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Surprise Medical Bills

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A Kaiser Family Foundation survey finds that among insured, non-elderly adults struggling with medical bill problems, charges from out-of-network providers were a contributing factor about one-third of the time. Further, nearly 7 in 10 of individuals with unaffordable out-of-network medical bills did not know the health care provider was not in their plan's network at the time they received care.

"Surprise medical bill" is a term commonly used to describe charges arising when an insured individual inadvertently receives care from an out-of-network provider. This situation could arise in an emergency when the patient has no ability to select the emergency room, treating physicians, or ambulance providers. Surprise medical bills might also arise when a patient receives planned care from an in-network provider (often, a hospital or ambulatory care facility), but other treating providers brought in to participate in the patient's care are not in the same network. These can include anesthesiologists, radiologists, pathologists, surgical assistants, and others. In some cases, entire departments within an in-network facility may be operated by subcontractors who don't participate in the same network.[1] In these non-emergency situations, too, the in-network provider or facility generally arranges for the other treating providers, not the patient.

For insured patients, the surprise medical bill can involve two components. The first component reflects the difference in patient cost-sharing between in-network and out-of-network providers. For example, in a managed care plan that provides coverage in- and out-of-network (sometimes called a PPO plan), a patient might owe 20% of allowed charges for in-network services and 40% of allowed charges for out-of-network services. A second component of surprise medical bills is due to "balance billing." Typically health plans negotiate fee schedules, or allowed charges, with network providers that reflect a discount from providers' full charges. Network contracts also typically prohibit providers from billing patients the difference between the allowed charge and the full charge. Because out-of-network providers have no such contractual obligation, however, patients can be liable for the balance bill in addition to any cost-sharing that might otherwise apply.

Data on the prevalence of surprise medical bills and costs to consumers are limited. The Affordable Care Act (ACA) requires health plans in and out of the Marketplace to report data on out-of-network costs to enrollees, though this provision has not yet been implemented.[2] Research studies offer some clues as to the prevalence and cost to patients due to surprise medical bills:

- One national survey found that 8% of privately insured individuals used out-of-network care in 2011; 40% of those claims involved surprise (involuntary) out-of-network claims. This survey found that most surprise medical bills were related to emergency care.
- In 2011, the New York Department of Financial Services studied more than 2,000 complaints involving surprise medical bills, and found the average out-of-network emergency bill was $7,006. Insurers paid an

average of $3,228 leaving consumers, on average, "to pay $3,778 for an emergency in which they had no choice."

- The same New York study found that 90% of surprise medical bills were not for emergency services, but for other in-hospital care. The specialty areas of physicians most often submitting such bills were anesthesiology, lab services, surgery, and radiology. Out-of-network assistant surgeons, who often were called in without the patient's knowledge, on average billed $13,914, while insurers paid $1,794 on average. Surprise bills by out-of-network radiologists averaged $5,406, of which insurers paid $2,497 on average.
- A private study of data reported by health insurers in 2013 to the Texas Department of Insurance suggest that emergency room physicians often do not participate in the same health plan networks as the hospitals in which they work. Three Texas insurers with the largest market share reported that between 41% and 68% of dollars billed by for emergency physician care at in-network hospitals were submitted by out-of-network emergency physicians. Analysis of provider directories of these three insurers found that between 21% and 45% of in-network hospitals had no in-network emergency room physicians.

Federal and State protections against surprise medical bills

Policymakers at the federal and state level have expressed concern that surprise medical bills can pose significant financial burdens and are beyond the control of patients to prevent since, by definition, they cannot choose the treating provider. Various policy proposals have been advanced, and some implemented, to address the problem. These include hold harmless provisions that protect consumers from the added cost of surprise medical bills, including limits or prohibitions on balance billing. Others include disclosure requirements that require health plans and/or providers to notify patients in advance that surprise balance billing may occur, potentially giving them an opportunity to choose other providers.

Federal policy responses

Several federal standards have been adopted or proposed to address the problem of surprise medical bills in private health plans generally, in qualified health plans offered through the Marketplace, and in Medicare. These standards vary in scope and applicability:

- ***Out-of-network emergency services (all private health plans)*** – The ACA requires non-grandfathered health plans, in and outside of the Marketplace, to provide coverage for out-of-network emergency care services and apply in-network levels of cost sharing for emergency services, even if the plan otherwise provides no out-of-network coverage. For example, if an HMO would normally cover 80% of allowed charges for in-network care and nothing for out-of-network care, the HMO would have to pay 80% of allowed charges for an out-of-network emergency room visit. This provision does not, however, limit balance billing by out-of-network emergency providers.

- ***Proposed changes to coverage for out-of-network non-emergency services (Marketplace plans)***– Recently the Centers for Medicare and Medicaid services issued final rules to begin to address surprise medical bills for non-emergency services for individuals covered by qualified health plans offered through the Marketplace. New standards would apply when an enrollee receives care for essential health benefits from certain out-of-network providers in an otherwise in-network setting. Applicable providers would be limited to those providing ancillary services (for example, anesthesia care for surgery performed in an in-network hospital) but would not include providers who render the primary service (for example, the surgeon.) The rule does not specify that the primary provider must be the admitting provider or otherwise affirmatively selected by the patient. Plans would be required to apply out-of-network cost sharing for such care toward the plan's annual out-of-pocket limit for in-network cost sharing. This

requirement would be waived whenever plans notify enrollees in writing in advance that such surprise medical bills might arise. Plans can notify enrollees as part of the pre-authorization process for a service, if applicable, or up to 48 hours before the service is rendered, whichever is longer. Balance billing charges arising from surprise medical bills would not be limited or counted toward the enrollee's annual OOP limit. Finally, this standard would not affect enrollees of HMO or EPO plans that do not cover non-emergency out-of-network services at all. Such plans comprise 73% of all QHPs offered in the federal Marketplace in 2016.

- ***Out-of-network services (Medicare)*** – Rules governing the traditional Medicare program generally limit patient exposure to balance billing, including surprise medical bills. Providers that do not participate in Medicare are limited in the amount they can balance bill patients to no more than 15% of Medicare's established fee schedule amount for the service.[3] Since these rules were adopted in 1989, the vast majority of providers accept Medicare assignment, and beneficiary out-of-pocket liability from balance billing has declined from $2.5 billion annually in 1983 ($5.65 billion in 2011 dollars) to $40 million in 2011. The rules are somewhat different for Medicare Advantage plans, which typically have more limited provider networks compared to traditional Medicare and which may not provide any coverage out-of-network. For emergency services, Medicare Advantage plans must apply in-network cost sharing rates even for out-of-network providers. Balance billing limits similar to those under traditional Medicare also apply. For non-emergency services, enrollees in PPO plans in surprise medical bill situations would be liable for out-of-network cost sharing, but Medicare balance billing rules would still apply, while enrollees in HMO plans might not have any coverage for non-emergency out-of-network services.

STATE POLICY RESPONSES

- ***New York's comprehensive approach to surprise medical bills*** – Last year a new law took effect in New York limiting surprise medical bills from out-of-network providers in emergency situations and in non-emergency situations when patients receive treatment at an in-network hospital or facility. To date, this law stands out as offering the most comprehensive state law protection against surprise medical bills. For emergency services, patients insured by state-regulated health plans (e.g., not including self-funded employer plans) are held harmless for costs beyond the in-network cost sharing amounts that would otherwise apply. For non-emergency care, patients who receive surprise out-of-network bills can submit a form authorizing the provider to bill the insurer directly, and then are held harmless to pay no more than the otherwise applicable in-network cost sharing. In both situations, out-of-network providers are prohibited from balance billing the patient; although providers who dispute the reasonableness of health plan reimbursement may appeal to a state-run arbitration process to determine a binding payment amount. The New York law applies only to state-regulated health plans. However, patients who are uninsured or covered by self-insured group health plans may also apply to the state-run arbitration process to limit balance billing by providers under certain circumstances.
- ***Limited provisions addressing surprise medical bills*** – A number of other states have laws limiting balance billing by out-of-network providers in certain circumstances. Some of these laws apply only to certain types of health plans (HMO vs. PPO) or only to certain types of providers or services (for example, for ambulance providers or emergency care services.)[4]
- ***NAIC model act*** – This fall, the National Association of Insurance Commissioners (NAIC) proposed changes to its health plan network adequacy model act to address surprise medical bills. NAIC model acts do not have the force of law, but often encourage state legislative action. For example, twenty states had adopted the previous NAIC model act on network adequacy or similar laws for network-based health plans. In addition, federal health insurance laws and regulations sometimes cite NAIC model act standards. The

model act revisions would apply new standards for in-network facilities (hospitals and ambulatory care facilities) with non-participating facility based providers (such as anesthesiologists or emergency physicians). For emergency services, state-regulated plans would be required to apply in-network cost sharing rates for surprise medical bills (extending the ACA's requirement for non-grandfathered plans to grandfathered plans as well). For balance billing amounts, out-of-network facility-based providers would be required to offer patients 3 choices: (1) pay the balance bill, (2) for balance bill amounts greater than $500, submit the claim to a mediation process with the provider to determine an allowed charge amount, or (3) rely on any other rights and remedies that may be available in the state. Similar requirements would apply for non-emergency services. In addition, health plans that require pre-authorization of facility-based care would be required to notify enrollees that surprise medical bills could arise, and plans would be required to provide enrollees with a list of facility-based providers that are participating in the plan network. Finally, plans would be required to keep data on all requests for mediation involving surprise medical bills and, upon request, report it to the state regulator.

Discussion

Surprise medical bills can contribute significantly to financial burden and medical debt among insured individuals, though data on the incidence and impact of this problem are limited. Federal authority to track the incidence and impact of surprise medical bills exists but has not yet been implemented.

Policy makers have considered and adopted various responses, yet tradeoffs are involved in protecting consumers from surprise bills. There is concern among some as to whether or how new consumer protections might affect insurance premiums. Establishing requirements both on what health plans must cover and on amounts that out-of-network providers can bill can limit the impact on premiums, though providers may balk at restrictions on how much they can charge.

The problem of surprise medical bills is likely to continue, and may increase to the extent plans create narrower provider networks. The very nature of the problem means that consumers will be hard pressed to take action to avoid surprise medical bill situations absent intervention by policy makers.

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[1] Another Kaiser Family Foundation report on medical debt featured one patient who had surgery and follow-up rehab services at an in-network hospital, only to learn that the rehab floor was operated by an out-of-network subcontractor.

[2] Transparency reporting requirements for non-Marketplace plans under Section 2715A of the ACA had an effective date of September 23, 2010. Transparency reporting requirements for Marketplace plans under Section 1311(e) of the ACA had an effective date of January 1, 2014.

[3] So-called non-participating Medicare providers can decide on a service-by-service basis whether to accept Medicare assignment and forego balance billing. They are distinct from "opt-out" providers, who refuse to accept Medicare reimbursement for any patient and who are not subject to any limits on what they can charge Medicare beneficiaries.

[4] See also Hoadley, Ahn, and Lucia, "Balance Billing: How are States Protecting Consumers from Unexpected Charges?" September 2015.