only initiate arbitration of balance bills that exceed \$1,000; but, unlike in Texas, bills can be aggregated to reach the threshold.³⁹ New Jersey insurers do not feel that this process has materially reduced their out-of-network spending.⁴⁰ And indeed there have been reports of hospitals whose business plans encourage consumers to come to their out-of-network emergency rooms where they can collect extremely high charges.⁴¹

³⁴ Troy Oeschner, Deputy Superintendent for Health, New York Department of Insurance. New York’s New Law to Protect Consumers from Surprise Medical Bills, July 2014. Available at <https://consumersunion.org/wp-content/uploads/2014/05/NY-Surprise-Bills-Webinar-7-2-14.pdf>

³⁵ Florida Insurance Code, Chapter 641, Health Care Service Programs, section 641.3154. Available at http://www.leg.state.fl.us/statutes/index.cfm?mode=View%20Statutes&SubMenu=1&App_mode=Display_Statute&Search_String=641.3154&URL=0600-0699/0641/Sections/0641.3154.html

³⁶ Florida Agency for Health Care Administration. Statewide Provider Health Plan Claim Dispute Resolution Program. Available at https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Commercial_Managed_Care/docs/SPHPClaimDRP/AnnualReportFeb-2014.pdf

³⁷ One of the reasons for low use of dispute resolution in Florida, according to Maximus, the contractor responsible for administering the Florida dispute resolution program, is that providers have to pay for the process and there’s no set limit to what it can cost.

³⁸ New Jersey Department of Banking and Insurance. In the Matter of Violations of the Laws of New Jersey by Aetna Health Inc., Order No. A07-59 July 2007. Available at http://www.state.nj.us/dobi/pressreleases/pr070725_ordera07_59.pdf

³⁹ State of New Jersey Department of Banking & Insurance. Claims Payment: Claims Handling Appeals the the Program for Independent Claims Payment Arbitration (PICPA). Available at <http://www.state.nj.us/dobi/chap352/352appealqanda.html>

⁴⁰ One recent Millman study, commissioned by New Jersey insurers, concluded that “there is very limited incentive for providers whose patients see them involuntarily or in emergencies to participate in insurer networks, because out-of-network physicians can collect reimbursement at their full billed charges without any limits.” Boyarsky V and Pyenson B. Horizon BCBS Commercial Out-of-Network Reimbursement Analysis. Milliman, Feb. 20, 2015, p. 8. Available at: http://www.horizonblue.com/sites/default/files/pdf/Horizon_Commercial_OON_Reimbursement_Report_02202015.pdf

⁴¹ Creswell J et al. New Jersey Hospital Has Highest Billing Rates in the Nation. New York Times, May 16, 2013. Available at <http://www.nytimes.com/2013/05/17/business/bayonne-medical-center-has-highest-us-billing-rates.html?pagewanted=all&r=0>

In 2015, legislation was introduced to create a New York-style dispute resolution system in New Jersey, which drew vocal opposition primarily from the New Jersey Medical Society and certain specialty groups. The bill's sponsors are continuing to press the issue, however, and have asked the stakeholder groups to propose reasonable revisions to allow the bill to move forward.

Maryland takes a different approach. The law establishes payment formulas for out-of-network hospital-based physicians⁴² who agree to accept a patient's assignment of benefits as full payment for the service.⁴³ Within thirty days of receipt of a claim, the law requires insurers to pay out-of-network hospital-based physicians the greater of either: 1) billed charges paid in 2009 (adjusted for inflation by the Medicare Economic Index or MEI);⁴⁴ or 2) 140% of allowed charges for in-network services, based on the the same covered service in the same geographic area for a similarly licensed in-network physician.⁴⁵ Moreover, the law requires an insurer to disclose its reimbursement rates for a particular service when requested by the out-of-network physician. It also provides the option for out-of-network physicians to file a complaint or file a civil action in court.

Connecticut's new law is even more prescriptive. Payment for out-of-network emergency services must be the greater of: 1) the allowed amount for in-network services, 2) the usual and customary reasonable rate for such services (defined by statute as the 80th percentile of all charges for the covered service by health providers in the same or similar specialty, from the same geographic region, as reported via a benchmarking database run by a nonprofit;⁴⁶ or 3) the amount Medicare would pay for the service. Surprise bills from out-of-network non-

emergency providers in hospitals will be reimbursed at the in-network rate as payment in full, unless both the insurer and the provider agree otherwise. There is no provision for dispute resolution or mediation.

5. INFORMATION ABOUT CONSUMERS RIGHTS

Unless consumers are explicitly informed that they don't have to pay out-of-network bills, confusion can reign. The vast majority of consumers are unaware of their rights: Consumer Reports' survey found that 87% of those surveyed don't know the relevant state agency that can handle health insurance complaints and 72% are unsure if they have a right to appeal if their health plan refuses coverage for medical services. Of those consumers who do take action when they get an unexpected bill, 77% of them complain to insurance companies and providers, and less than 1% to the state regulator.⁴⁷

While **Colorado's** existing law holds consumers harmless from paying surprise bills, the law has no provision for informing them of that fact and there is no public-facing information on consumer protections on the state Insurance Department's website. More importantly, doctors can send balance bills with no requirement that they inform the patient that she doesn't have to pay, and "anecdotally we've heard that people do end up paying," according to one Colorado consumer advocate.

Similarly, **New Jersey** has no provision for notifying consumers of its hold harmless protection.

New York's new law, by contrast, specifies multiple layers of notification to make sure consumers understand that they do not have to pay surprise balance bills and what steps they may have to take if they receive a surprise

⁴² It also has similar payment provisions for on-call physicians.

⁴³ Maryland Health Care Commission Report, Ibid.

⁴⁴ For the average rate of billed charges, the law requires the insurer to add the rates paid to similarly licensed providers out-of-network for all occurrences under the Current Procedural Terminology Code (CPTC) for that covered service and dividing it by the total number of occurrences of that CPTC. Maryland Insurance Code, section 14-205(e)(2).

⁴⁵ For the average rate of allowed charges, the law requires the insurer to add the rates paid to similarly licensed providers in-network for all occurrences under the Current Procedural Terminology Code (CPTC) for that covered service and dividing it by the total number of occurrences of that CPTC. Maryland Insurance Code, section 14-205(e)(1).

⁴⁶ Presumably, FAIR Health. FAIR Health is a national independent, not-for-profit corporation whose mission is to bring transparency to healthcare costs and health insurance information through comprehensive data products and consumer resources. FAIR Health uses its database of billions of billed medical and dental services to power a free website that enables consumers to estimate and plan their medical and dental expenditures. The website also offers clear, unbiased educational articles and videos about the healthcare insurance reimbursement system. FAIR Health website <http://fairhealthconsumer.org>

⁴⁷ Consumer Reports National Research Center, Ibid.

bill. For instance, health plans that receive a bill from an out-of-network provider must clearly indicate in the Explanation of Benefits that the bill is from an out-of-network provider. Out-of-network providers must include in the bills that they send to consumers a notification that consumers are not required to pay balance bills and an explanation of the steps they should take when they get one, along with a copy of the Assignment of Benefits form, which is required to trigger the law's hold-harmless process. Consumer-facing information on the surprise bill law is also posted on the website of the Department of Financial Services, which regulates insurance in the state.

Similar to New York, **Connecticut's** new omnibus law imposes on providers strict requirements for consumer communication regarding non-emergency care. Providers must determine, prior to admission or the provision of care, whether the patient is covered under a health insurance policy. Then, the provider must notify patients about their out-of-network status. Prior to any scheduled admission, service or procedure, providers who are out-of-network must inform patients in writing or by mail: 1) about the charges for admissions, procedures or services, 2) that they may be charged more and be responsible for paying more for unforeseen services; and 3) if they have insurance, that the services will likely be treated as out-of-network and that out-of-network rates are likely to apply.

These new requirements will go into effect beginning January 1, 2016. Similar provisions apply to health insurers, effective July 1, 2016, which would require website and telephone contact information so that patients can obtain information on: 1) in-network costs, 2) allowed amounts for services, 3) the estimated out-of-pocket costs, 4) key data on such things as quality measures, patient satisfaction, provider network status, providers accepting new patients, languages spoken, and 5) information on out-of-network costs.⁴⁸

In **Texas**, out-of-network balance bills of more than \$500 each must include language "sufficient to notify a patient" that he or she is entitled to mediation.⁴⁹ The amended law, which took effect September 1, 2015, strengthens the notice requirement: the bill must now include "a conspicuous, plain-language explanation" of the process. But there's no enforcement mechanism and advocates worry that some bills won't include the required disclosure.

In **California**, consumers may have no idea what the current protections are against out-of-network billing. Consumer notice requirements are lacking under both of the state's two regulators, so providers and plans may not advise consumers of their rights. Consumers can file a complaint with the relevant regulator, if they know to complain.

Consumer Reports' recent survey showed, however, that most Californians don't know where to lodge health insurance complaints, for any reason. The Department of Managed Health Care, handled approximately one hundred and fifty consumer complaints regarding balance billing for emergency care in 2014—a practice clearly prohibited for DMHC-regulated plans for more than five years. Acting on patterns observed from complaints that had been filed, the Department recently settled several enforcement actions against Anthem Blue Cross, one of the state's largest insurers, ordering restitution for affected consumers.⁵⁰ Complaining to the regulator, thus, can be effective—but only if consumers have notice of their rights.

⁴⁸ Connecticut omnibus bill. Ibid.

⁴⁹ Texas Insurance Code Title 9, Subtitle F, Chapter 1456, Section 1456.004. Health Insurance and Other Health Coverages; Physicians and Health Care Providers; Disclosure of Provider Status. Available at <http://www.statutes.legis.state.tx.us/Docs/IN/pdf/IN.1456.pdf>

⁵⁰ California Department of Managed Health Care. In the Matter of the Investigation of: Anthem Blue Cross of California, Enforcement Matter No. 11-377, Agreement and Order. February 3, 2015. In this action, the plan inaccurately stated on its EOBs that enrollees were financially responsible for out-of-network emergency room services, contrary to state law. Available at: <http://wpso.dmhca.gov/enfactions/docs/2257/1426289813792.pdf>. See also California Department of Managed Health Care. Letter of Agreement between DMHC and Anthem Blue Cross, Enforcement Action 11-371. May 8, 2015. The Department leveraged a \$1.5 million administrative penalty against the insurer for failing to cover alpha fetal protein (AFP) testing at in-network rates. Available at: <http://wpso.dmhca.gov/enfactions/docs/2294/1432760550987.pdf>

A Grid of State Legislative Solutions

As this state overview shows, addressing the five essential consumer protections can be tricky and some state approaches appear to be stronger than others. Consumers Union created a grid to help advocates and legislators get to the strongest legislative approach. For a full copy of Consumers Union's Grid of State Legislative Solutions, see the Appendix.

Creating an Action Plan: Tips for Advocates

Conversations with consumer advocates, legislative staff and other stakeholders yielded some insights into how to go about enacting strong consumer protections from surprise balance billings. Consider the following approaches:

Collect consumer stories and data. In many states, advocates find that state legislators and their staff may be well aware of the surprise bill problem because they or someone they know has experienced it themselves. Publicizing consumer stories and bringing consumers to testify before legislators and sharing their stories with the media, can help create support. For example, a 2012 report from the New York State Department of Financial Services⁵¹ included such hair-raising examples as a patient who received bills totalling \$99,000 from two out-of-network plastic surgeons who reattached a finger severed in a table saw accident, and a neurosurgeon who charged \$159,000.

Assess the local situation. Laws and regulations already on the books may offer some protection and may be able to be improved through small steps. Look into regulator's current capacity to monitor surprise out-of-network bills and help consumers resolve them. If possible, research complaints to the state Insurance Department (but at the same time be aware that most consumers don't know that they have the option to complain). Understand the local market: what are dominant insurers currently doing about surprise balance billing and improving network transparency

and adequacy? Are there shortages of certain types of providers that are putting pressure on hospitals to stay adequately staffed?

Data outlining the extent of the problem can also help. In Texas, an advocacy group analyzed reports filed by insurers with the Department of Insurance and found that two of the state's three largest insurers—Humana and United Healthcare—had not a single in-network emergency room physician in a majority of the hospitals in their network.⁵²

Encourage regulators to play a more active role. Insurance commissioners and other state regulators can play an extremely helpful role on this issue. They can: 1) collect, analyze and resolve consumer problems and complaints; 2) improve consumer assistance services for surprise bills, for example, by improving web content on these issues, publicizing complaint hotlines, and strengthening disclosures in health plan and provider documents; 3) work with health plans, providers and consumer groups to investigate the source of the problems, and potential remedies; and 4) propose and implement stronger consumer protections and payment dispute resolution procedures.

In 2011 and 2012, The New York Department of Financial Services found that surprise medical bills were a leading source of consumer complaints to its complaint hotline, with approximately 2,000 complaints received per year, plus an additional

⁵¹ New York State Department of Financial Services. An Unwelcome Surprise: How New Yorkers Are Getting Stuck with Unexpected Medical Bills. March 7, 2012, page 2. Available at: <http://www.governor.ny.gov/sites/governor.ny.gov/files/archive/assets/documents/DFS%20Report.pdf>

⁵² Pogue S. Surprise Medical Bills Take Advantage of Texans. Center for Public Policy Priorities. Sept. 15, 2014. Available at http://forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf

1,400 reported to health insurers and HMOs. The Department wisely recognized that such complaints might be avoided if comprehensive protections were developed to reduce the incidence of surprise bills. The Department developed a policy report that analyzed the problem, and proposed a comprehensive set of consumer protections that were later adopted as a state law in March 2014.⁵³

Find allied groups. The most effective efforts to achieve consumer protections against surprise out-of-network bills have been those where a broad coalition of interests all work together. While individual consumers are greatly impacted by surprise out-of-network medical bills, so too are labor unions, small businesses, and large employers. Bringing together allied interests can help leverage resources to influence policymakers, creating momentum to achieve important policy reform.

Bring insurers and providers to the table. Provider opposition can, of course, kill a bill. In Colorado, for example, a proposed law modeled on New York's experience was defeated after "scorched-earth" opposition from the Colorado Medical Society. In New Jersey, strengthened surprise bill protections had strong support from consumer advocates and insurers, as well as from a core group of interested legislators, with some specialty provider groups opposed. The bill's progress stalled during the 2015 legislative session, but the bill's sponsors are continuing to meet with stakeholder groups, working to develop compromise language that could enable the bill to pass in the lame duck session in November/December 2015.

On the other hand, New York's new law was the product of years of intensive negotiations that included all relevant stakeholders: doctors, hospitals, insurers, regulators, and consumers. This might be a lengthy and contentious process, and including all stakeholders is certainly no guarantee of success. The fact is that physicians—particularly specialty doctor groups—may have no incentive to resolve consumers' surprise bill problems if insurers are simply paying

their full charges. Nonetheless, stakeholder groups working together have managed to work it out in a number of states.

Resources from Consumers Union

Consumers Union has several resources that can help enact an effective plan for protecting consumers from surprise bills, including:

- [Nationally representative survey](#) quantifying problem of surprise medical bills for the first time (the survey instrument is available for repurposing, should you want to create estimates for your specific state).⁵⁴
- Tips for [consumer friendly provider directories](#).⁵⁵
- [Network adequacy standards](#).⁵⁶
- [A story bank of surprise bill stories](#), with the ability to do targeted story collection.
- Links to legislative language.
- [Recognized experts](#) who can provide testimony or legislative review.

Call or visit our website for more surprise medical bills information: <http://consumersunion.org/surprise-medical-bills/surprise-medical-bills-resources/> and join our campaign: EndSurpriseMedicalBills.org

⁵³ An Unwelcome Surprise, Ibid.

⁵⁴ Consumer Reports National Research Center, Ibid.

⁵⁵ Making Provider Directories Meaningful. Ibid.

⁵⁶ Consumers Union. Network Adequacy Standards and Transparency Needed to Protect Consumers. April 2015. Available at http://consumersunion.org/wp-content/uploads/2015/04/Network_Adequacy_principles_040815.pdf

Conclusion

Consumers continue to be confronted with surprise out-of-network medical bills. The issue is a pervasive problem that is compelling to legislators, the media, and the public at large.

On a daily basis, we hear from consumers who have been faced with bills from doctors and other providers that they did not expect to have to pay.

As this guide shows, there are a variety of policy steps that can be taken to protect consumers and they can be attempted incrementally, depending on the state's appetite for change.

The greatest difficulty is overcoming resistance from providers—however, selected victories around the country show that it's possible to bring all parties to the table, but success often hinges on an even-handed approach to addressing final bill payment.

In states where we can't bring insurers and providers to the table to hammer out an acceptable solution, a disclosure of holes in the provider network (as done in Texas) might be a useful first step. But caution is needed—merely putting pressure on health plans to close those network holes can lead to higher premiums for consumers if complementary action is not taken to address excessive provider charges.

Surprise Out-of Network Medical Bills: Grid of State Legislative Solutions

A surprise medical bill is any bill for which a health insurer paid less than a consumer expected. A surprise out-of-network bill is when a consumer goes to an in-network facility but unknowingly gets treated by and billed by an out-of-network provider. Consumer Report’s May 2015 survey found that almost one-third of the privately insured population had received surprise medical bills and one out of four people got surprise bills from an out-of-network provider. Few of the consumers surveyed knew of their rights or even where to complain. States should consider the remedies below to help protect fully insured consumers. Uninsured consumers and those in self-insured plans will need similar remedies.

Inaccurate provider directories mislead patients into choosing a provider that is not in network.		
OVERARCHING REMEDY	DO CONSIDER	DON'T CONSIDER
Insurers must maintain accurate and up-to-date network provider directories and consumers must easily be able to identify and link to the correct directory for their plan.	<p>Relieve consumers of payment responsibility for out-of-network bills caused by inaccurate provider directories, including requiring restitution for consumers who relied on inaccurate directories when enrolling in or using care. (PA, NY, CA)</p> <p>Undertake “secret shopper” investigations to assess the accuracy of provider directories.</p> <p>Create standards for directory accuracy, with auditing and penalties for noncompliance. (CA) At a minimum, apply federal provider directory standards for Marketplace plans to the entire market, including a requirement for frequent updates. (CA=weekly)</p> <p>Institute a notice requirement for patients if their doctor is dropped or opts out of a network during plan year.</p>	

Lack of appropriate consumer disclosures to guard against out-of-network care and clarify extent of out

OVERARCHING REMEDY	DO CONSIDER	DON'T CONSIDER
<p>Inform consumers whether providers are in-network or out-of-network in a way that preserves meaningful consumer choice and clearly signals when networks are narrower than average.</p> <p>In-network hospitals must report on network status of all providers who practice at that hospital, including contracting providers.</p>	<p>Create new summary measures that signal to the consumer the relative amount of out-of-network coverage available under their plan options.</p> <p>Require in-network hospitals to report to regulators and/or health plans the percent of emergency department physicians who are out of network (TX) or require in-network hospitals to report to regulators and/or health plans the percent of all physicians with admitting privileges who are out of network.</p> <p>Require providers to make pre-service disclosure of estimated patient costs at least three business days before service to allow patients to make other plans or arrange for in-network providers.</p> <p>Relieve consumers of payment responsibility for undisclosed out-of-network bills (NY).</p>	<p>Permit a blanket disclaimer that informs the consumer that they might be treated by an out-of-network provider at some unspecified point in the future.</p> <p>Require disclaimer, but with too little advance notice to enable consumers to consider other provider options.</p>

In-network doctors, labs, etc., not routinely available at in-network hospitals.

OVERARCHING REMEDY	DO CONSIDER	DON'T CONSIDER
<p>Improve presence of these providers in the network.</p> <p>Establish ban on balance billing that explicitly protects the consumer from having to pay unavoidable or inadvertent out-of-network charges or balance bills. Provide alternative remedies when an outright ban on balance billing not in place.</p>	<p>Include standards for in-hospital status in network adequacy regulations.</p> <p>Relieve consumers of out-of-network payment responsibility in situations when an out-of-network provider performs a service at an in-network facility without sufficient prior notice to patient.</p> <p>In addition, or alternatively, require that cost sharing associated with surprise out-of-network bills count towards consumers' in-network out-of-pocket maximums and deductibles.</p>	<p>Force hospitals to use only doctors and labs that are part of the hospital's networks. This could result in service shortages.</p> <p>Have the health plan pay full charges when balance billing prohibited. (See alternatives below.)</p>

Uncertainty about provider payments for surprise out-of-network medical bills.

OVERARCHING REMEDY	DO CONSIDER	DON'T CONSIDER
An explicit remedy for how providers will be paid by insurers when balance billing is prohibited, including a clear independent dispute resolution process, that leaves consumers out of the mix.	<p>An objective, transparent reference point or formula for settling provider reimbursement when balance billing is prohibited.</p> <p>An independent dispute resolution process if providers wish to appeal the basis amount. Cost of dispute review process paid for by providers and insurers (NY, NJ).</p>	Require insurers to pay out-of-network providers' full charges for surprise medical bills. This could reduce providers' incentive to join networks and result in higher insurance premiums and other costs to consumers.

Consumers unaware of their rights to challenge surprise bills.

OVERARCHING REMEDY	DO CONSIDER	DON'T CONSIDER
A robust program is critical to inform consumers of their rights and complaint channels. Strong and transparent consumer complaint categories for regulators that reveal network adequacy and out-of-network billing problems are needed.	<p>Extend consumer external appeal rights to include out-of-network referrals. (NY)</p> <p>Include consumer assistance and regulator contact info on the bottom of all EOBs to fully insured enrollees so consumers can inquire about their rights, register complaints, and receive help. (MD)</p> <p>If balance billing is permitted, require out-of-network providers to include consumer information about rights and complaint channels, with their balance bills. (NY)</p> <p>Require that all official complaint/grievance decisions prominently display information about appeal rights to state agency, with contact information.</p> <p>Create a marketing campaign to increase awareness of role of regulators and consumer rights. (OR)</p>	Adopt surprise medical bill policies without consumer notification provisions. Consumers who receive balance bills may pay them if unaware of available protections.





POLICY & ACTION FROM CONSUMER REPORTS