HB

193

<TARGET><BILL>HB 193</BILL><SUBJECT>HB 193</SUBJECT><COMM>HL&C30</COMM></TARGET>

ALASKA STATE LEGISLATURE

Session
State Capitol, Rm. 418
Juneau, AK 99801
(907) 465-3892
Fax: (907) 465-6595

Interim
1500 W. Benson Blvd.
Anchorage, AK 99503
(907) 269-0234
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Rep.Jason.Grenn@akleg.gov

House Finance Committee

Dept. of Law
Finance Subcommittee
Chairman

Dept. of Administration
Finance Subcommittee
Chairman

REPRESENTATIVE JASON GRENN

March 30, 2018

TO: **Representative Sam Kito, Chair**
Labor and Commerce Committee

FROM: **Representative Jason Grenn** JG

SUBJ: **Hearing Request for HB 193 – HEALTH CARE; BALANCE BILLING**

I am writing to respectfully request a hearing for House Bill 193: Health Care; Balance Billing. HB 193 establishes a ban on balance billing for medical providers and institutes a hold harmless clause for insurance providers during an emergency situation, effectively removing the patient from the billing situation.

Included in this bill packet:

- HB 193 Sponsor Statement
- HB 193 ver I Sectional Analysis
- HB 193 ver I
- HB 193 Supporting Documents
  - Balance Billing: How Are States Protecting Consumers from Unexpected Charges? Georgetown University Health Policy Institute
  - Balance Billing by Providers State Consumer Protections - The Commonwealth Fund
  - Surprise Medical Bills - The Henry J. Kaiser Family Foundation
  - Surprise-Balance-Billing – National Academy for State Health Policy
  - Alaska American College of Emergency Physicians - Letter of Support
  - Emergency Department Practice Management Association - Letter of Support
- HB 193 Opposing Documents
  - America's Health Insurance Plans
- HB 193 Additional Documents
  - Emergency CPT Code Reference Table

If you have any questions please feel free to contact me or my staff person, Ryan Johnston, at 465-6641. Thank you for your consideration of this request.

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REPRESENTATIVE JASON GRENN

SPONSOR STATEMENT
House Bill 193

House Bill 193 is focused on protecting Alaskans in emergency situations from being surprised with unexpected medical bills. The most common occurrence for balance billing is during emergency situations where patients are left without the option or wherewithal to ensure they are treated by an in-network provider. As a result, they find themselves on the hook for hefty medical bills, despite having proper health insurance. HB 193 would help Alaskans already dealing with the turmoil of a medical emergency by removing them from the billing side of the equation. When a patient is already in a dire situation, they should not be punished for the inability of an in-network provider to respond to their crisis.

HB 193 bans the practice of medical providers from balance billing in emergency situations and requires insurance providers to hold harmless their clients. This covers emergency situations inside and outside of hospitals. If a patient was transported to a hospital, or an emergency situation arose during a medical procedure requiring an out-of-network provider, this legislation mandates the insurance and medical providers to develop a fair and equitable payment agreement. Instead of being left to handle the labyrinth of medical billing on their own, the patient will be held harmless in these situations.

Medical costs are a major concern in Alaska. HB 193 is a part of a national movement to protect consumers from unexpected costs in an already difficult situation. Twenty-one states have a ban of some kind on balance billing and more states are looking are into the issue. Unexpected and excessive medical bills from out-of-network providers contribute to the growing problem of consumer medical debt, which continues to be a significant cause of personal bankruptcy. The goal of this legislation is to hold a patient harmless while the medical and insurance providers come to an agreement for the services rendered.

I urge your consideration and support of House Bill 193.

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SECTIONAL ANALYSIS
House Bill 193 ver I

Section 1: Establishes a "Hold Harmless" standard for insurance providers in the situation where a covered person receives medical care from an out-of-network medical provider in an emergency situation. An insurance provider will hold a covered person harmless to ensure that the covered person only pay what would have been paid if the medical provider was an in-network provider.

Outlines the standards to establish the situations where a medical provider cannot balance bill a covered person. An insurance provider shall pay a non-network health care provider if the health care provider renders to a covered person;

- emergency services or treats an emergency medical condition
- services at an in-network facility
- services for which a referral was made by an in-network health care provider to an out-of-network health care provider without the explicit written consent of the covered person.

The covered person is still required to pay the in-network rates for the deductible, coinsurance and copayment. The amount paid by the covered person is required to be counted towards the covered persons deductible.

The final payment determined for the medical provider will subtract any amount paid by the covered person.

The insurance provider is to pay the greater of three possible amounts;

- the median negotiated contract rate generated using the in-network health care providers for the service provided;
- That is equal to the 80th percentile of charges for the services calculated using a method that establishes a statistically credible profile that reflects the general cost differences between the geographical area where the service was preformed and the other geographical areas when performed by a health care provider in the same or similar specialty; or
- That would be paid under Medicare for the service provided.

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Medical providers are required to send all bills to the insurance provider, except for the deductible, coinsurance and copayment.

Contains a clause that if a covered person knowingly elects to use an out-of-network medical provider then they can be balanced billed for the services.

Section 2: Health care insurance plans obtained under AS 39.30.090 or provided under AS 39.30.091 will be subject to the requirements of secs. 21.36.512 and 21.36.513.

Section 3: Bans the practice of "Balance Billing" by a medical provider under the criteria of section 1 of the bill. Stipulates that the medical provider can still bill for the deductible, coinsurance and copayment.

States that a medical provider will be paid according to section 1 of the bill.

Section 4: Establishes the punishment for medical providers under the Unfair Trade Practices and Consumer Protection.

Fiscal Note

State of Alaska
2018 Legislative Session

Bill Version: HB 193
Fiscal Note Number:
() Publish Date:

Identifier: HB193-DCCED-DOI-03-02-18
Title: HEALTH CARE; BALANCE BILLING
Sponsor: GRENN
Requester: (H) Health and Social Services

Department: Department of Commerce, Community and Economic Development
Appropriation: Insurance Operations
Allocation: Insurance Operations
OMB Component Number: 354

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2019 Appropriation Requested	Included in Governor's FY2019 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2019**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Fund Source (Operating Only)

None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues

None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimated SUPPLEMENTAL (FY2018) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2019) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what date are the regulations to be adopted, amended or repealed?

Why this fiscal note differs from previous version/comments:

Not applicable, initial version.

Prepared By: Lori Wing-Heier, Director — Phone: (907)465-2560
Division: Division of Insurance — Date: 03/02/2018
Approved By: Catherine Reardon, Director — Date: 03/02/18
Agency: Division of Administrative Services, DCCED

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2018 LEGISLATIVE SESSION

BILL NO. HB 193

Analysis

HB193 requires insurers to provide the in-network level of benefits for services in certain circumstances. The bill ensures that insurers will provide in-network cost sharing levels for emergency services and when a covered person has no control over out-of-network provider services. The bill also provides that the insurer is not obligated to pay a non-network health care provider at the in-network rate if an in-network provider is available to render services and the covered person knowingly chooses to obtain services from a non-network health care provider. The bill includes a provision that the insurer shall pay non-network providers the in-network rate under the health care insurance plan as payment in full unless the insurer and provider agree otherwise.

The bill prohibits an insurer from balance billing, but identifies the term to mean the differences in the covered person's "out of pocket costs, including copayment, deductible, or coinsurance" between in-network versus non-network providers under the plan agreement which may or may not include amounts in excess of the allowed amount.

The Division of Insurance does not anticipate a fiscal impact from this legislation.

Fiscal Note

State of Alaska
2018 Legislative Session

Bill Version: HB 193
Fiscal Note Number:
() Publish Date:

Identifier: HB193CS(HSS)-DOA-DRB-04-05-18
Title: HEALTH CARE; BALANCE BILLING
Sponsor: GRENN
Requester: (H) Health and Social Services

Department: Department of Administration
Appropriation: Centralized Administrative Services
Allocation: Health Plans Administration
OMB Component Number: 2152

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2019 Appropriation Requested	Included in Governor's FY2019 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2019**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Personal Services	***		***	***	***	***	***
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	***	**0.0**	***	***	***	***	***

Fund Source (Operating Only)

None							
Total	***	**0.0**	***	***	***	***	***

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues

None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimated SUPPLEMENTAL (FY2018) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2019) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency?
If yes, by what date are the regulations to be adopted, amended or repealed?

Why this fiscal note differs from previous version/comments:

Not applicable, initial version.

Prepared By: Michele Michaud Phone: (907)465-3225
Division: Retirement and Benefits Date: 04/05/2018
Approved By: Leslie Ridle, Commissioner Date: 04/05/18
Agency: Department of Administration

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2018 LEGISLATIVE SESSION

BILL NO. CSHB 193

Analysis

The Division of Retirement and Benefits (the Division) anticipates fiscal impact to the AlaskaCare employee and retiree medical plans and submits an indeterminate fiscal note until an actuarial analysis can be conducted.

AlaskaCare already holds members harmless for emergency services received from an out-of-network provider. However, the bill does not appear to be limited to emergency services. This bill establishes three potential reimbursement methodologies for insurers to compensate out-of-network providers. Depending on which methodology applies, a network provider could be guaranteed a higher reimbursement if they leave the network. This could hamper efforts to broaden AlaskaCare's provider networks by weakening negotiation power with out-of-network providers through the creation of an out-of-network reimbursement floor, and the inability to apply steerage mechanism, such as increased member cost share, to services received out of network. Any methodology that sets a reimbursement floor based on billed charges may ultimately increase out-of-network reimbursement.

The "greater of" language may lead to increases in reimbursements for out-of-network providers currently compensated below these amounts. This bill does not appear to restrict the "greater of" provisions to services rendered in Alaska. This could result in services provided out-of-network in some geographic locations outside of Alaska to be reimbursed at rates higher than the billed amount. The "greater of" methodology will require specialized claims processing, currently unavailable to our contracted vendors. There will likely be costs to either build/maintain or purchase a program to calculate or increased administrative fees to our third party administrator to manually adjudicate every impacted claim.

This bill requires that member cost share be prohibited from being applied when calculating these new reimbursement amounts, leaving the AlaskaCare plans liable for the difference between a member's copayment amount calculated on an in-network service rate and the new calculated amount off of the higher reimbursement structure.

HB 193 Definitions

Sec. 47.32.900. Definitions. In this chapter,

(1) **"ambulatory surgical center"** means a facility that

(A) is not a part of a hospital or a physician's general medical practice; and

(B) operates primarily for the purpose of providing surgical services to patients who do not require hospitalization;

Sec. 21.07.250. Definitions. In this chapter,

(1) *[Repealed, Sec. 65 ch 41 SLA 2016].*

(2) *[Repealed, Sec. 65 ch 41 SLA 2016].*

(3) **"emergency medical condition"** means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent person who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention would result in serious impairment of bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

(4) **"emergency services"** means medical care services or items furnished or required to evaluate and treat an emergency medical condition;

(6) **"health care provider"** means a person licensed in this state or another state of the United States to provide medical care services;

Sec. 21.54.500. Definitions.

(15) **"health care insurance plan"** means a health care insurance policy or contract but does not include an excepted benefits policy or contract;

(16) **"health care insurer"** means a person transacting the business of health care insurance, including an insurance company licensed under AS 21.09, a hospital or medical service corporation licensed under AS 21.87, a fraternal benefit society licensed under AS 21.84, a health maintenance organization licensed under AS 21.86, a multiple employer welfare arrangement, a church plan, and a governmental plan, except for a nonfederal governmental plan that elects to be excluded under 42 U.S.C. 300gg-21(b)(2) (Health Insurance Portability and Accountability Act of 1996);

80th Percentile Benchmark for Biling Codes in an Area (Emergency)

CPT Code 99285 : Emergency department visit, Problem with Significant Threat to Life or Function

In Network	Primary Medical Procedure	Medicare Facility Limiting Charge	% of Medicare
WA (King County)	$455.00	$199.74	228%
WA (Spokane)	$480.00	$190.89	251%
AK	$404.00	$266.59	152%
VT	$257.00	$184.21	140%
OR (Eugene)	$370.00	$187.10	198%
OR (Portland)	$350.00	$192.51	182%
ID	$317.00	$177.23	179%
ND	$146.00	$182.88	80%
MT	$310.00	$195.53	159%
WY	$474.00	$188.18	252%
DE	$263.00	$195.52	135%

Average	178%

Out-of-Network	Primary Medical Procedure	Medicare Facility Limiting Charge	% of Medicare
WA (King County)	$1,177.00	$199.74	589%
WA (Spokane)	$1,874.00	$190.89	982%
AK	$1,057.00	$266.59	396%
VT	$614.00	$184.21	333%
OR (Eugene)	$1,241.00	$187.10	663%
OR (Portland)	$909.00	$192.51	472%
ID	$667.00	$177.23	376%
ND	$376.00	$182.88	206%
MT	$785.00	$195.53	401%
WY	$1,262.00	$188.18	671%
DE	$651.00	$195.52	333%

Average	493%

Information from FairHealth and CMS

CPT Code 99284: Emergency department visit, Problem of High Severity

In Network	Primary Medical Procedure	Medicare Facility Limiting Charge	% of Medicare
WA (King County)	$278.00	$135.71	205%
WA (Spokane)	$479.00	$190.89	251%
AK	$276.00	$180.71	153%
VT	$174.00	$125.11	139%
OR (Eugene)	$235.00	$127.02	185%
OR (Portland)	$235.00	$130.74	180%
ID	$167.00	$120.29	139%
ND	$129.00	$124.20	104%
MT	$197.00	$132.76	148%
WY	$304.00	$127.78	238%
DE	$242.00	$132.75	182%

Average	175%

Out-of-Network	Primary Medical Procedure	Medicare Facility Limiting Charge	% of Medicare
WA (King County)	$599.00	$135.71	441%
WA (Spokane)	$1,269.00	$190.89	665%
AK	$725.00	$180.71	401%
VT	$416.00	$125.11	333%
OR (Eugene)	$595.00	$127.02	468%
OR (Portland)	$626.00	$130.74	479%
ID	$242.00	$120.29	201%
ND	$345.00	$124.20	278%
MT	$368.00	$132.76	277%
WY	$769.00	$127.78	602%
DE	$445.00	$132.75	335%

Average	407%

Information from FairHealth and CMS

CPT Code 99283 Emergency department visit, moderately severe problem

In Network	Primary Medical Procedure	Medicare Facility Limiting Charge	% of Medicare
WA (King County)	$157.00	$71.59	219%
WA (Spokane)	$251.00	$68.33	367%
AK	$206.00	$69.97	294%
VT	$92.00	$65.98	139%
OR (Eugene)	$171.00	$66.95	255%
OR (Portland)	$158.00	$68.95	229%
ID	$135.00	$63.40	213%
ND	$63.00	$65.50	96%
MT	$113.00	$69.96	162%
WY	$213.00	$67.36	316%
DE	$105.00	$69.97	150%

Average	222%

Out-of-Network	Primary Medical Procedure	Medicare Facility Limiting Charge	% of Medicare
WA (King County)	$378.00	$71.59	528%
WA (Spokane)	$669.00	$68.33	979%
AK	$693.00	$69.97	990%
VT	$219.00	$65.98	332%
OR (Eugene)	$447.00	$66.95	668%
OR (Portland)	$400.00	$68.95	580%
ID	$296.00	$63.40	467%
ND	$185.00	$65.50	282%
MT	$299.00	$69.96	427%
WY	$478.00	$67.36	710%
DE	$266.00	$69.97	380%

Average	577%

Information from FairHealth and CMS

From: tom check
To: wendyc@gci.net; Hkbrakes@gmail.com; Rep. Sam Kito; Rep. Adam Wool; Rep. Andy Josephson; Rep. Louise Stutes; Rep. Chris Birch; Rep. Gary Knopp; Rep. Colleen Sullivan-Leonard; Rep. Mike Chenault; Rep. Bryce Edgmon
Subject: Emergency physician support for HB193
Date: Wednesday, April 4, 2018 1:21:55 PM

Dear Representative,

I am writing to express strong support for HB 193. I am an emergency physician providing care at Mat-Su Regional Medical Center and the medical director for Mat-Su borough EMS. Every day I work hard to provide evidence-based, cost effective care for patients in the emergency department and those in the community requesting 911 medical response. An adequate, integrated 911 and emergency department system saves lives and prevents costly disability and suffering, but requires adequate financial resources, including reasonable compensation for skilled emergency medical providers who are in short supply in the Alaska market. Preservation of the 80% rule while banning balance billing is a fair compromise for patients and providers which does not put our entire health care safety net at risk.

Thank you for your consideration,

Thomas Check, MD

From:	mark lee
To:	Rep. Sam Kito; Rep. Adam Wool; Rep. Andy Josephson; Rep. Louise Stutes; Rep. Chris Birch; Rep. Gary Knopp; Rep. Colleen Sullivan-Leonard; Rep. Bryce Edgmon
Subject:	Hb 193
Date:	Tuesday, April 3, 2018 9:07:18 AM

Dear Distinguished Legislators:

I am writing in support of house bill 193 which maintains the 80th percentile rule. I urge you all to support it. I am an emergency medicine physician in Palmer and unlike my colleagues, I am retiring soon and I still support HB 193. Hopefully that gives you more of an objective view. Thanks for considering.

Mark D. Lee, JD, MD.

3 April 2018

Dear Representative,

I am an Emergency Medicine physician working at the Providence Alaska Medical Center Emergency Department in Anchorage. I am writing in support of HB 193.

HB 193 will protect patients and families across the state from the high costs and sticker shock that can come from "surprise medical bills." Both doctors and patients support this important measure, which will provide consumer protections for patients, strengthen access to care, and put an end once and for all to surprise bills.

As emergency physicians in Alaska, we know firsthand about the gaps in patient healthcare coverage that can cause patients to postpone or avoid treatment until it's too late. According to a national survey, 44% of people reported that they didn't seek treatment when they were sick or injured because of costs. At the same time, 35% of Americans would have trouble paying their regular bills if faced with a $400 health emergency. This is alarming, but not surprising, and we must work together to ensure that patients can safely access emergency care without worrying about going bankrupt.

What good is insurance if it fails us in an emergency? Insurance companies are shifting hundreds of millions of dollars in costs to patients and doctors each year through higher premiums, deductibles and cost-sharing requirements. At the same time, Alaska insurance companies are narrowing their networks – making them smaller through limiting access to doctors and care, which means fewer options and choices for patients and creating large coverage gaps where care patients thought would be covered, turns out not to be. These gaps are leading to surprise bills, adding even more costs for patients.

Alaska patients and families deserve better. Right now, the state has a regulation in place that requires insurance companies to cover these unexpected out of network costs during emergencies through fair and appropriate payments to doctors. But, Alaska insurance companies are working to undermine this regulation – and we need your help to ensure patients are protected in the long run. We're working to support a new bill, HB 193, that will end surprise billing altogether and provide the protection patients need.

HB 193 is a comprehensive solution that protects patients and ends surprise bills by requiring insurers to cover unexpected, emergency out of network care, and limiting patient financial exposure. HB 193 will protect patients from receiving large bills that their insurance companies have refused to pay. By establishing an appropriate and fair reimbursement standard between insurers and doctors, the bill takes patients out of the middle and improves access to care.

HB 193 sets a fair minimum standard, the 80th percentile rule that has been working in Alaska since 2004, which insurers use as a benchmark to pay out-of-network physicians, providers or facilities for unexpected care. HB 193 bans balance billing, meaning no

further bills would go to patients in these situations. Because doctors will be payed fairly, there is no need for additional bills.

Please work hard to pass HB 193 to continue protecting Alaskans from surprise bills.

Sincerely,

Shannon D. Faber, MD
Alaska Emergency Medicine Associates

April 7, 2018

Dear Labor and Commerce Committee Members:

I am writing today to express my support for HB 193. I am an emergency medicine physician in Anchorage, Alaska. I feel strongly that this bill will provide better access to care and provide consumer protections for patients.

HB 193 supports the 80th percentile rule that has been working in Alaska since 2004. The 80th percentile rule is now being used in multiple states, and it is working well to provide consumer protection and to pay physicians fairly. It is supported by the National Council of Insurance Legislators.

HB 193 provides fair pay for physicians which eliminates the need for additional bills for patients. It will also provide support for the safety net for care that is so important to us in Alaska because of our geographical position. It is imperative that we have access to excellent emergency care and access to specialists.

Your hard work and dedication to the citizens of Alaska is appreciated. I hope you will support HB 193.

Sincerely,

Sandra W. Horning, MD, FAAP, FACEP

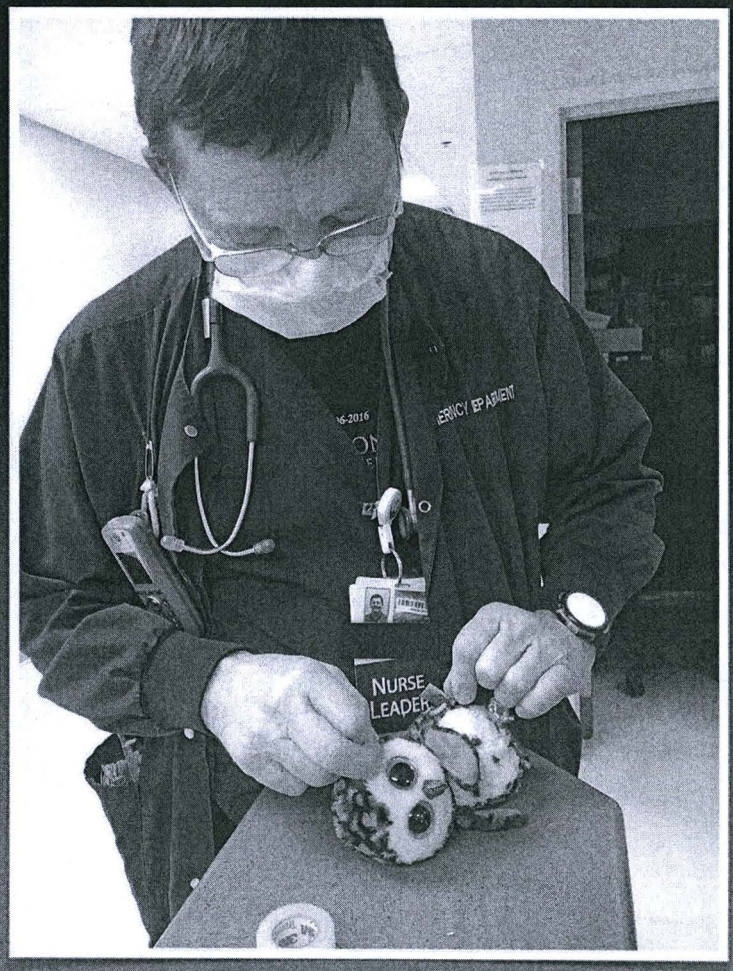
HB 193: A patient protection bill

Anne Zink, MD, FACEP

Alaska Chapter of the
American College of Emergency Physicians (ACEP)

ASK ONE QUESTION:

RIGHT FOR THE PATIENT?



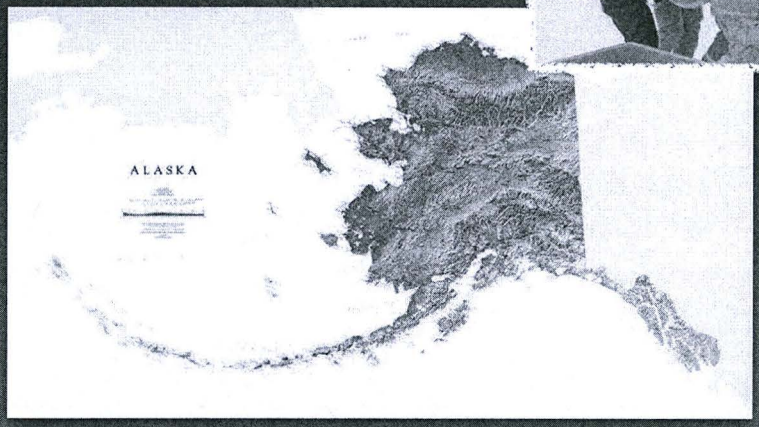
An Act Relating to Emergency Service and Balance Billing

=

End the **Surprise Insurance Gap** during a Medical Emergency

A Patient Experience

A team for you!



EMS

Bills

Emergency Physician #1

Hospital #1

Radiologist #1

Hospital #2

Emergency Physician #2

Surgeon

Hospitalist

Anesthesiologist

Radiologist #2

Medication

Laboratory work

44% of people reported that they didn't seek treatment when they were sick or injured because of costs

35% of Americans would have trouble paying their regular bills if faced with a $400 health emergency

Medical bills are the number one reason for bankruptcy in this country

http://www.healthcarefinancenews.com/news/healthcare-spending-and-costs-rise-many-americans-are-going-without-necessary-medical-care
https://www.nasdaq.com/press-release/patient-payment-responsibility-increases-11-in-2017-20180305-00308
https://www.fool.com/retirement/2017/05/01/this-is-the-no-1-reason-americans-file-for-bankrup.aspx

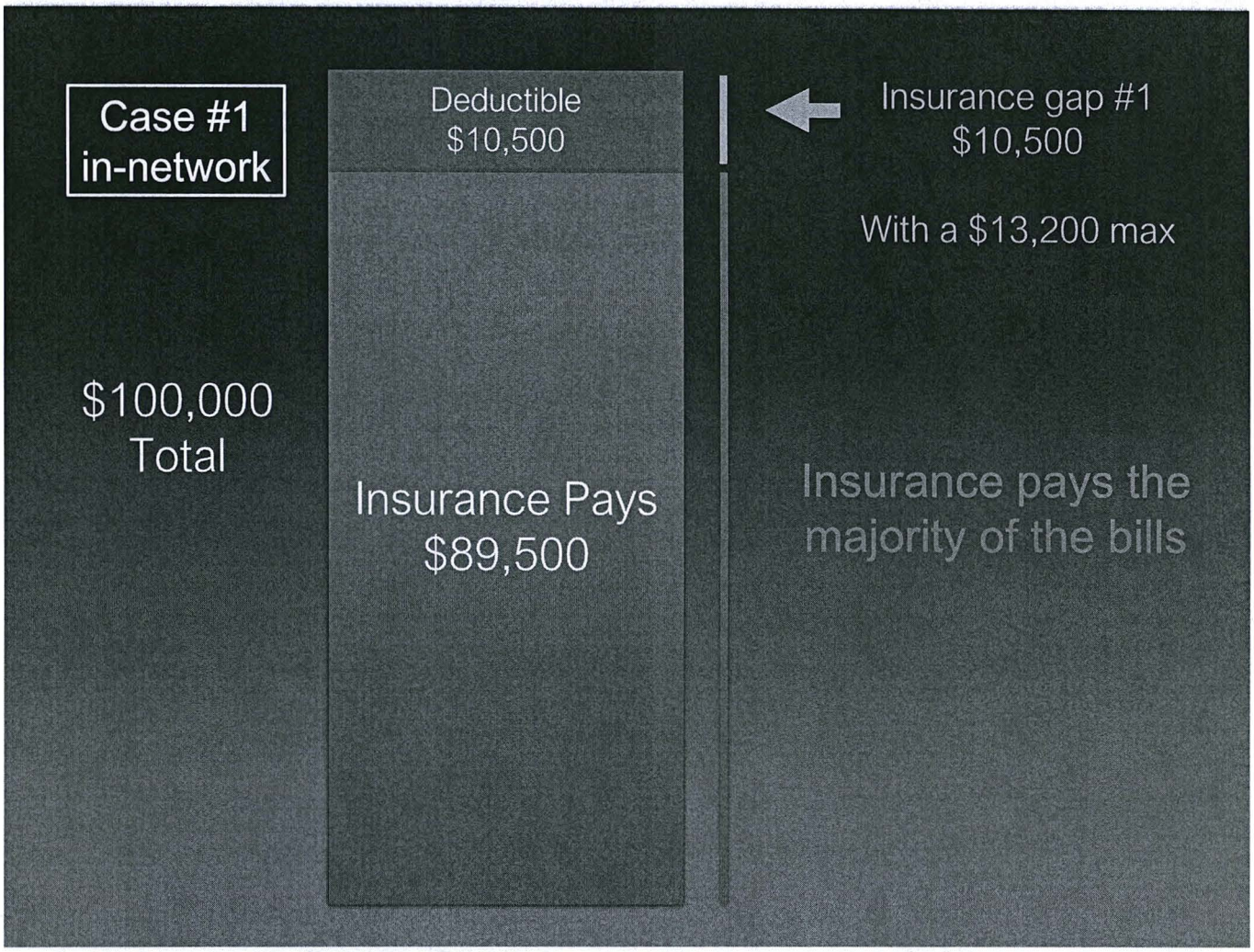
"But I have Health Insurance"

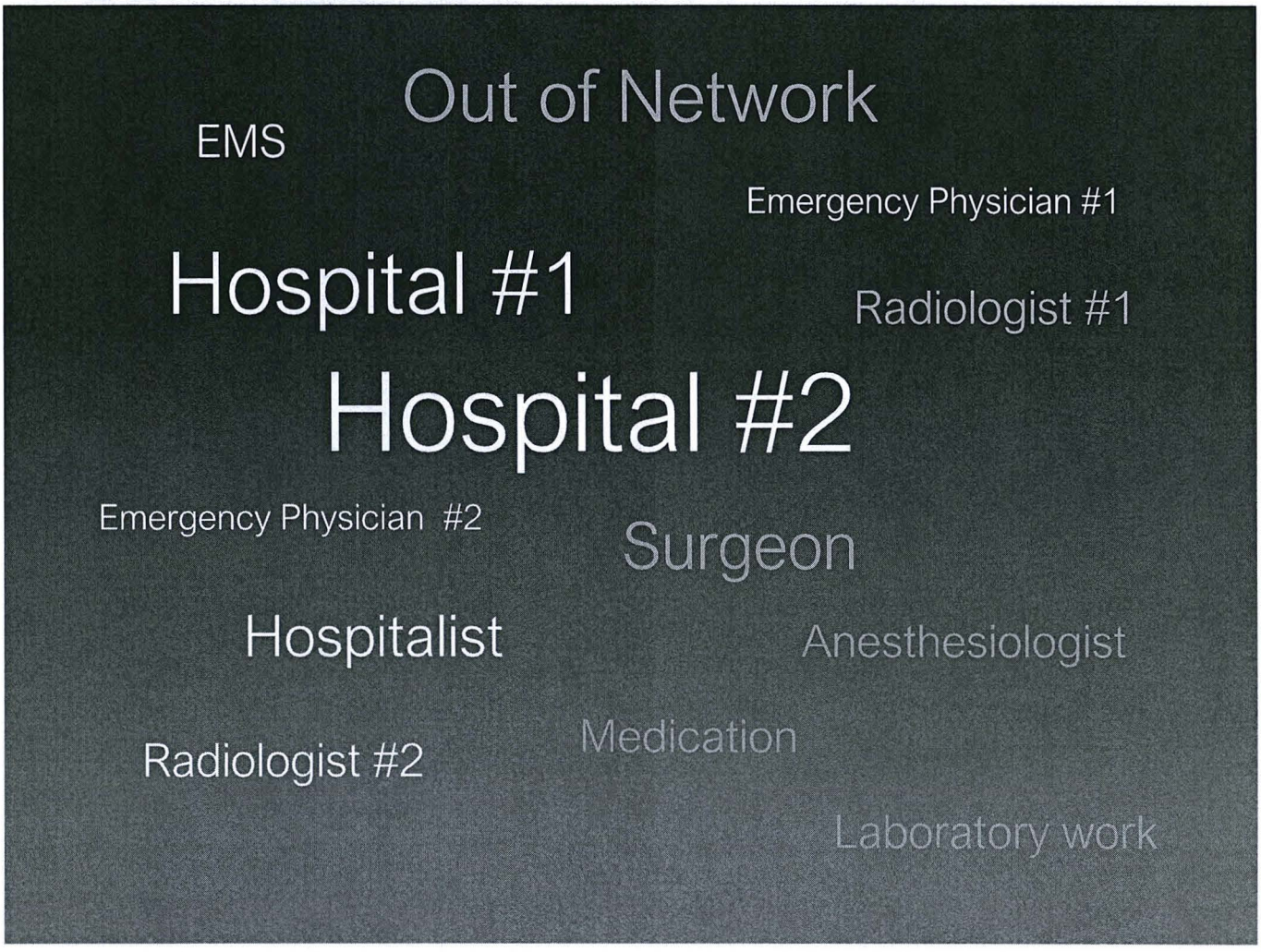
This is a bronze ACA plan in Alaska today

Pay $21,000 a year ($1750 a month) for my family of four

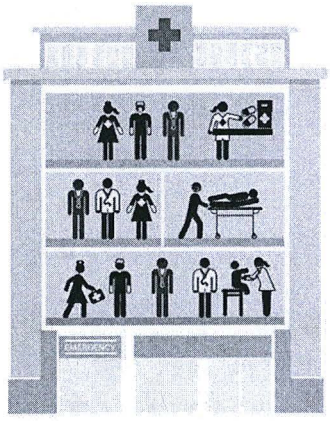
↓ eductibles and Maximums

	Deductible		Out of Pocket Maximum	
	Individual	Family	Individual	Family
In Network	$5,250.00	$10,500.00	$6,600.00	$13,200.00
Out of Network	$10,500.00	$21,000.00	N/A	N/A


Case #1
in-network
Deductible
$10,500
Insurance gap #1
$10,500
With a $13,200 max
$100,000
Total
Insurance Pays
$89,500
Insurance pays the
majority of the bills

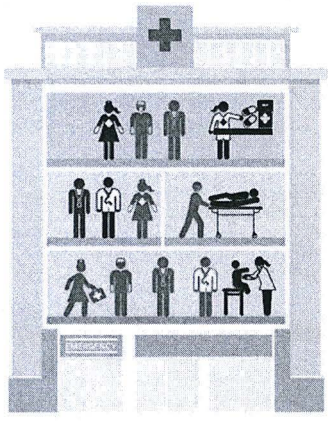

Out of Network
EMS
Emergency Physician #1
Hospital #1
Radiologist #1
Hospital #2
Emergency Physician #2
Surgeon
Hospitalist
Anesthesiologist
Medication
Radiologist #2
Laboratory work

WHAT YOU THINK YOUR INSURANCE COMPANY COVERS



When you walk into your in-network hospital, you expect all doctors to be covered.

WHAT YOUR INSURANCE COMPANY ACTUALLY COVERS



Insurance companies have narrowed their networks, leaving some doctors out-of-network.

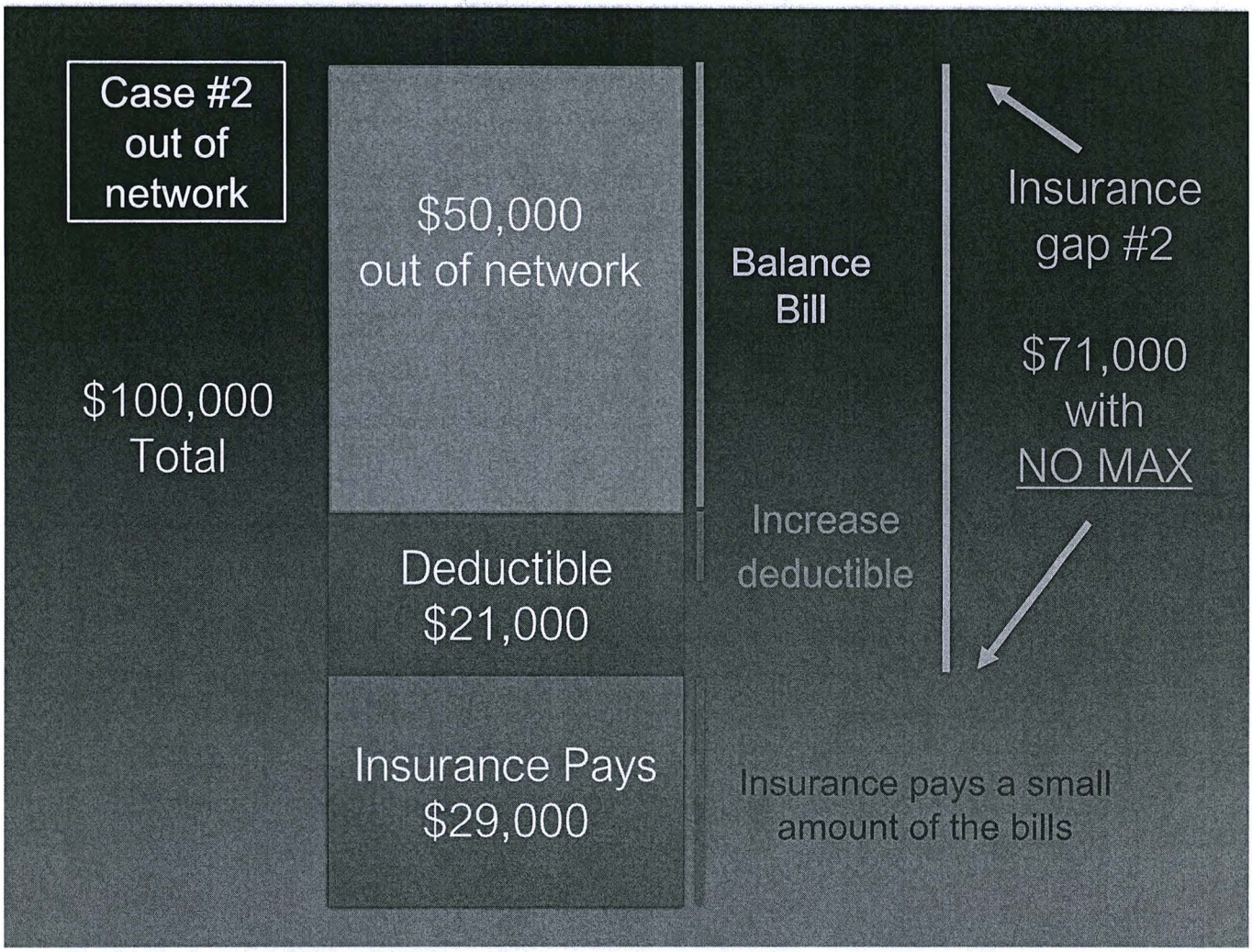
Physicians want to be in-network

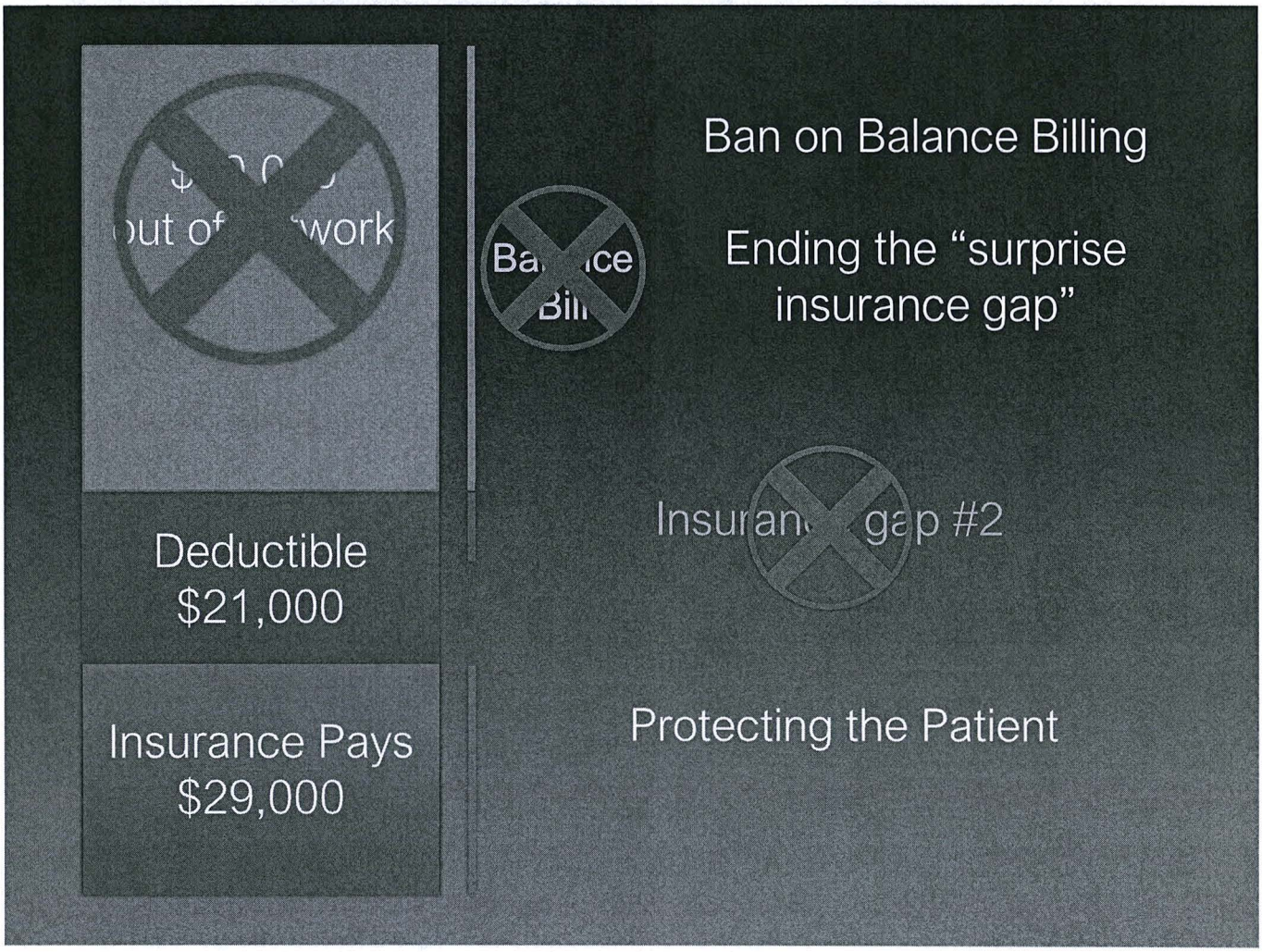
We chose medicine to care for patients

Often times insurance companies will not allow us to be in-network or at such low rates we can not keep the doors open

A 2015 study found that 50% of Alaska marketplace plans offer narrow networks, leaving patients with few in-network choices, and exposing them to surprise bills

http://ldi.upenn.edu/sites/default/files/rte/state-narrow-networks.pdf


Case #2
out of
network
$100,000
Total
$50,000
out of network
Deductible
$21,000
Insurance Pays
$29,000
Balance
Bill
Increase
deductible
Insurance
gap #2
$71,000
with
NO MAX
Insurance pays a small
amount of the bills


Deductible
$21,000
Insurance Pays
$29,000
Ban on Balance Billing
Ending the "surprise
insurance gap"
Protecting the Patient

A Providers Perspective - Keeping a Safety Net

Three options for staying in business:

1. Limit who I see
2. Fair in network reimbursement
3. Bill the patient

EMTALA Law = legally & ethically requires we see every patient, medical screen and stabilize

Fair out of network reimbursement helps promote in network participation

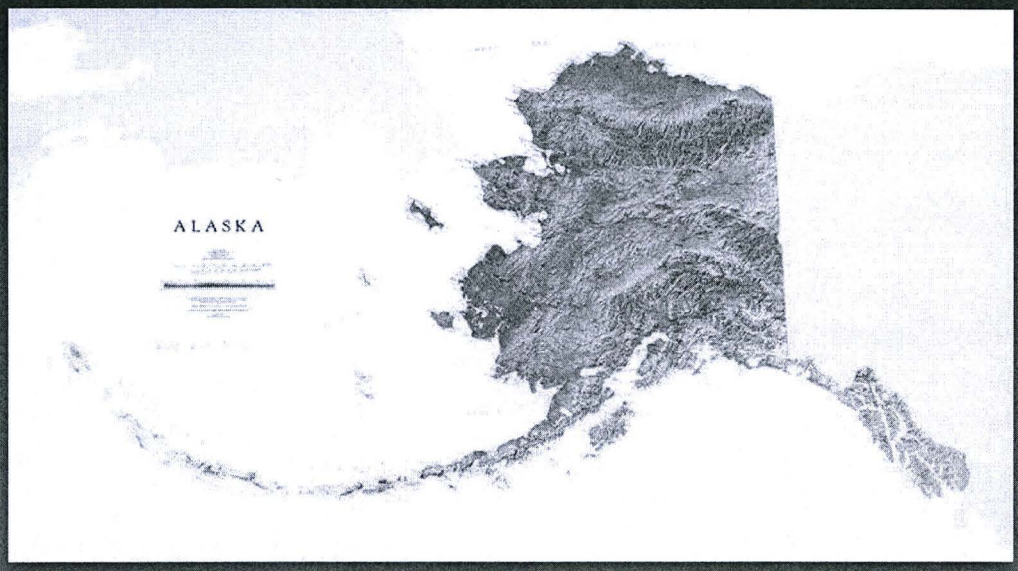
To preserve a safety net they must be two things:

1. Be Geographically Relevant

2. Based on not-for profit, independent transparent database not controlled by industries

Part #1: Geographically Relevant

Alaska and the 80th Percentile Regulation: Myths and Reality



A lot of noise with out a lot of fact

ALASKA PUBLIC MEDIA PBS npr GIVE

TELEVISION RADIO NEWS KIDS & FAMILY SUPPORT ABOUT US

An obscure rule may be driving up Alaska health care costs

By Annie Feidt, Alaska's Energy Desk - Anchorage - January 15, 2016

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Opinions

The moment has probably passed for Alaska health care reform. The future is here.

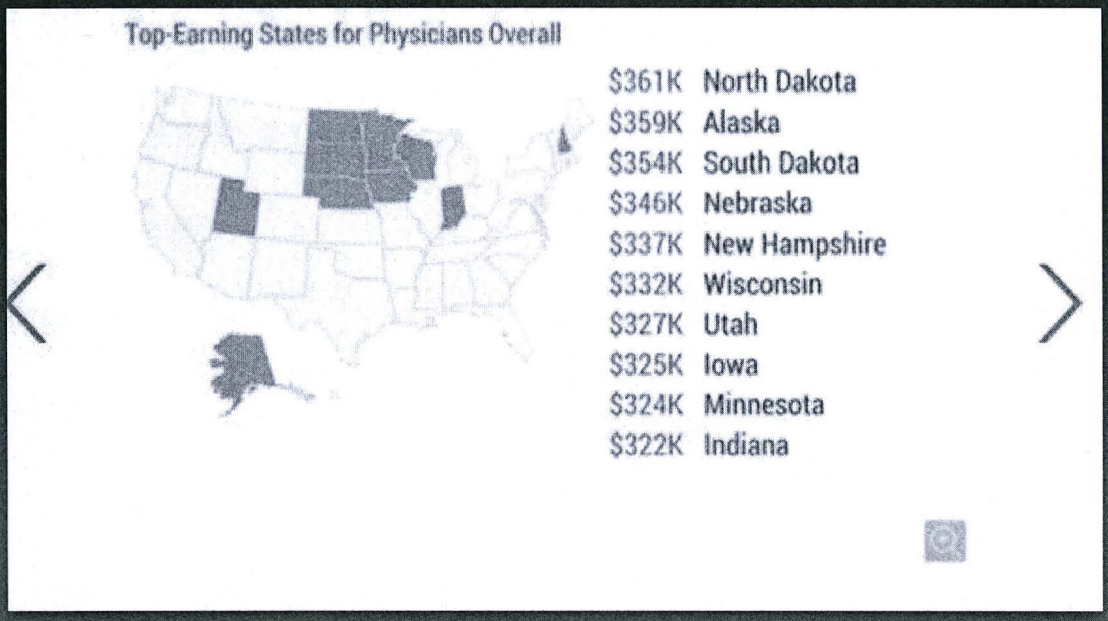
Author: Charles Wohlforth | Opinion Updated: March 25 Published March 25

Alaska is expensive but not the most expensive

Location	Health Spending per Capita
1. District of Columbia	$11,944
2. Alaska	$11,064
3. Massachusetts	$10,559
4. Delaware	$10,254
5. Vermont	$10,190
6. Connecticut	$9,859
7. North Dakota	$9,851
8. New York	$9,778
9. New Hampshire	$9,589
10. Rhode Island	$9,551

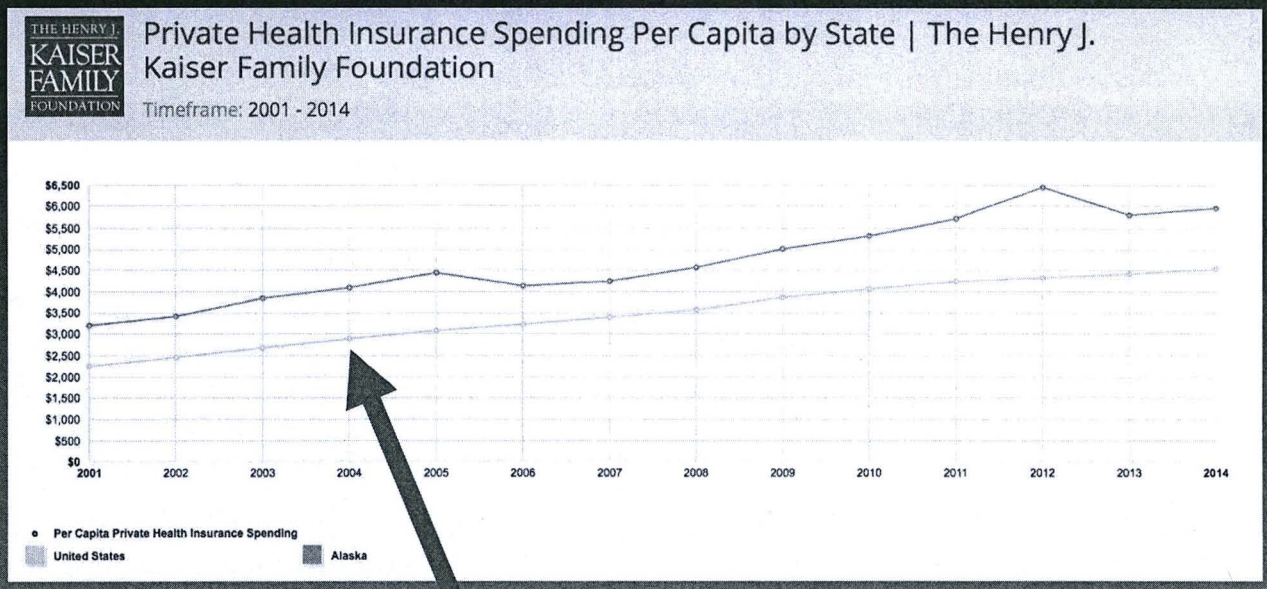
https://www.kff.org/other/state-indicator/health-spending-per-capita/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Rural states pay more for physicians



https://www.medscape.com/slideshow/compensation-2017-overview-6008547#10

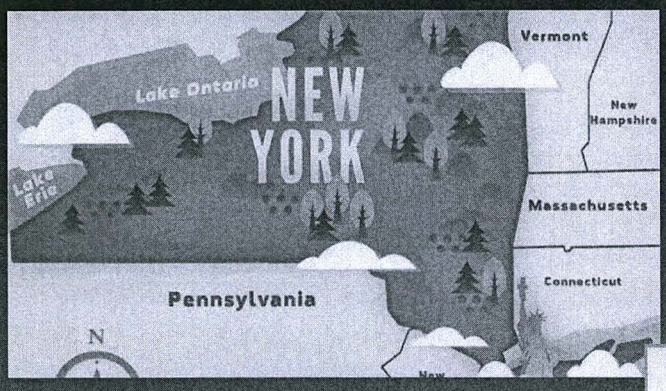
The 80th percentile rule did not change the Alaska per capita private health insurance spending curve



2004

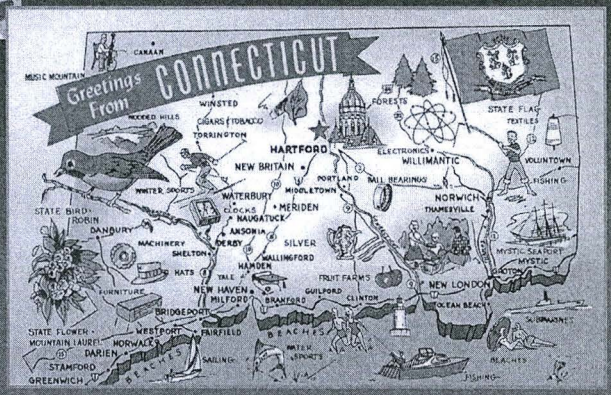
ator/private-health-insurance-spending-per-capita-by-state/?currentTimeframe=0&sortModel=%7B%22colId%22:%2

ka is not the only state with an 80th percentile regulation or sta

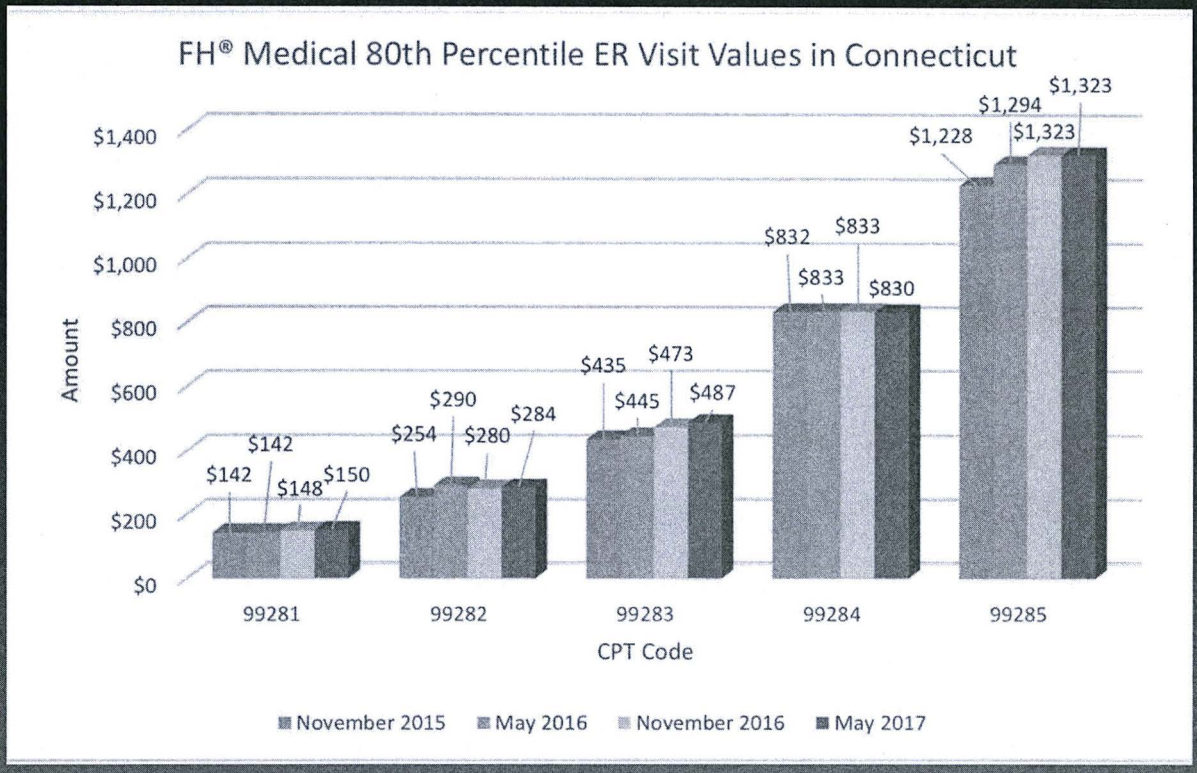


Both CT and NY in 2014 passed legilation that established the 80th percentile as a benchmark for payment with a ban on balance billing

Many other states are considering similar patient protection measures

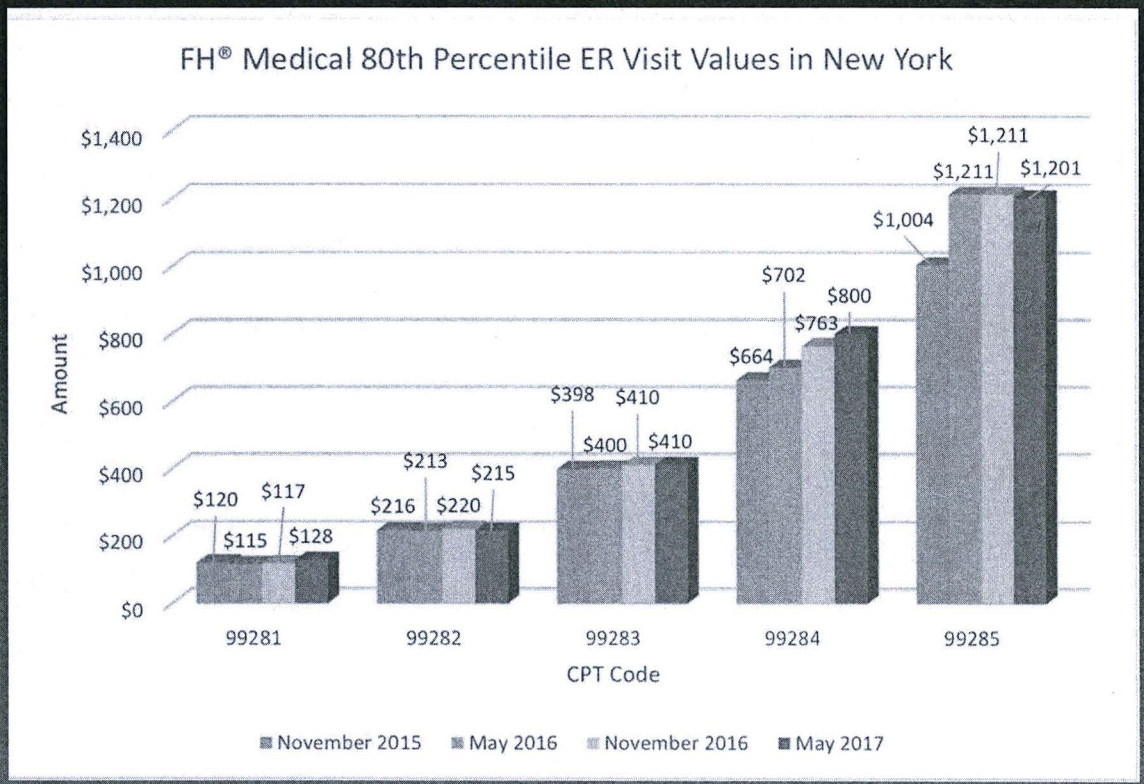


No increase in charges after then 80th in Connecticut



https://www.fairhealthconsumer.org

No increase in charges after then 80th in New York



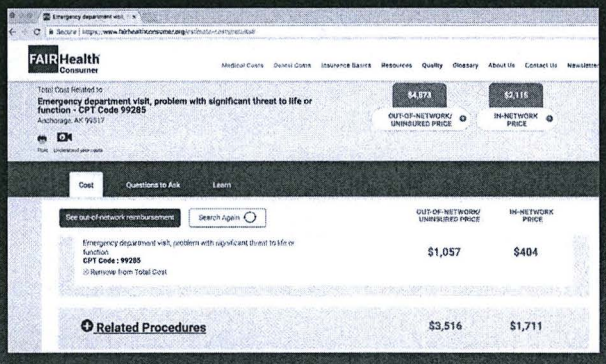
https://www.fairhealthconsumer.org

HB 193 uses 2017 National Insurance Commissioners model legation regarding out-of-net work balance billing stated as a guide :

A. For the purposes of this subsection, "usual and customary cost" shall mean the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the commissioner. The nonprofit organization shall not be affiliated with a carrier.

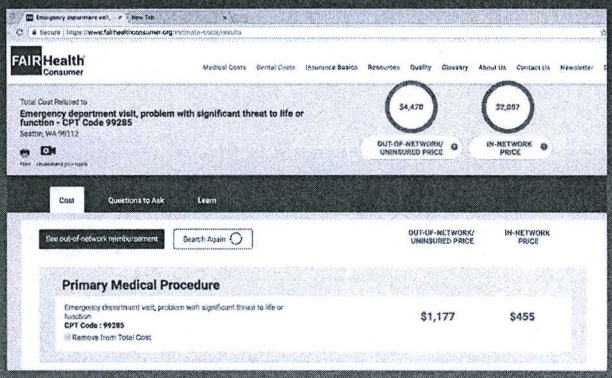
http://ncoil.org/2017/12/12/ncoil-adopts-model-act-on-out-of-network-balance-billing-transparency-model/

mergency cost are already the same or less than our neighbors



Anchorage for a
99285 code (most complex) :

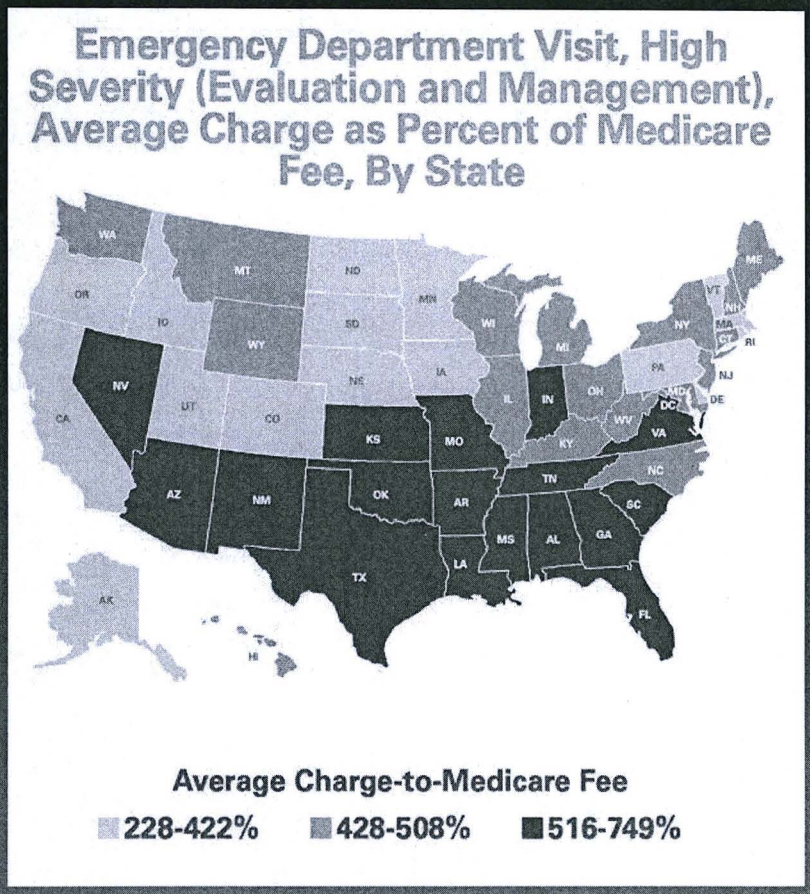
Out of Network: $1057
In network: $404



Seattle for a
99285 code (most complex) :

Out of Network: $1177
In-network $455

https://www.fairhealthconsumer.org



https://www.ahip.org/wp-content/uploads/2015/09/OON_Report_11.3.16.pdf

80th percentile is a Patient Protection Issue:

It is not about how much doctors make:

It is about who pays the bill:

The patient who has already paid for insurance

or

The insurance company

Part #2: Based on not-for-profit, independent, transparent database not controlled by industries

"The one organization that was the most enthusiastic about making these data available in a transparent manner, that also best satisfies the evaluation criteria laid out easier in this report, is also the organization that owns the most current, comprehensive and transparent database - FAIR HEALTH"

- NORC report, funded by CMS, 2014

"Health Care is Complicated"

The goal is a healthy a population at a cost we can afford

1. Geographically Relevant

2. Transparent Objective Data

3. Puts the patients health interest first

HB 193 is a compromise that will Protect Alaska Patients

- **HB 193 ends surprise bills.** HB 193 will ban balance billing for unexpected out-of-network care. There will be no more surprise medical bills for patients and physicians will be fairly reimbursed by insurers.

- **HB 193 protects patients from high costs.** Under HB 193, insurers are required to pay for unexpected out-of-network care, reducing patient financial exposure to bills their insurance companies currently refuse to pay.

- **HB 193 maintains access to care.** The bill helps ensure that patients can safely and easily access the care they need in an emergency. And, because insurance companies will compensate physicians fairly, emergency systems will be able to keep sub-specialists on call for emergency care.

After all, what good is health insurance if it fails us in an emergency?

Please support HB 193

In doing so, you support Alaska patients and the safety net to care for them when an emergency arises

America's Health Insurance Plans

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004

202.778.3200
www.ahip.org

March 16, 2018

The Honorable Representative Ivy Spohnholz
Chair, House Health and Social Services Committee
State House
Alaska State Capitol
Juneau, AK 99801-1182

Re: HB 193 – Balance Billing

Dear Representative Spohnholz,

I write today on behalf of America's Health Insurance Plans (AHIP) to express our concerns with HB 193, which takes the important step of banning balance billing by out-of-network providers but establishes a troublesome reimbursement mechanism.

AHIP is the national association whose members provide insurance coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

Health plans develop provider networks to offer consumers and employers access to affordable, high-quality care. Health plan networks have been demonstrated as an effective means of containing costs and limiting patient out-of-pocket costs. When providers contract with carriers, patients benefit. Enrollees who receive services from a facility participating in their plan's network have a reasonable expectation that their providers at that facility will also be in-network. Unfortunately, patients may still be seen by an out-of-network provider because some interactions that patients have in a facility could be with ancillary service providers (e.g. anesthesia, radiology, and pathology) who do not have a contract with the health plan to provide covered services at in-network rates. Sometimes these providers, especially emergency room providers, refuse to contract with the facilities or insurers. We appreciate the sponsor's efforts to ban surprise balance bills and share his goals to provide that important consumer protection.

AHIP previously submitted comments to the Division of Insurance, agreeing with the Alaska Health Care Commission that the Division's current reimbursement mechanism based on out-of-network providers' billed charges is increasing costs. We are concerned the methodology being proposed here may also result in difficulties for carriers to contract with providers and develop robust networks.

The rate of payment to out-of-network providers should be set at a level that does not destabilize provider contracts in the state and instead continues to encourage health plans and providers to enter into mutually beneficial contracts.

Reimbursement to out-of-network providers should not be based on a methodology that uses billed charges – instead we strongly support a reasonable reimbursement based on what the market is already paying for those services (i.e. accepted rates, contracted rates, or government payment fee schedules). Billed charges are generally higher than the amount paid to providers under negotiated health plan contracts, or Medicare or Medicaid payment rates.

A study using Alaska-specific data from FAIR Health has shown average billed charges at up to 1617.4% of Medicare reimbursement rates.[1] The Alaska data shows a general trend of much higher billed charges that the national average. We believe that this data confirms the findings of the Alaska Health Care Commission that providers with high market share are pricing their services to ensure that they are below the 80th percentile and receive payment for their full billed charge, while artificially inflating costs for consumers across the entire health care system. [2]

The proposed approach harms insurers' efforts to build strong networks, hospitals' efforts to contract with providers, and consumers by increasing their costs, since cost-sharing is a percentage of the allowed amount. When providers can be virtually assured that they will receive their full billed charge by not contracting with health plans, this type of reimbursement methodology provides no incentive for providers to join networks, restricts the ability of carriers to manage costs through contracting with providers, and encourages already-contracting providers to remove themselves from networks. Using billed charges as a reimbursement rate would also create greater challenges for hospitals working to find and contract with providers of hospital-based services who will agree to participate in the same health insurance plans' networks as the hospital. Finally, requiring reimbursement at the billed charges amount would leave consumers open to higher cost sharing and charges that they should not have to incur.

Regarding a reimbursement mechanism based on what the market is currently paying for services, we appreciate that this bill provides other possible reimbursement amounts. However, the proposed reimbursement at 350% of Medicare is higher than anywhere else in the country. The Medicare reimbursement rates are already higher in Alaska than the rest of the country, in recognition of the increased costs of care. Requiring private plans to pay over three times what the government has already establishes as a fair payment amount is untenable. We believe that a reimbursement amount that high will have the same effects as discussed above for a billed-

---

[1] *Charges Billed by Out-of-Network Providers: Implications for Affordability*. Page 13. America's Health Insurance Plans. September 2015. Available at https://www.ahip.org/wp-content/uploads/2015/09/OON_Report_11.3.16.pdf.
[2] *Findings and Recommendations 2009-2013. Alaska Health Care Commission*. Available at http://dhss.alaska.gov/ahcc/Documents/AHCC-Findings-Recommendations2009-2013.pdf.

charges based reimbursement – raising costs and destabilizing provider networks. We thus recommend that the benchmark specified should be significantly lower than the proposed 350% of the Medicare reimbursement rate.

We appreciate the opportunity to provide comments and look forward to continued discussions with you on this important issue.

Sincerely,

Sara Orrange
Regional Director, State Affairs

NFIB

The Voice of Small Business®

ALASKA

April 3, 2017

The Honorable Neal Foster, Co-Chair
House Finance Committee
Alaska State House of Representatives
State Capitol Building
Juneau, Alaska 99801-1182

RE: House Bill 193

Dear Representative Foster,

On behalf of the National Federation of Independent Business/Alaska, I wish to respectfully express our opposition to House Bill 193. NFIB, the Voice of Small Business, is the largest small-business advocacy group in the Alaska.

Health-care costs have been the No. 1 issue facing small-business owners since 1986, and those concerns are growing, according to NFIB's members. As health-care costs go through the roof, small-business owners have very few choices when selecting insurance coverage for their employees. The tipping point is here, and small businesses are begging for solutions to rising health-care costs, lack of access and other issues, not additional mandates.

For many small employers in Alaska insurance premiums for small groups or single coverage have, with the exception of this year, experienced continued jaw-dropping statistics of double-digit increases in the past few years. This is completely unsustainable over the long-term. Much of the increase is driven by the additions to coverage by state mandates.

Unfortunately, HB 193 mandates specified coverage for which small employers providing health insurance bear the cost. Increased mandates force employers to consider whether they can afford to continue coverage or are forced by increased prices to eliminate health insurance for their employees. Mandates prevent small employers from providing affordable insurance programs tailored to its specific work force.

This mandate does not specifically include the state employee programs. In fairness, if the state legislature does not believe it is a benefit important enough to mandate on its own programs, how can it be fair to mandate it on small employers and individual policy purchasers.

HB 193 is discriminatory against small employers as the mandate applies to those who provide coverage regulated by state insurance statutes, but not programs offered by the state and other governmental entities or large employers who typically offer ERISA programs or unions providing federally regulated health plans. Thus it creates a less fair business environment for small employers and a false promise to many Alaskans.

At a minimum, HB 193 should be amended to cover all public employees, including the state, the university, and municipalities.

Sincerely yours,

Dennis L. DeWitt
Alaska State Director

cc: NFIB Alaska Leadership Council
Representative Jason Grenn

aetna

March 27, 2018

The Honorable Representative Ivy Spohnholz
Chair, House Health and Social Services Committee
State House
Alaska State Capitol
Juneau, Alaska 99801-1182

RE: House Bill 193 – "An Act relating to insurance trade practices and frauds; and relating to emergency services and balance billing."

Dear Representative Spohnholz,

Aetna respectfully requests your consideration of our comments for HB 193 (insurance trade practices and frauds; and relating to emergency services and balance billing). While HB 193 works to eliminate balance billing, it continues to put the patient in the middle and creates a concerning reimbursement methodology.

This bill seeks to protect health plan members from the negative financial consequences when they unsuspectingly receive care from an out-of-network provider at an in-network facility. In this type of situation the patient may be "balance billed" by an out-of-network provider that treated the patient at an in-network facility without the patients' knowledge of the provider being a non-participating provider in their health plan network. The non-participating provider can send surprise billings to a patient who did everything correctly in preparing for their treatment, seeking an in-network facility and provider. Often the surprise billing comes from providers that provide radiology, anesthesiology, pathology, neonatology or emergency department services. HB 193 attempts to address this practice but it does not outright prohibit balancing billing.

Health plans have long opposed the practice of balance billing and we share patients' frustration with medical surprise bills. The easiest solution is for providers to contract with health plans. At the very least, the patient should not be put in the middle when providers do not contract with carriers.

HB 193 also sets up a concerning reimbursement methodology on page 2 of the bill, lines 21 to 31. Using the words "the greater of the amount" on line 22 creates a situation where it would be rare that a plan would ever pay below the 80th percentile in Alaska. The 80th percentile is traditionally well over 350% of Medicare as outlined by this bill. We would suggest that lines 25 to 29 are completely struck to eliminate the 80th percentile in this legislation. As an organization, we have advocated for the removal of the minimum 80th percentile rule as the guideline for claims reimbursement. Aetna understands that the rule was put in place to

aetna

protect consumers from excessive out-of-network bills in 2004 but now we believe the rule is having adverse effect on the market.

Increasingly, a small number of providers control a majority of the market share for medical specialties. This means that specialty care providers are often able to command up to 100% of their full billed charges since the methodology is focused on billed charges in the geographical area where services are performed. By its very nature, the 80th percentile rule means that the 80% of all providers (ranked in percentile 1-80) will receive 100% of billed charges. Unfortunately, the 80th percentile rule is driving up overall health care costs because health care providers know that incremental increases to their billed charges to just above the 80th percentile raises the overall charge profile. Overtime, the cost of health care services has dramatically increased far beyond the amount allowed by CMS.

There are many examples of claims for non-participating providers where the charges, and thus, the 80th percentile allowable are in excess of 400% of CMS and beyond CMS allowable amounts. This rule is no longer protecting the customer and the purchasers of health care from unnecessarily high health care costs. In addition to higher non-par allowable amounts, the rule has also impacted the cost of care for contracting providers. If a provider knows that they can receive 400% of the CMS allowable amount if they are a non-participating provider then the incentive for entering into a health plan contract is greatly diminished.

Many states allow claims reimbursement for out-of-network services to be based on a percentage of Medicare – however, that percent of Medicare is not 350% as the bill suggests on page 2, lines 30 to 31. While a percent of Medicare for an out-of-network service is completely acceptable as a reimbursement methodology – this percent can be based on the amount that would be paid under Medicare for emergency service, excluding any in-network copayments or coinsurance with respect to an enrollee.

Aetna would like to work with you to ensure proper patient protections are in place while also encouraging physician participation in health plan networks. To that end we believe HB 193 should be amended to include language expressly prohibiting balance billing while eliminating the 80th percentile reimbursement rule.

Thank you for the opportunity to submit our concerns about HB 193.

Sincerely,

Shannon Butler
Senior Director of Government Affairs, West Region

NFIB

The Voice of Small Business®

ALASKA

April 6, 2017

The Honorable Sam Kito, Chair
House Labor & Commerce Committee
Alaska State House of Representatives
State Capitol Building
Juneau, Alaska 99801-1182

RE: House Bill 193

Dear Representative Kito,

On behalf of the National Federation of Independent Business/Alaska, I wish to respectfully express our opposition to House Bill 193. NFIB, the Voice of Small Business, is the largest small-business advocacy group in the Alaska.

Health-care costs have been the No. 1 issue facing small-business owners since 1986, and those concerns are growing, according to NFIB's members. As health-care costs go through the roof, small-business owners have very few choices when selecting insurance coverage for their employees. The tipping point is here, and small businesses are begging for solutions to rising health-care costs, lack of access and other issues, not additional mandates.

For many small employers in Alaska insurance premiums for small groups or single coverage have, with the exception of this year, experienced continued jaw-dropping statistics of double-digit increases in the past few years. This is completely unsustainable over the long-term. Much of the increase is driven by the additions to coverage by state mandates.

Unfortunately, HB 193 mandates specified coverage for which small employers providing health insurance bear the cost. Increased mandates force employers to consider whether they can afford to continue coverage or are forced by increased prices to eliminate health insurance for their employees. Mandates prevent small employers from providing affordable insurance programs tailored to its specific work force.

HB 193 is discriminatory against small employers as the mandate applies to those who provide coverage regulated by state insurance statutes, but not programs offered by many local governmental entities, public education entities or large employers who typically offer ERISA

programs or unions providing federally regulated health plans. Thus it creates a less fair business environment for small employers and a false promise to many Alaskans.

While we oppose mandates for many reasons, we appreciate that state employees will also be covered by this mandate. However, HB 193 should be amended to cover all public employees, including the university, and municipalities.

Sincerely yours,

Dennis L. DeWitt
Alaska State Director

cc: NFIB Alaska Leadership Council
Representative Jason Grenn

House Labor and Commerce Committee — HB 193: Balance Billing
Len Sorrin — April 15, 2018

- Thank you, Chair Kito and Members of the Committee.
- For the record, I am Len Sorrin with Premera Blue Cross Blue Shield of Alaska.
- I am here today testifying **with concerns on HB 193**
- We share your commitment to ensuring that our members are not subject to balance billing or surprise billing by non-contracted providers. We understand that surprise billing imposes substantial and unexpected financial burdens on Alaskan families, many of who are already struggling.
- The challenge is to achieve that goal while moderating Alaska's health care premiums and costs, which are already among the highest in the nation. HB 193 can achieve the goal of banning balance billing, but it will exacerbate Alaska health care costs and premiums as a result of its use of the 80th percentile and 350% of Medicare as the likely rates to be paid to providers under the bill.
- The 80th percentile provision in the bill has been characterized as just one of three options in the bill. That much is true. However, the bill requires that carriers pay the highest of the three options. The 80th percentile will be the highest in the vast majority of cases. And in the rare case it is not, an even higher rate will be mandated.
- Make no mistake: the use of the 80th percentile as the highly likely mandatory choice for reimbursement will increase costs for Alaskans. Outside analyses confirm this.
- The recent study by Milliman makes clear that the 80th percentile standard has contributed to the unsustainable level of health care costs in Alaska. In 2015, the Alaska Health Care Commission recommended that Alaska "consider modifying the current usual and customary charge payment regulation to eliminate the unintended adverse pricing consequence."
- In addition to the problems presented by the use of the 80th percentile standard, the Department of Administration stated that the bill's reimbursement structure "could encourage providers to leave the networks and could result in long-term growth in the cost of services."
- Our experience reflects that concern. Let me provide you examples.

The 80th percentile regulation requires that it be updated twice a year. This creates a cost compounding impact that often exceeds the broader health care cost trend, increasing costs even further.

Premera's 80th percentile updates in 2017 resulted in UCR trends that were over 4 times higher than Premera's overall unit cost trend for 2017. That drives a real escalation in overall costs, increasing premiums and consumer out-of-pocket expenses

The guaranty of 80th percentile reimbursement for out of network care has also caused contracted rates to be far higher than they would be otherwise. Our contracted network rates in Alaska for the four hospital-based specialties are between 32% and 275% higher than in Washington as a percent of Medicare…and that is on top of Medicare rates that are already 25% higher here. Other specialties range upward of 1000% of Medicare.

- The challenge in determining fair reimbursement is to not disrupt what can be a very challenging environment for health plans to build networks in Alaska. Premera's Alaska network has grown in the last few years and continues to do so. But it's been very hard work, due in part to the attraction of the 80th percentile requirement for out-of-network care.

- That challenge can be greater when attempting to contract with hospital based emergency care, anesthesiology, radiology pathology, where members are unable unable to choose their provider. As a result, these provider types are guaranteed to see health plan members at an in-network hospital with or without a contract, and hence have less incentive than providers generally to contract with health plans.

- We want to continue our progress in building bigger and stronger networks for our members to access, offering members lower out of pocket costs.

- Reimbursing out of network care at the 80th percentile of billed charges as part of a solution to balance billing will impede that effort. While balance billing may be prohibited, Alaskans will be exposed to ever-increasing out of pocket costs as providers take advantage of the out-of-network reimbursement levels unencumbered by the risk of balance billing members. Member coinsurance costs overall will be higher when based on the 80th percentile standard than they would when based on a more market-based rate. Premiums will increase as well.

- We've proposed removing the 80th percentile with three options for reimbursement standards: the first two are the median health plan fee schedule for the specific specialty (as is in the present bill) and two different percent of Medicare options. The third option we've proposed is even simpler: it's simply the median contracted fee schedule.

- It's hard to come up with a better indicator of the actual health care market than one based on the median fee schedule to which providers and health plans have agreed. Markets are defined by a price or term to which parties agree.

- This is an opportunity for a balance billing solution for Alaskans to actually reflect the market in Alaska and maintain broad and affordable network access for Alaskans.

- We would also like to share with the committee concerns unrelated to the reimbursement methodology.

- First, we have suggested an amendment to the "hold harmless" section. The provision currently requires an insurer to "hold harmless" or ensure that a member does not incur costs in excess of what they owe for the in-network benefit under the bill. Premera will of course pay claims under the bill at the in-network benefit level and the member's responsibility under their contract with us will be limited to that amount. However, we have no ability to control whether a non-contracted provider will bill a member in excess of the amounts allowed under the bill. We would request that the provision be amended to reflect that reality.

- Second, we agree with the Department of Administration that the bill's intent is to apply to services rendered during emergency care. We also agree with their concern that the bill actually reaches far beyond those services. Separate from emergency services and emergency medical conditions, the bill's terms extend to any non-network provider who provides "services at an in-network hospital or ambulatory surgical center." That would apply to literally any service provided by an out-of-network provider at an in-network facility…for example a surgical service of any kind.

- This will result in a prohibition of balance billing far broader than intended and will also mandate the higher in-network benefit level required under the bill even for consumers who choose to see an out-of-network provider. **A prohibition on balance or surprise billing should protect consumers who are unable to choose a network provider and not those who are free to do so**.

- To resolve this, we suggest that "in-network hospital" and "in-network ambulatory surgical center" be linked only to "emergency services" and the treatment of an "emergency medical condition" to resolve any ambiguity on the reach of the bill.

- The bill also provides balance billing protection to any patient who has not consented in writing to balance billing when being referred to an out-of-network provider. Insurers have no way to know whether or not a referring physician was involved at some point, or whether a patient agreed in writing to be responsible for the additional costs of out-of-network care.

As a result, paying that claim correctly is difficult if not impossible. It would also be exceedingly rare for a referral to be involved in emergency care.

- Finally, the bill in any form will require changes to claims systems, changes to member benefit structures and a range of member and other communications. In addition, product and rate filings for 2019 will commence very shortly. In order to ensure that implementation is thorough, and that the impacts of the bill to all of these processes is well understood, we request an effective date of plans filed or renewed on or after January 1, 2019.

- Thank you. I would be happy to respond to any questions you might have.

American College of Emergency Physicians®

ALASKA CHAPTER

ADVANCING EMERGENCY CARE

April 19, 2018

Rep. Sam Kito
Chair
House Labor and Commerce Committee
Room 403 Capitol Bldg.
Juneau, AK, 99801

Re: HB193 support

Dear Representative Sam Kito:

We are writing today on behalf of the Alaska Chapter of the American College of Emergency Physicians to follow up on invited testimony Anne Zink, MD, Alaska ACEP Past President, made regarding HB193. Dr. Zink very clearly represented our views in her oral testimony April 15 and we thank you for inviting her and taking the time to listen to her statements. We are dismayed, however, by the misleading testimony we heard from parties opposed to HB193, and write now to clarify for the record some of the statements we heard that were alarming and, we believe, misleading.

We are Alaskans

You might wonder why Alaskan emergency doctors are so passionate about this subject. We live in Alaska. We are part of this community and the lives that we care for are those of our families, our friends, and our community members. In our emergency rooms across the State we are the ones that care for patients that have no insurance, inadequate access to care because they have poorly reimbursed government sponsored Medicaid and Medicare, or have insurance, but have unaffordable coinsurance and deductibles.

The testimony and letters you received from insurance carriers are misleading

Len Sorrin spoke in generalities that do not reflect our Alaska market, and we want to make sure you have accurate information that reflects the local context in Alaska. He stated that if you were cared for in an emergency "almost certainly your surgeon is in-network." He

also said that hospitalists, internal medicine or primary care doctors working in the hospital, are employees of hospitals. These statements are not true for Alaska. In Alaska, most hospitalists are not employees of hospitals. Instead, they are contracted groups just like other physician groups and specialists. At the same time, in Alaska, surgeons contract with insurance companies just like all other specialists and not all surgeons will be in your insurance network. While many Anchorage orthopedists recently joined the Premera network, there are some surgical specialties that have very thin network coverage in Alaska. Providers may also be in-network for one insurance provider but out-of-network for another.

These clarifications are important because HB 193 directly relates to these providers when they are not in-network. Mr. Sorrin's statements, if left uncorrected, could lead you to underestimate the extent of the problem patients face with unexpected out of network care.

We are talking about *Emergency Services*

Len Sorrin said that when you see a doctor in an office you typically provide your insurance card and the physician's office will tell you whether they are in your network or not. This statement is not relevant to emergency care. When patients have emergencies we do not ask what insurance company they use prior to providing care, nor do patients ask if we are in-network. When someone is having an emergency they are cared for, and that is our responsibility through EMTALA. Typically, there is one specialist per sub-specialty on call per day, and there is not necessarily a specialist on call for each person's specific insurance plan. Finding specialists to take call is an extremely difficult burden to our system. In an emergency room there is absolutely no time to sort out who is in-network at the time of care.

For some specialties there is often one specialist on call in the entire State of Alaska. There are times when no doctors are on call at all for the entire state in certain specialties. Examples are Cardiothoracic surgery, Orthopedic Hand specialists, and Oral Maxillofacial surgery. There are simply too few of these specialists in our state to have someone on call every day.

The example of asking the anesthesiologist if they are in-network before the surgery starts is a great one. It's an important question, but when you need an emergency surgery even if the answer is "not in-network" you will need to proceed with the surgery. The anesthesiologist is the only one in the hospital covering emergencies. That is why HB193 is needed.

HB 193 does not drive doctors out of network

It was also said at the hearing that providers "will be driven out of network to get a better reimbursement rate." This is completely inaccurate in two ways.

1. We have the 80th percentile rule in place presently and provider networks are growing, not shrinking. As an example, just a few years ago there were no orthopedists in-network for orthopedics in Anchorage. Now, almost all the orthopedists are in-network. This legislation does not change the 80th percentile rule that we have in place; it merely

places a ban on balance billing. If providers were going to leave their in-network status because of the 80th percentile rule, they would have already done so.

2. This bill is for emergency services only. This bill eliminates balance billing when patients have emergencies and cannot control who their providers will be. In our previous testimony, we have shown that with the 80th percentile rule in place, emergency care charges in this state are consistent with the Seattle area for both in and out-of-network, as shown with FAIR Health. The care that we worry will generate balance billing is specialty care. Emergency care for specialists is an ethical and community responsibility, but it's certainly not a money maker. No one wants to be woken up at 3 a.m. to take an emergency to the operating room. No one wants to work holidays and weekends away from their families. This care is not what keeps doctors' offices open. Specialists are never going to leave networks so that they can get paid more for the 3 a.m. emergency. There aren't enough emergency cases for this to be a profitable strategy, and HB193 will not change this.

Inaccuracies regarding 80th percentile

We also heard testimony that Premera fears the use of the 80th percentile will exacerbate healthcare costs and premiums. This statement completely ignores that we have had the 80th percentile in place in this State since 2004. This bill changes nothing about reimbursement and merely ends the surprise coverage gap when patients are surprised that insurance companies are not covering their care. This bill does not change costs at all; it just prevents patients from getting unexpected bills for emergency charges that exceed the 80th percentile.

We heard testimony that referred to a "recent study by Milliman." There have been multiple Milliman studies, but none were recent (2011 and 2014) and none were done to investigate the 80th percentile rule's effect on Alaska's healthcare market. None looked at the effect of balance billing on the healthcare market. None were focused on emergency services. They all have been based on old data and not our current situation. Extrapolating these statements from reports that were not intended to answer this question is invalid and inappropriate.

Reducing costs

The goal of reducing costs for Alaska healthcare is important and is not addressed by this bill. The 80th percentile rule has been pointed to by insurance companies as the reason for high healthcare costs in this state. But we suffer the same ills of the whole country. The top five locations of health spending per capita in our country are: Washington DC ($11,944), Alaska ($11,064), Massachusetts ($10,559), Delaware ($10,254) and Vermont ($10,190). What has pushed these States to costs greater than $10,000? It's certainly not the 80th percentile rule. We should be looking at what is driving costs for the country and identify what we can change in Alaska.

A March 2018 study in JAMA by Papanicolas "Health Care Spending in the United States and Other High-Income Countries" is a great tool that can be used to help drive our policies in

Alaska. The study found that the driver of costs was not physician salaries; it was #1 high pharmaceutical costs, #2 high margin, high volume procedures, #3 high utilization of CT and MRI imaging, and #4 high administrative costs. It is not surprising that specialists in our State are taking heat that they are driving up healthcare costs. The mistake is pointing to the 80th percentile rule as the problem. The problem is the kind of healthcare our country has decided to provide, and utilization of procedures and imaging will not be changed by banning balance billing.

The goal is to protect patients

Alaska patients and families need full protection from surprise bills. This bill will strengthen the healthcare system, offering protection first and foremost to patients, and ensuring the doctors and emergency rooms can keep their doors open and keep staffed with needed specialists and providers to best treat patients in emergencies.

We hope we can count on your support for HB 193.

Thank you for your consideration.

Sincerely,
Alaska ACEP Board of Directors

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Surprise Medical Bills

Karen Pollitz (https://www.kff.org/person/karen-pollitz/)

Published: Mar 17, 2016

A Kaiser Family Foundation survey (http://kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-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 b 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 negotiat fee schedules, or allowed charges, with network providers that reflect a discount from providers' full charges. Network contracts also typically prohibit providers from billing patient 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 (http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12007/abstract) 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 (http://www.statecoverage.org/files/NY-Unexpected_Medical_Bills-march_7_2012.pdf) 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 (http://forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf) of data reportec 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 proposed changes (http://www.gpo.gov/fdsys/pkg/FR-2015-12-02/pdf/2015-29884.pdf) to address surprise medical bills for non-emergency services for individuals covered by qualified health plans offered through the Marketplace. Proposed standards would apply when an enrollee receives care for essential health benefits from an out-of-network provider in an otherwise in-network setting (for example, anesthesia care for surgery performed in an in-network hospital.) 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. The proposed rule would waive this requirement whenever plans notify enrollees in writing at least 10 days in advance (for example, as part of a plan pre-authorization process) that such surprise medical bills might arise. The proposed rule indicates that CMS may consider an alternative under which all out-of-network cost sharing for surprise medical bills would count toward the in-network OOP limit, regardless of whether the plan provides advance notification, but notes the agency is "wary of the impact of such a policy on premiums." The proposal would not apply to balance billing charges arising from surprise medical bills. In addition, the proposal would seem to not affect enrollees of HMO or EPO plans that do not cover non-emergency out-of-network services at all. Such plans comprise 73% (http://avalere.com/expertise/managed-care/insights/fewer-ppos-offered-on-exchanges-in-2016) 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 (http://kff.org/medicare/issue-brief/paying-a-visit-to-the-doctor-current-financial-protections-for-medicare-patients-when-receiving-physician-services/) 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 (http://kff.org/report-section/comparison-of-consumer-protections-in-three-health-insurance-markets-comparison-of-specific-areas-of-consumer-protections/) 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 (http://www.dfs.ny.gov/consumer/hprotection.htm) 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 (http://www.naic.org/store/free/MDL-74.pdf) 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 (http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf72891) 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.

Endnotes

1. Another Kaiser Family Foundation report (http://kff.org/private-insurance/report/medical-debt-among-people-with-health-insurance/) 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.
   ← Return to text (https://www.kff.org/private-insurance/issue-brief/surprise-medical-bills/#endnote_link_173415-1)

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.
   ← Return to text (https://www.kff.org/private-insurance/issue-brief/surprise-medical-bills/#endnote_link_173415-2)

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.
   ← Return to text (https://www.kff.org/private-insurance/issue-brief/surprise-medical-bills/#endnote_link_173415-3)

4. See also Hoadley, Ahn, and Lucia (http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf420966), "Balance Billing: How are States Protecting Consumers from Unexpected Charges?" September 2015.
   ← Return to text (https://www.kff.org/private-insurance/issue-brief/surprise-medical-bills/#endnote_link_173415-4)

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

Christina Cousart

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

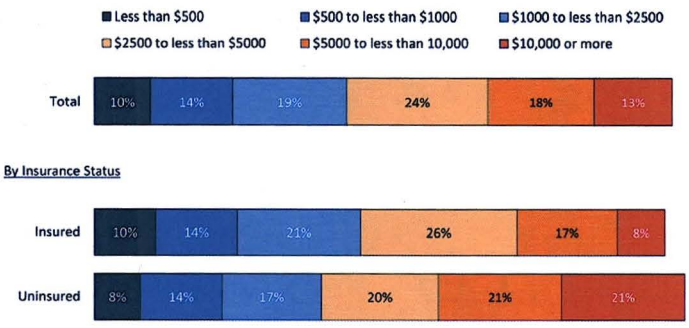
The issue is especially complicated as recent fluxes in the health care industry - triggered by growth and shifts in coverage - are occurring in tandem with experimentation by providers and insurers to reduce costs. As the industry stabilizes, it is yet to be seen what methods of controlling costs may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

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

Figure 1

People Report Problems Paying Medical Bills of Varying Dollar Amounts

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



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

KAISER FAMILY FOUNDATION

The Rise of Surprise Billing

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

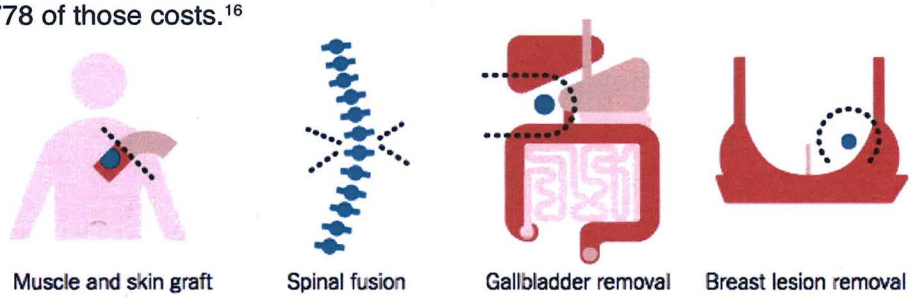
Surprise balance billing is a growing trend in the U.S, with a 2015 Consumers Union poll finding that nearly one-third of privately insured Americans have received a surprise medical bill within the past two years.[4] In 2014, the New York Department of Financial Services named it as a top complaint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

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

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

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

Figure 2



	Muscle and skin graft	Spinal fusion	Gallbladder removal	Breast lesion removal
Potential out-of-network doctor bill	$150,500	$115,625	$44,000	$18,500
Average paid to in-network doctors	$1,781	$5,893	$1,892	$688

Sources: America's Health Insurance Plans; Healthcare Bluebook

Illustrations by Jennifer Daniel/The New York Times

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

Federal Activity Around Surprise Billing

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

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

Box 1. Federal Legislation Addressing Balanced Billing

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

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

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

State Actions to Address Surprise Billing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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Balance Bill (n): An unexpected bill sent by a hospital, doctor, or clinic for an amount beyond that paid by the patient's insurance.

Balance Billing: How Are States Protecting Consumers from Unexpected Charges?

How seven states—California, Colorado, Florida, Maryland, New Mexico, New York, and Texas—have approached protecting consumers from certain types of balance billing.

By Jack Hoadley, Sandy Ahn, and Kevin Lucia

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The Center on Health Insurance Reforms (CHIR), based at Georgetown University's McCourt School of Public Policy, is composed of a team of nationally recognized experts on private health insurance and health reform. We work regularly with a multidisciplinary group of faculty and staff dedicated to conducting research on issues related to health policy and health services.

CHIR faculty and staff study health insurance underwriting, marketing and products, as well as the complex and developing relationship between state and federal rules governing the health insurance marketplace. CHIR provides policy expertise and technical assistance to federal and state policy-makers, regulators and stakeholders seeking a reformed and sustainable insurance marketplace in which all consumers have access to affordable and adequate coverage.

Introduction

Large bills from an out-of-network health care provider can be an unexpected surprise to consumers who did not knowingly decide to obtain health care outside the plan's provider network. As health plans embrace tighter networks as a tool for improving quality or reducing premiums, the potential for such bills may grow. Although insurers may protect their plan members in some cases, there is no broad protection from these types of bills in federal law or in most states. Several states have acted to protect consumers from the need to pay balance bills, at least in emergency situations. New York started implementation of expanded protections in April, providing a test of what may be the most comprehensive state approach to date. But even these states have struggled with how to implement protections while balancing legitimate interests of health plans and health care providers. This issue brief summarizes and compares seven state approaches to protecting consumers from balance billing.

What is a Balance Bill?

Americans purchase health insurance to protect themselves against the cost of care for a significant illness or health condition. In doing so, they hope to protect themselves against large and unaffordable bills from health care providers. Yet even with insurance, some consumers face bills for the difference between an insurer's payment to the provider and the provider's charges, often referred to as balance bills or surprise bills.[1] These bills occur most often when consumers receive covered services from out-of-network providers.[2] Large balance bills are often stressful for consumers and are a significant source of medical debt.[3]

Most health insurance plans for working-age Americans today involve a provider network.[4] Networks can take the form of a closed network in many health maintenance organizations (HMOs) or exclusive provider organizations (EPOs), in which the plan normally pays only for care delivered by a network provider. Under an open network, such as a preferred provider organization (PPO) or other point-of-service plans, the plan typically covers out-of-network care, but imposes higher cost sharing or a higher deductible when using out-of-network providers. PPOs are the most common insurance choice, at least for those with employer-based coverage.[5] Some consumers elect to enroll in plans with more restricted networks, most often when these plans are available at lower premiums. For other consumers, especially those who value their existing relationships with providers, easier access to providers outside the network may be preferable.

Typically, when a consumer uses a network provider, the consumer is held harmless; in other words, the consumer does not have to pay the difference between the insurer's coverage and the provider's billed charges. This assurance is based on the network contract between the plan and the provider and on state laws regulating these relationships. But when a consumer uses a non-network provider, there is often no contractual relationship to prevent the provider from balance billing the consumer regardless of whether the health plan makes no payment (e.g., closed-network HMO) or partial payment (e.g., open-network PPO).

Provider networks involve a set of agreements among the plan, the health care provider, and the plan enrollee. Network providers agree to accept a payment rate that may be less than they would charge on the open market, but in return they expect to get a higher share of business from the plan's enrollees. The plan selects providers based on providers' willingness to accept these lower rates, the plan's need to have adequate providers to serve their policyholders, and the goal of maintaining high-quality care. Consumers, in selecting a plan, may consider the tradeoffs between broader networks and lower premiums. But in selecting a plan, they should understand the financial consequences of obtaining care outside the network. Network negotiations and thus the ultimate costs—premiums and other cost sharing—borne by plan enrollees are influenced by factors such as the market concentration of providers and health plans.

Scenarios for Balance Billing

Consumers receive care from non-network providers in a variety of scenarios. Depending on the scenario, the legal and financial consequences differ.

- *Scenario 1: Informed Use of Non-Network Providers.* In the simplest and probably most common scenario, the consumer makes a voluntary, informed decision to go out of network for a particular service. For example, he or she may want to receive a surgical procedure from a particular surgeon who does not participate in the plan's network. The consumer is aware that he or she will be responsible either for the entire bill (if enrolled in a closed-network plan) or will pay both higher cost sharing and a balance bill for the amount by which the provider's charge exceeds the health plan's payment for out-of-network care.
- *Scenario 2: Emergency Settings.* In this scenario, the consumer has some type of medical emergency and is taken to a hospital for emergency care.[6] Even if the consumer makes sure to go to a network hospital, there is no certainty that the emergency department (ED) is staffed by network providers. In these situations, the consumer has little or no ability to choose a network or non-network provider. Most consumers probably assume that the network hospital is staffed by network physicians and other health professionals. In reality, this is not always the case. Data are not widely available to track how often these situations arise. But a recent study of networks for the three largest insurers in Texas found that at least one of five in-network hospitals had no in-network emergency department physicians (for one of these insurers, over half of the network hospitals had no in-network ED physicians).[7] In some emergency situations in which the consumer is treated by a non-network provider, the health plan may agree to reimburse the provider at a certain level, but a provider can balance bill the consumer for any additional charges since there is no contractual obligation to accept the health plan's payment as payment in full.
- *Scenario 3: Surprise Billing Situations in a Network Hospital.* Beyond the emergency context, consumers may still find themselves in scenarios in which they are treated unexpectedly by a non-network provider. One common situation occurs when the consumer makes sure to identify an in-network hospital and providers to perform a procedure or service, but still encounters non-network providers in other roles. This could occur when a woman arranges to have her baby delivered by a network obstetrician and hospital, but the anesthesiologist is not part of her health plan's network. Or it could occur when an individual arranges for knee replacement surgery with a network surgeon but the assistant surgeon or surgical assistant helping with the surgery and the radiologist performing the MRI are not in network. Another scenario arises following an emergency department encounter when the patient is stabilized and no longer in emergency care. Follow-up care during the hospital stay may be provided by an out-of-network cardiologist, infectious disease specialist, or physical therapist. The non-network providers in these situations can bill the patient, and there is no guarantee how much the insurer will pay (if at all) for coverage for these types of "surprise bills."
- *Scenario 4: Consultations or Services Outside the Network.* While the above scenarios are the most common, situations may also arise in which the consumer needs a consultation with or services from a specialist not in a health plan's network. This could occur when there are gaps in the plan's network or when network directories are inaccurate. In theory, this situation allows all parties involved more time to identify the possibility of an uncovered charge than in emergency or surprise bill scenarios.

There are few sources of data that document how frequently these situations occur, although a study of 2004 claims data found that out-of-network care represented 10 percent to 13 percent of charges in PPOs or similar plans.[8] According to a survey-based analysis conducted in 2011, 8 percent of consumers used an out-of-network physician, most frequently in the emergency department. About 40 percent of those consumers (3 percent of the overall sample) went out of network involuntarily at least once over a 12-month period—more frequently in inpatient or ED settings.[9] Decisions by health plans to offer narrower networks could increase the potential for balance billing.[10]

Protecting Consumers

Federal law does not currently protect consumers from balance billing or surprise billing in these scenarios. The Affordable Care Act (ACA) only guarantees that the health plan must provide coverage for emergency services even if the providers are out of network (Scenario 2).[11] Specifically, the plan must pay these out-of-network providers the greatest of the plan's median payment amount for in-network providers, a payment based on the methods the plan generally uses to determine payments for other out-of-network services (e.g., a percentage of usual and customary fees), or the amount that Medicare would pay for the service.[12] When providers are paid adequately, they are less likely to balance bill. But some providers may not consider these amounts adequate, and the ACA neither prohibits balance billing nor requires the plan to hold the consumer harmless. Furthermore, ACA rules do not apply to situations in which a consumer unknowingly receives care from an out-of-network provider (Scenario 3) or in which in-network providers are unavailable (Scenario 4).

States take various approaches to protecting consumers from balance billing. Nearly all states require HMO contracts to hold consumers harmless when they go to in-network providers; a smaller share apply the same protections for PPOs.[13] Thus providers participating in a health plan's network are obligated under their contracts with insurers to hold consumers harmless by forgoing balance bills.

Although most states have no provisions that address billing for care received from out-of-network providers, about one-fourth of states have elected to protect consumers against bills from non-network providers in at least some circumstances.[14] Some of these state laws have a very narrow scope (e.g., one law applies only to ambulance services). Most state laws apply to emergency services received from non-network providers (Scenario 2) and less frequently in surprise billing situations (Scenario 3). Some states have limited these protections to a subset of insurance products; for example, more states apply protections to HMOs than to PPOs.[15]

Under federal law, employer-sponsored plans that are self-funded by the employer are generally exempt from state regulation.[16] Thus, consumers with self-funded employer health plans must use network providers to avoid receiving balance bills. In practice, employer-sponsored plans may elect to take a similar approach as that offered by some states and protect policyholders from some balance bills.

What Should Consumers Do To Prevent Unexpected Charges?

- When possible, use provider directories and other plan-provided information to locate in-network providers.
- When possible, ask providers whether they are in the plan's network. If providers are not in network, ask whether they will accept the plan's payment as payment in full.
- In cases where a provider sends a balance bill, review the health plan's explanation of benefits and any notices about consumer rights.
- Before paying a balance bill, contact both the health plan and the provider. Ask whether the plan is willing to pay the bill. If not, ask whether the provider will accept a lesser amount.
- Contact the state insurance department to see if any remedy is available under the state's laws.

In the absence of legal protections, consumers do not always face balance bills. Even if the plan design is a closed network, a plan may elect to provide coverage for selected services delivered by non-network providers. As noted above, health plan contracts may protect members who receive emergency services or when the network cannot meet a particular need. Plans may seek to negotiate a rate with providers in these situations, but often pay the full billed charges to ensure that their members are "kept out of the middle" and protected from a balance bill.[17] These situations could be limited to requests by members or their providers, but in some cases plans may elect to use their discretion more broadly.

Alternatively, some providers elect to write off the unpaid amounts after insurers make a payment, either by not sending a balance bill or not making active efforts to collect payment from the patient. Providers may do so to preserve a good doctor-patient relationship. Some hospitals have sought to make sure that facility-based

physicians participate in the same networks that include the hospital. But narrower networks have made this more difficult, especially when excluded providers respond with high charges. For example, United Healthcare in Missouri recently decided to stop paying the full charges of non-network emergency department physicians.[18]

Purpose of Study and Methodology

To protect consumers from balance billing, some states focus narrowly on making consumers aware of the potential financial consequences when going out of network. Other states focus on removing the consumer from payment disputes by regulating the amount of payments from the insurer to the out-of-network provider.

In an effort to determine how states are protecting consumers from balance billing, we analyzed the legal framework in seven states: California, Colorado, Florida, Maryland, New Mexico, New York, and Texas. We chose these states because they represent a range of state approaches to balance billing protections. In addition to analyzing state laws, we conducted 19 interviews with state regulators, insurers, providers, and consumer advocates from our study states to gain a comprehensive understanding of how state laws are affecting consumers' experiences with surprise bills.

Specific Elements of Consumer Protection

Four key elements are highlighted in state approaches to protecting consumers from balance billing. The states in this study use a variety of these elements in different combinations, as described in the next section.

Disclosure and Transparency. Several states have taken steps to help make consumers aware that they may face balance bills in situations where they are unable to use network providers in emergencies (Scenario 2) or encounter out-of-network providers as part of a care team when they use network providers (Scenario 3). It is the standard in many states to require insurers to have language in notices and plan summaries about the financial consequences of going out of network. Some states go beyond that to require notices to consumers at the point of service describing the potential for seeing a non-network provider and receiving a balance bill. Other state provisions are aimed more broadly at bringing greater transparency to networks and medical bills by providing consumers with information on the composition of the plan's network, such as accurate provider directories. In addition, some states seek to make public specific information on the cost of using a non-network provider and summary information on how often network hospitals have non-network providers delivering care (e.g., non-network emergency physicians in a network hospital).

Balance Billing Prohibitions. Several states protect consumers more directly by prohibiting non-network providers from billing patients, beyond any allowed cost sharing, in certain situations. States are more likely to address the emergency setting (Scenario 2), but some states have also sought to address surprise billing (Scenario 3). In some states, the ban applies only if the non-network provider accepts payment for the claim directly from the insurer based on an assignment of benefits. Assignment of a claim means that the consumer transfers the right to reimbursement to the provider, who becomes entitled to direct payment from the insurer (even though there is no network relationship between the plan and provider). In states taking this approach, providers agree to accept the plan's payment as payment in full, and the consumer is liable only for applicable cost sharing. Physician groups often advocate for assignment in these situations, since it is easier to collect payments from insurers than from patients.

Hold Harmless Provisions. An alternative to a ban on balance billing is to require that insurers hold plan members harmless by paying providers their billed charges (or some lower amount that is acceptable to the provider) in situations such as emergency care. From the consumer's perspective, either a ban on balance billing or a hold harmless rule yields the same result, although practical matters may complicate the effectiveness of

both approaches. For example, hold harmless rules could require the consumer to be aware of their ability to pass the bill to the insurer rather than pay the billed amount. Also, the costs incurred by insurers will eventually be passed to consumers through higher premiums.

Adequate Payment. Although both balance billing prohibitions and hold harmless provisions achieve the goal of protecting the consumer, they may leave health plans and providers in conflict over the question of adequate payment. Some states have specific rules to set payment rates for these situations, for example requiring that insurers pay non-network providers at the usual and customary rates they pay to network providers. Other states, instead of setting a specific rate, refer providers and insurers to an independent mediation or dispute resolution process to settle on a fair rate of payment. These mechanisms help to protect consumers because they allow both providers and health plans to know what they will pay or be paid, which in turn helps to address the conflicts over payment.

How States Use Elements of Consumer Protection

California takes a direct approach to protect consumers by prohibiting physicians from balance billing in emergency cases (Scenario 2). The policy, established by the Department of Managed Health Care (DMHC), treats all emergency department services as in network and applies only to plans under the jurisdiction of the DMHC, not the Department of Insurance.[19] Generally HMOs and PPOs fall under DMHC jurisdiction, representing most of the market.[20, 21]

As part of the rules, California requires that plans pay providers a "reasonable and customary" payment rate. It goes beyond "usual and customary" in that payment must be based on "statistically credible information that is updated at least annually" and must take into account factors such as the provider's training and experience, the nature of the service provided, and fees usually charged by a provider.[22] As one stakeholder reports, the provider and the plan "have to work it out," but "no one thinks the standard is completely clear." If providers are unhappy with the plan's payment, they can use the state's voluntary, non-binding independent dispute resolution process (IDRP).[23] Although disputes between plans and providers are common, respondents indicate that use of this voluntary process is limited.[24]

California has no disclosure requirements beyond the standard information required at the point of service regarding the use of out-of-network providers. In the view of one stakeholder, disclosure may be valuable in principle, but it does not provide the type of consumer protection achieved by a state's prohibition on balance billing.

Colorado takes a policy approach that differs from that used in California. The state treats covered services by non-network providers at a network facility as if they are in network and requires health plans to hold their members harmless in both emergency and surprise billing situations (Scenarios 2 and 3) when patients are treated in network facilities, as well as for referrals when the plan's network is deemed inadequate (Scenario 4).[25]

The Colorado approach thus puts the burden on health plans to pay the provider's billed charge or some other amount that is agreeable to the provider. Nevertheless, one insurer reports that the consumer protections are working well, although acknowledging that health plans typically must pay the provider's full billed charges and rarely are able to negotiate rates. Another stakeholder suggests there is a gap in the protections for consumers with high-deductible health plans, in which the plan cannot pay if the member has not met the deductible.[26] In these situations, the member must challenge the provider on the amount billed in order to avoid paying full billed charges.

Florida has a statute that takes the same general approach as California by prohibiting balance billing for emergency services (Scenario 2), but only for HMO products. In these situations, plans are required to pay the lesser of the provider's charges, the usual and customary charges for similar services in the community, or a charge mutually agreed to by the plan and the provider.[27] Florida also prohibits out-of-network providers from balance billing HMO patients for covered services that are authorized by the HMO.[28] Regulators interpret the statute as prohibiting balance billing for any ancillary services provided to a patient in an in-network hospital if admitted by an in-network physician, including services by non-network providers.

If disputes arise, the state has an independent dispute resolutions (IDR) process administered by a third party.[29] The IDR process is rarely used, in part because providers perceive that decisions tend to favor insurers or because providers would have to pay for the cost of the IDR if they are unsuccessful.

Maryland protections originally applied only to consumers enrolled in HMOs, and some balance billing protections were expanded in 2010 to PPO enrollees. Maryland prohibits providers from balance billing HMO consumers for covered services including but not limited to emergency services (Scenarios 2 and 3). HMOs must hold consumers harmless for covered services provided by out-of-network providers and pay at prescribed rates; for example, provider rates for emergency services are based on Medicare reimbursement rates.[30] The PPO law grants the protection against balance billing to patients who assign benefits to their physicians.[31] For physicians who are not hospital-based or on-call, however, the prohibition on balance billing applies only if the patient assigns benefits to the physician and the out-of-network physician fails to disclose certain information to consumers prior to providing health care services, including an estimate of the cost of services and a statement that the physician can balance bill for covered services.[32]

Stakeholders generally believe that the state's laws are working well for consumers, and a 2015 report by the Maryland Health Care Commission on the extension to PPOs concluded that "the law, generally, achieved its intended purpose."[33] One stakeholder characterizes the PPO law this way: "We are still seeing balance billing occur, but it's not as prevalent as it used to be." There are gaps, however. Several stakeholders note that there is currently no balance billing protection for costly air ambulance services and for services of non-physician providers (e.g., hospital-based surgical assistants).

Maryland's approach is distinctive in two respects. First, it does not incorporate a dispute resolution process. Second, Maryland has specific requirements for payment levels that must be met by health plans for different types of health services and different types of physicians.[34] For example, for services other than evaluation and management, an HMO must pay at least 125 percent of the average rate it paid during the previous calendar year.[35] A PPO must pay 140 percent of the average rate paid the previous year or the average rate paid in 2010 to an on-call physician.[36]

New Mexico was included in this study to illustrate what happens in a state that has no specific state legislation to address balance billing by out-of-network providers. Because we focused on a single state in this situation, we cannot say whether it is representative of other states without legislation. A stakeholder in New Mexico reports that the state has relatively few providers, and so health plans tend to have contracts with most providers in the state. As a result, legislation to protect consumers from balance billing situations has not been necessary because balance billing occurs infrequently. One stakeholder notes that at least one health plan often holds their members harmless when non-network providers are used, despite the absence of any requirement to do so. This includes paying the full-billed charges to protect their members if they cannot work out a lower payment with the provider. If the providers in these situations are unwilling to negotiate, the health plan apparently chooses to pay full billed charges to protect their members.

New York is the only state to combine various elements of consumer protection for Scenarios 2 and 3, including disclosure, transparency, and a process to resolve payment disputes. The new law, enacted in April 2014, went into effect starting April 1, 2015 for any new insurance contract or contracts renewed after March 31, 2015.[37] The law builds on some existing protections that applied to HMOs but not to other insured products. The stakeholders we interviewed generally agree with the principles enshrined in the law, and since enactment, the state has consulted closely with stakeholders to work through implementation details and guidance.

Under the new law, the state bans balance billing by providers in emergency situations. It extends that protection to surprise billing and other situations, as long as the consumer assigns the provider's claim to the insurer.[38] Thus, in surprise billing situations where assignment is in place, no balance bill can be charged to the consumer. The link to assignment may have helped garner support from physician groups, because it makes it easier for them to collect payments.

New York requires plans to establish a reasonable payment amount, and plans must disclose their methodology and how it compares to usual and customary rates, which are defined as the 80th percentile of the amounts made available by Fair Health, an independent entity created in 2009 to maintain a database of charges for medical procedures.[39] If the provider is not satisfied with the amount paid, the state has created an independent dispute resolution process. The IDR process uses licensed physicians in active practice; they can choose either the provider's original billed charge or the plan's original

payment—as opposed to any amount in the middle. In making a decision, the IDR must consider the patient's characteristics, the doctor's training and experience, and the usual and customary rate based on the Fair Health data. As an alternative, the parties can negotiate a settlement on their own and notify the IDR. The IDR can also direct the parties to negotiate a settlement.[40] The IDR system is designed to create incentives for providers and plans to set their charges and payments at more reasonable levels. Stakeholders express cautious optimism for the IDR process, although they will wait for some actual experience with the process before making any final assessments. Some issues remain. One insurer is concerned that physicians could distort the Fair Health data by increasing their charges, while a physician stakeholder worries that the IDR could be complex for smaller physician practices to navigate successfully.

In the new law, New York includes a more extensive set of disclosure requirements for health plans, hospitals, physicians, and other providers.[41] The goal is to make it easier for consumers to look at out-of-network benefits when doing comparison shopping prior to selecting a plan and to understand the potential charges prior to using services from an out-of-network provider. One stakeholder describes the new rules as: "Each party will be responsible for disclosing the information about which it has knowledge." For example, plans are required to maintain accurate and regularly updated provider directories, provide clear statements of how bills are calculated, and provide examples of out-of-pocket costs for frequently billed services.[42] Hospitals are required to provide lists of their standard charges, the insurance plans with which they participate, and whether their employed or contracted physician groups participate in these insurance plans.[43] Physicians are required to make available their participation status with health plans and their "reasonably anticipated charges" (on request).[44] Also, if a doctor is scheduling a hospital service and that particular doctor knows who else is going to be providing additional services or "be in the room," he or she must disclose whether those doctors participate with the patient's insurance.[45]

Texas provides varying protections for each of three product types. For HMOs, regulators interpret the law to hold consumers harmless for emergency services (Scenario 2) and when medically necessary covered services are not reasonably available from in-network providers, including some situations in Scenario 3. Some stakeholders report that the HMO law is confusing for consumers; regulators indicate that their current interpretation and practice will be more clearly articulated in upcoming regulations.[46] Regulators believe that their current approach has resulted in few balance billing issues for HMO enrollees, but other stakeholders are concerned that the protections "may not always translate into practice."[47] Similarly, Texas rules require EPOs to hold consumers harmless when they cannot reasonably use a preferred provider, including emergencies; regulators indicate that this approach also includes surprise billing situations.[48]

For PPOs, its most popular product, Texas relies primarily on disclosure and mediation to help consumers, but does not guarantee that consumers are protected from balance billing. Pursuant to 2013 rules, PPO plans in Texas must provide up-to-date provider directories. Directories must identify hospitals that have agreed to facilitate the use of preferred providers and must disclose the percentage of out-of-network claims filed by providers at each contracted hospital, by provider type.[49] Directories must also identify all contracted providers at network facilities and specify those facilities without any contracts with a particular type of provider.[50] In order for a network to be adequate, at least one hospital must be available where all types of facility-based physicians are available in network. If there is a sudden decrease in the availability of a type of facility-based provider, plans must post this on their website.[51]

The state also requires that PPOs provide general disclosures informing consumers that they may receive care from out-of-network providers, but one stakeholder points out that consumers "have to know to ask" which providers are in network. PPO and EPO consumers can also receive information about their right to get estimates of the amounts the plan will pay, if they request this information from their health plan.[52] In addition, the state collects information from insurers on frequently used services, including charges and actual paid amounts in and out of network. The state then publishes the information on a website that identifies costs for out-of-network care. One stakeholder, however, told us that there have been problems with inconsistencies in the cost data that are reported, resulting in a recent proposal by the department of insurance to refine its data collection. Another believes the state is "making progress," but found it "not so clear that [state efforts have] made a difference." On the other hand, regulators believe improvements will be seen as the recent rules begin to have an impact.

When out-of-network services are provided in an emergency or inadequate network situation, Texas law requires that PPOs pay at least the usual and customary rate for the services in the area. It has also established

a mediation process and allows consumers to initiate mediation if the balance bill from a single out-of-network provider based at a facility exceeds $1,000 (bills from multiple providers involved in one service may not be combined).[54] Providers must inform consumers of their right to mediation when balance billing, and insurers must do so in the explanation of benefits. The mediation evaluates whether the provider's charge is excessive and whether the amount the insurer paid meets the usual and customary standard. Stakeholders report that few consumers use the process; many cases never go to mediation because the parties settle on a payment amount (some suggest that insurers often pay the full charges). Of the 900 cases filed in 2014, only one went to actual mediation, which regulators indicate was the first case for mediation. Other stakeholders suggest that the $1,000 threshold limits the availability of mediation, and that consumers (despite being notified) may not be aware of their right. A bill to decrease the threshold to $500 has passed the legislature and is awaiting action by the governor.

Summary of State Approaches

Our seven study state approaches are summarized in Table 1.

Table 1. Summary of Laws and Regulations Affecting Out-of-Network Balance Billing in Study States

	California	Colorado	Florida	Maryland	New Mexico	New York	Texas
Hold harmless or provider prohibition on balance billing in emergency situations (Scenario 2)	Yes, for HMOs and some PPOs	Yes	Yes, for HMO plans	Yes, for HMOs and tied to assignment for PPOs[c d]	No	Yes	Yes, for HMOs and EPOs[f]
Hold harmless or provider prohibition on balance billing in surprise bills (Scenario 3)	No	Yes	Yes, for HMOs[b]	Yes, for HMOs and tied to assignment for PPOs[c d]	No	Yes, tied to assignment[d]	Yes, for HMOs and EPOs[f]
Hold harmless or provider prohibition on balance billing in other situations (Scenario 4)	No[a]	Yes	No	Yes, for HMOs and tied to assignment for PPOs[c d]	No	Yes, tied to assignment[d]	Yes, for HMOs and EPOs[g]
State mediation or dispute resolution process	Yes, not much used	No	Yes, not much used	No	No	Yes	Yes, if more than $1,000
Disclosure rules beyond standard notices	No	No	No	Yes[e]	No	Yes	Yes

Sources: Cal. Code Regs. tit. 28, § 1300.71.39; Colo. Rev. Stat. § 10-16-704 (3)(a)(I); Fla. Stat. Ann. § 641.513; Fla. Stat. Ann. § 641.3154; Fla. Admin. Code r. 59A-12.030; MD. Code Ann. Health-Gen. §§ 19-710(p), 19-710.1 and 19-712.5; MD. Code Ann. Insurance §§ 14-205.2 and 14-205.3; N.Y. Fin. Services Law §§ 601 to 608; N.Y. Comp. Codes R. & Regs. tit. 23 § 200; N.Y. Pub. Health Law § 24 and Insur. Law § 3217-a; Tex. Insur. Code Ann. §§ 1271.055, 1271.155, 1467.051; 28 Tex. Admin. Code §§ 3.3725; 3.3705; 3.3708; 22 Tex. Admin. Code §§ 187.85 to 187.89; proposed regulation 28 Tex. Admin. Code § 11.1611(e).

[a] Per California's Knox-Keene Act, regulators indicate that if there is a network gap for medically necessary treatment, plan members may be protected. See Ca. Health & Safety Code § 1367 and 1367.03. Also, regulators indicate that if consumers relied upon an inaccurate provider directory, he/she can appeal to the Department of Managed Health Care's Help Center.

[b] Under Fl. Stat. Ann. § 641.3154, out-of-network providers are prohibited from balance billing for ancillary services when the HMO has authorized the covered service. Regulators also interpret the statute as prohibiting balance billing for ancillary services when an in-network physician admits the patients to an in-network hospital.

[c] For PPOs, protection against balance billing does not apply for physicians other than hospital-based or on-call if these other physicians disclose, prior to delivering services, information on estimated costs and the fact that a balance bill is possible.

[d] Assignment means that the consumer transfers the right to reimbursement from the health plan directly to the provider so that the health plan can pay the provider directly.

[e] Maryland's pre-disclosure requirements do not apply to hospital-based or on-call physicians and only apply to other out-of-network physicians prior to providing a service if they want to balance bill.

[f] Texas regulators indicate that their current interpretation requires HMOs to hold consumers harmless when they receive ER services or when in-network providers are unavailable for medically necessary covered services; proposed HMO regulations reflect this interpretation. Tex. Insur. Code §§ 1271.055 and 1271.155; see proposed regulation 28 Tex. Admin. Code § 11.1611(e). For EPOs, Texas rules require the EPO to hold the enrollee harmless when an insured cannot reasonably use a preferred provider; regulators interpret this to include surprise billing situations. 28 Tex. Admin. Code § 3.3725.

[g] Texas requires PPOs and EPOs to have a disclosure stating that consumers may be entitled to have their services paid at in-network rates if their reliance on an inaccurate provider directory causes them to go out of network. For EPOs, the disclosure statement states that if a consumer goes out of network because an in-network provider is unavailable or the consumer received out-of-network ER care, "the insurer, must, in most cases resolve the non preferred provider's bill." Tex. Admin. Code § 3.3705 (f)(1) and (f)(2). Texas rules further require the EPO to hold the enrollee harmless when an insured cannot reasonably use a preferred provider. 28 Tex. Admin. Code § 3.3725.

Cross-Cutting Issues

Several issues arise out of the experiences observed in the seven study states. These provide potential lessons for other states that may be considering regulatory approaches.

Protecting Consumers. Other than in Texas, stakeholders report that state balance billing legislation has been reasonably effective in keeping consumers out of the middle of disputes between non-network providers and health plans over the correct level of payments. While protections exist in Texas, there has been disagreement among stakeholders over the effectiveness of the protection. Also because Texas law has neither a ban on balance billing nor a hold harmless provision for PPOs, it does not offer consumers the same degree of protection as provided in other states. By contrast, in New Mexico, which lacks a balance billing statute, consumers have been protected because of market dynamics that have generally encouraged broad networks and insurer practices that include paying full billed charges when necessary. The steps taken recently by United Healthcare in Missouri, however, show the limits of private actions to protect consumers.[55]

Even in the states with laws in place, however, there are noteworthy gaps. As noted, some states have segments of the insurance market (e.g., PPOs in Florida or some PPOs in California) in which the rules do not apply. And no state has the ability to address coverage that is self-funded by employers or unions because these insurance arrangements are regulated exclusively under federal law.

Emergency Versus Surprise Billing Settings. There appears to be a greater consensus about protecting consumers from balance bills in emergency situations (Scenario 2) than for other surprise billing situations (Scenario 3). This result is not unexpected since consumers have the least control in medical emergencies. Even if the consumer goes to the emergency department of a network hospital,[56] he or she has essentially no control over whether the physicians or other providers who provide treatment in the emergency department are in the plan's network. The surprise bill settings identified in Scenario 3, however, are starting to attract more attention from policymakers. Legislation in New York specifically addresses surprise billing situations, and California legislators are considering an extension of protections to these situations.[57]

Both Maryland and New York have created a linkage between assignment of insurance benefits and restrictions on balance billing (applying to any surprise billing situations in New York and to some PPO billing disputes in Maryland). In part, this was a political compromise whereby physicians obtained an easier means of payment through assignment in exchange for agreeing not to balance bill, while insurers consented to assignment to help protect their members from getting caught in the middle of a billing dispute. Maryland stakeholders are generally satisfied with how this limited protection has worked to date, and New York stakeholders seem cautiously optimistic.

Balancing Interests of Insurers and Providers. The difference between a direct ban on balance billing by providers and requirements on insurers to hold their plan members harmless mainly revolves around which stakeholders are at financial risk. Under hold harmless rules, the insurer is at risk for paying whatever the provider charges. Under balance billing bans, the provider is at risk for accepting an amount less than the amount billed—or even an amount the provider considers reasonable. To the extent that either stakeholder is dissatisfied with the process, there is a greater chance that consumers can get caught in the middle despite the protections built into law.

To balance the interests of all stakeholders, several states have either incorporated stronger approaches to setting rates or included a dispute resolution process. A state requirement that plans pay based on their own usual and customary rates, without more specific rules, leaves the insurers with greater leverage. The Maryland approach provides enough specificity so that most stakeholders believe that the system works well enough. Providers had previously raised concerns that insurers sometimes took advantage of loopholes to keep payments low, but they have been alleviated somewhat by statutory adjustments to the payment formula. Maryland's reliance in part on historical payment rates may sometimes disadvantage certain insurers, but these situations seem uncommon.

One Maryland insurer reports a clear preference for having a set rate for payment rather than the uncertainty that may occur under New York's greater reliance on dispute resolution. But New York stakeholders believe that their approach will work for them. One physician stakeholder emphasizes that a formula fails to recognize

that physicians have different abilities and charge histories. Although New York does not require that payments be based on the usual and customary rates calculated by an independent entity (Fair Health), those rates could become something of a "safe harbor" in practice, especially if the IDR process relies heavily on this standard.

The Role of Mediation and Dispute Resolution. Mediation or dispute resolution processes have a mixed record to date in California and Florida. Regulators in Florida indicate that the potential cost to participate for providers is a barrier, particularly if they are unsuccessful. In California, regulators reported that insurers have little incentive to participate because balance billing is already prohibited for emergency services.

While the IDR process in New York became effective in April 2015,[58] some stakeholders hope that the threat of its use and the procedure for selecting the amount ultimately paid to the provider will convince both providers and insurers to charge or pay at more reasonable levels. They suggest the IDR will be a success if health plans and providers use the process infrequently. One stakeholder compared the IDR to the binding arbitration model that Major League Baseball uses today, which succeeds by encouraging "bids" that are close enough together to encourage voluntary settlements in advance of arbitration.

By contrast, stakeholders in Texas suggest that requiring consumers to initiate the dispute resolution process poses an overly high barrier to its use, even if the current $1,000 threshold were lowered. Overall, the success of a mediation or dispute resolution process appears to depend both on who initiates the process and the cost of using the process. Low use of a dispute resolution process may signal success if it creates an incentive for health plans and providers to negotiate or accept rates that are viewed as reasonable.

Disclosure and Transparency. Most of our study states have made some provisions to improve consumer disclosures. Disclosure provisions may be used in lieu of more direct protections (PPOs in Texas) or to complement other measures (New York). But it remains an open question how much value consumers derive from disclosure rules. One consumer advocate suggests that disclosure rules can yield good information, especially if it means more accurate and easy-to-use provider directories; however, she thinks that disclosure does little to protect consumers from balance billing. At best it helps a small subset of consumers who take an active role in reviewing their disclosures. At worst and more likely, as some respondents note, it is one more piece of paper that consumers receive when they have a health care encounter, without improving their understanding of the financial implications of receiving in- versus out-of-network care. At the same time, transparency provisions in Texas have encouraged data disclosures that have proved valuable for advocates and journalists who use the data to identify and highlight problem areas.

Plans have an interest in making sure their members know which providers are in the network, but insurers' track record of providing this information has been mixed at best.[59] Some insurers report taking steps to improve how they provide information. One health plan highlights its efforts to use care managers to alert members which specialists are in network when they schedule care—information that is useful because it arrives at a time when the member is seeking out new providers.

Impact on the Market. The market environment is critical because it creates a context for how states approach consumer protection relative to balance billing. The design of provider networks vary, in part because the supply, distribution, and expertise of providers vary from state to state, as do the concentration and market leverage of health insurers. In New Mexico, one stakeholder suggests that the need for state protections is minimal because there are few non-contracted providers in the state. In other words, most plans have contracts with most providers. But in many states, this is not the case.

The presence of non-network physicians and other providers in network hospitals has been documented in Texas, but occurs in other states as well. In some markets, insurers may have the leverage to encourage or require participating hospitals to guarantee that all of their clinicians contract with the network. But in many markets, physicians or other providers have enough market power to block these efforts. In our stakeholder interviews, we heard about specialist physicians (e.g., anesthesiologists) and other providers (e.g., surgical assistants) who frequently avoid contracting with insurer networks. Some stakeholders express concerns that balance billing restrictions might interfere with negotiations over networks. For example, a hold harmless provision might encourage providers to stay outside the network since they would likely get paid at higher rates (i.e., their full charges or a regulated rate) if they decline to participate in a plan's network.

Narrow Networks. In recent years, insurers have changed the designs of their provider networks, and many are offering narrower networks.[60] These changes may lead

more people to use out-of-network providers and thus may increase the likelihood of balance billing. While most respondents indicate that there were no documented trends in that direction, there have been anecdotal reports linking balance billing to narrower networks. The trend could increase the likelihood of surprise billing situations, in which non-network providers are delivering services in network hospitals or in which patients are referred to non-network specialists. It could also lead to more situations in which network providers are unavailable (either because of gaps in a network or because network providers are not taking new patients). Furthermore, the use of narrower networks could influence the willingness of health plans and providers to protect consumers in the absence of legal remedies.

Politics of Balance Billing Legislation. Passing meaningful consumer protection legislation can be challenging, particularly since legislators must balance the interests of insurers, providers, and consumers. Although all stakeholders may agree that consumers should not be caught in the middle of payment disputes between insurers and providers, they tend to disagree on how to implement that protection. Both the degree of market concentration and the political clout of providers and health plans can influence the ability of states to pass legislation to protect consumers. Some stakeholders suggest that the political clout of Texas physicians has been a factor in the more modest approach taken there. Similarly, in the 2015 Florida legislative session, a subcommittee of the Florida House of Representatives reported out a bill that would have extended the prohibition on balance billing in emergency settings to PPOs. The bill would have also modified the payment standard to the greater of the negotiated amount, the in-network amount, or the Medicare allowable amount.[61] The bill, however, was not enacted. Although supported by the insurance industry it was opposed by the Florida Medical Association. The Colorado Medical Society was also instrumental in convincing a state Senate Committee to postpone legislation that would prohibit out-of-network providers at in-network facilities from balance billing.[63]

The comprehensive approach taken in New York, which tried to balance all stakeholder interests, will be tested as implementation proceeds. Accompanying issues, such as the desire of physicians to be paid on assignment when out of network or the desire of health plans to take their plan members out of the crossfire, can encourage agreement on legislation initiatives. Similarly, publicity over the growth of narrow networks and a push to address network adequacy in legislation may raise the related issue of balance billing.

Conclusion

Only a few states have acted through regulations or legislation to protect consumers against the unexpected charges that result when providers send balance bills to their patients. Even those states enacting protections typically limit their scope to scenarios in which consumers have limited control: in hospital emergency departments and when treated by a non-network provider while in an in-network facility. The states studied for this report took varied approaches but shared the goal of ensuring that consumers are not liable for charges that are mostly outside their control. But the approaches have different levels of effectiveness. The most effective protections appear to share two common elements. First, they do not require active intervention by the consumer. Second, they have a mechanism, acceptable to both plans and providers, for determining the amount of payment. Many consider New York's new law to be the most comprehensive approach in this domain; it will thus be important to monitor its impact.

The necessity of state remedies may be mitigated when the market environment encourages plans and providers to resolve bills from non-network providers without involving the consumer. But publicity over surprise balance bills can place this issue squarely on the political agenda and put pressure on stakeholders to find some common ground. Once a law or regulation is in place, states often return to the issue to address gaps or solve unresolved issues. Most states in this study with laws or regulations on the books (California, Colorado, Florida, and Texas) are or were considering bills in the 2015 legislative session to expand existing protections.[64] As seen from these examples, it may be easier to enact additional incremental measures after taking some initial steps, although this does not always guarantee success as seen recently in Florida and Colorado.

The evolution of provider networks may increase pressures on states to address balance billing. Colorado includes network inadequacy as one trigger for requiring plans to hold consumers harmless when using a non-network provider in a network hospital; other states may consider such approaches in the future. Conversely, state efforts to address network adequacy can help to reduce opportunities for unexpected bills. If there are a greater number of situations in which network providers are unavailable to provide care in emergency departments at network hospitals or in which patients must obtain needed care out of network, more consumers could feel the financial sting of surprise balance bills. The financial harm they may face is exacerbated because the amounts they pay for balance bills are not typically counted toward either deductibles or annual out-of-pocket maximums.[65] The promise of financial security in the Affordable Care Act could be called into to question if we see large increases in balance billing.

Endnotes

1 A balance bill is in addition to amounts owed by the patient in cost sharing under the terms of the insurance contract.

2 We looked at this issue previously in a 2009 policy brief; this brief draws on that earlier effort. Hoadley J, Lucia K, and Schwartz S, *Unexpected Charges: What States Are Doing about Balance Billing*, California HealthCare Foundation, April 2009.

3 Rosenthal E, *After Surgery, Surprise $117,000 Medical Bill From Doctor He Didn't Know*, New York Times, September 20, 2014; Pollitz K, et al., *Medical Debt among People with Health Insurance*, Kaiser Family Foundation, January 2014.

4 Traditional Medicare does not involve a provider network. In addition, Medicare has provisions that prohibit balance billing in most situations. In the few cases in which balance bills are permitted, they are limited to a small share of the amount paid by Medicare.

5 Kaiser Family Foundation and Health Research and Educational Trust, *2014 Employer Health Benefits Survey*, September 10, 2014. Available at http://kff.org/report-section/ehbs-2014-section-five-market-shares-of-health-plans/.

6 Ambulance services may also fall under this scenario.

7 Pogue S and Randall M, *Surprise Medical Bills Take Advantage of Texans*, Center for Public Policy Priorities, September 15, 2014.

8 McDevitt R., et al., *Financial Protection Afforded by Employer-Sponsored Health Insurance: Current Plan Designs and High-Deductible Health Plans*, Medical Care Research and Review 64(2):212-228, April 2007.

9 Also, about half of consumers with out-of-network encounters reported a lack of cost transparency (they reported they did not know how much they would have to pay for the service). Kyanko K, et al., *Out-of-Network Physicians: How Prevalent Are Involuntary Use and Cost Transparency?* Health Services Research 48(3):1154–1172, June 2013.

10 Corlette S, et al., *Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality Care*, Robert Wood Johnson Foundation, May 2014; Corlette S, et al., *Implementation of the Affordable Care Act: Cross-Cutting Issues: Six-State Case Study on Network Adequacy*, Robert Wood Johnson Foundation, September 2014.

11 The Public Health Service Act (PHS Act) section 2719A, amended by the Affordable Care Act, generally provides, among other things, that if a group health plan or individual health plan provides benefits for emergency services, an insurer must provide coverage for such emergency services without regard to whether the health care provider is in-network. Insurers generally cannot impose any copayment or coinsurance that is greater than what would be imposed if services were provided in network. The statute, however, does not require insurers to cover amounts that out-of-network providers may "balance bill." Current regulations at 29 C.F.R. §2590.715-2719A; 45 C.F.R. § 147.138 set forth minimum payment standards to ensure that a plan does not pay an unreasonably low amount to an out-of-network emergency service provider who, in turn, could simply balance bill the patient. See also Centers for Medicare and Medicaid Services, Center for Consumer Information & Insurance Oversight, *Affordable Care Act Implementation FAQs – Set 1.* Available at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html.

12 29 C.F.R. §2590.715-2719A (b)(3)(i)(A) to (C) and 45 C.F.R. § 147.138 (b)(3)(i)(A) to (C).

13 Kaiser Family Foundation, *State Restriction Against Providers Balance Billing Managed Care Enrollees.* Available at http://kff.org/private-insurance/state-indicator/state-restriction-against-providers-balance-billing-managed-care-enrollees/.

14 In this project, we did not conduct a 50-state survey of state laws. Two available sources for state laws are American Health Lawyers Association, 3 Health L. Prac. Guide Appendix B-2: State Law Charts (2014) and Kaiser Family Foundation, *State Restriction Against Providers Balance Billing Managed Care Enrollees.* Available at http://kff.org/private-insurance/state-indicator/state-restriction-against-providers-balance-billing-managed-care-enrollees/. These sources are not fully consistent on interpretations of state laws.

15 *See* Kaiser Family Foundation, *State Restriction Against Providers Balance Billing Managed Care Enrollees.* Available at http://kff.org/private-insurance/state-indicator/state-restriction-against-providers-balance-billing-managed-care-enrollees/.

16 Employee Retirement Income Security Act, § 514.

17 Some plans participate in a Multiplan agreement that acts like a supplemental provider network. Participating providers agree to accept amounts from a network fee schedule as payment in full and do not send balance bills. Plans agree to base their payments on the network fee schedule, which may be higher than fees paid to providers in their own network.

18 Shapiro J, *Policy Shift by Nation's Largest Insurer Could Leave Some with Unexpected Bills*, St. Louis Post-Dispatch, March 30, 2015.

19 Cal. Code Regs. tit. 28, § 1300.71.39 (2014). The policy was established through a regulatory interpretation of the Knox-Keene Act by the California Department of Managed Health Care (DMHC). It was challenged in court by providers, but was affirmed unanimously by the California Supreme Court. Prospect Medical Group, Inc. v. Northridge Emergency Medical Group, 45 Cal. 4th 497 (Cal.), Jan. 8, 2009.

20 Wilson K, *California Health Insurers: Brink of Change*, California Healthcare Foundation, February 2015. Available at http://www.chcf.org/publications/2015/02/california-health-plans-insurers.

21 DMHC also has the authority to enforce its regulations. *See* Cal. Code. Regs. tit. 28 § 1341. Recently, the agency reached a settlement with a group of emergency department physicians for sending illegal balance bills to 324 patients. *See* California Healthline, *DMHC Issues Fines Against Several Health Care Organizations*, March 26, 2015. Available at http://www.californiahealthline.org/articles/2015/3/26/dmhc-issues-fines-against-several-health-care-organizations.

22 Cal. Code Regs. tit. 28, § 1300.71 (2015).

23 California DMHC, *Independent Dispute Resolution Process (IDRP).* Available at https://www.dmhc.ca.gov/FileaComplaint/ProviderComplaintAgainstaPlan/IndependentDisputeResolutionProcess.aspx#.VW-Ces9Viko.

24 One area of complaints has been hospital-based specialists.

25 Colo. Rev. Stat. § 10-16-704 (3)(a)(I). Colorado also requires insurers to allow members to assign benefits to out-of-network providers. Colo. Rev. Stat. § 10-16-106.7.

26 By federal law, high-deductible plans (HDHP) under health savings accounts (HSAs) cannot have deductibles less than $1,300 for self-coverage and $2,600 for family coverage. Insurers are not permitted to start paying for covered benefits unless the consumer has met the deductible for the plan year (excludes preventive services). *See* IRS Publication 969, *Health Savings Account and Other Tax-Favored Health Plans,* 2014.

27 Fla. Stat. Ann. § 641.513 (West 2014).

28 Fla. Stat. Ann. § 641.3154 (West 2014).

29 Fla. Admin. Code r. 59A-12.030 (2014).

30 MD. Code Ann. Health-Gen. §§ 19-710(p); 19-710.1 and 19-712.5.

31 MD. Code Ann. Insurance §§ 14-205.2 and 14-205.3.

32 MD. Code Ann. Insurance § 14-205.3. This provision does not apply to hospital-based or on-call physicians.

33 The bill was scheduled to sunset in 2015, but a measure removing the sunset date became law on April 14, 2015.

34 MD. Code Ann., Health-Gen. § 19-710.1, MD. Code Ann. Ins.-Gen. § 14-205.2 (West 2015).

35 MD. Code Ann., Health-Gen. § 19-710.1 (West 2015).

36 MD. Code Ann. Insurance § 14-205.3 (West 2015).

37 N.Y. Fin. Services Law §§ 601 to 608 (McKinney 2015); N.Y. Comp. Codes R. & Regs. tit. 23 § 200 (2014). Since the cycle for many insurance contracts is January to January, the effective date of the new policies for many consumers will be January 1, 2016.

38 N.Y. Fin. Services Law §§ 603 and 606 (McKinney 2015).

39 N.Y. Fin. Services Law § 607 (McKinney 2015). FAIR Health was created after the state's attorney general uncovered potential conflicts of interest in the methods that health insurers were using to determine reimbursements to patients who received care from providers outside their health plans' networks. Settlement agreements with New York insurers focused on bringing fairness and transparency to the out-of-network reimbursement system. FAIR Health maintains a database of charge data for medical procedures and website designed to help consumers estimate charges for health care services. Insurers use the data to help determine reimbursement rates for out-of-network claims.

40 N.Y. Fin. Services Law § 607 (McKinney 2015).

41 N.Y. Pub. Health Law § 24 and Insur. Law § 3217-a (McKinney 2015).

42 N.Y. Insur. Law § 3217-a (McKinney 2015).

43 N.Y. Pub. Health Law § 24 (6) and (7) (McKinney 2015).

44 N.Y. Pub. Health Law § 24 (1) and (2) (McKinney 2015).

45 N.Y. Pub. Health Law § 24 (4) (McKinney 2015).

46 Tex. Insur. Code § 1271.00 and 1271.155 (2015); proposed regulation 28 Tex. Admin. Code § 11.1611. The language in the proposed regulation covers "circumstances where an enrollee cannot reasonably reach a network provider, including circumstances where an enrollee is not given a choice between network and non-network providers when receiving care at a network facility." *See* Pogue S and Randall M, *Surprise Medical Bills Take Advantage of Texans,* Center for Public Policy Priorities, September 15, 2014, noting confusion about the Texas HMO law.

47 Pogue S and Randall M, *Surprise Medical Bills Take Advantage of Texans,* Center for Public Policy Priorities, September 15, 2014.

48 28 Tex. Admin. Code § 3.3725.

49 28 Tex. Admin. Code § 3.3705 (2015).

50 28 Tex. Admin. Code § 3.3705 (2015).

51 28 Tex. Admin. Code § 3.3705 (2015).

52 28 Tex. Admin. Code § 3.3705 (2015).

53 28 Tex. Admin. Code § 3.3708 (2015).

54 Tex. Ins. Code Ann. § 1467.051 (West 2015); 22 Tex. Admin. Code §§ 187.85 to 187.89.

55 Shapiro J, *Policy Shift by Nation's Largest Insurer Could Leave Some with Unexpected Bills,* St. Louis Post-Dispatch, March 30, 2015

56 In the event that a patient arrives at a hospital that is not in the insurer's network, stakeholders report that the insurer typically negotiates a rate with the hospital for its services. Historically, these situations arise less often than encounters with out-of-network physicians and other providers. But as narrower networks are employed by insurers, they may arise more often in the future.

57 *See* A.B. 533 (Bonta), 2015-2016 Gen. Assembly, Reg. Sess. (Ca. 2015).

58 Because the law became effective mid-year, it will only applies immediately to consumers with new health plans or health plans that renew on or after April 1, 2015. The majority of consumers will have to wait until their health plans renew, i.e., January 1, 2016.

59 *See* Tahir S, *Why Can't Insurers Publish Accurate Provider Directories?* Modern Healthcare, December 13, 2014. Available at http://www.modernhealthcare.com/article/20141213/MAGAZINE/312139963; Corlette S, et al., *Implementation of the Affordable Care Act: Cross-Cutting Issues: Six-State Case Study on Network Adequacy,* Robert Wood Johnson Foundation, September 2014.

60 Corlette S, et al., *Implementation of the Affordable Care Act: Cross-Cutting Issues: Six-State Case Study on Network Adequacy,* Robert Wood Johnson Foundation, September 2014.

61 H.B. 681, 2015 Leg. Sess. (Fl. 2015).

62 Sexton C, *House Panel OKs Balance Billing Ban, Sponsor Says Unlikely to Pass this Year,* Saint Petersburg Blog, April 9, 2015. Available at http://www.saintpetersblog.com/archives/225230.

63 Colorado Medical Society, *SB 259 Provider Out-of-Network Legislation Defeated,* April 21, 2015. Available at http://www.cms.org/communications/sb-259-provider-out-of-network-legislation-defeated.

64 A.B. 533 (Bonta), 2015-2016 Leg. Sess. (Ca. 2015); S.B. 15-259, 2015 Gen. Assembly, Reg. Sess. (Co. 2015); H.B. 681, 2015 Leg. Session (Fl. 2015); H.B. 3102, 84th Leg., Reg. Sess. (Tx. 2015); H.B. 1638, 84th Leg., Reg. Sess. (Tx. 2015); S.B. 481, 84th Leg., Reg. Sess. (Tx. 2015).

65 One law professor has argued that network adequacy rules under the Affordable Care Act could be used to require exchange plans to contract with emergency department physicians at all network hospitals or that state insurance commissioners could apply such a policy for plans under their jurisdictions. Bagley N, *What Should the Law Do about Out-of-Network ER Docs?* The Incidental Economist, September 29, 2014. Available at http://theincidentaleconomist.com/wordpress/what-should-the-law-do-about-out-of-network-er-docs/.

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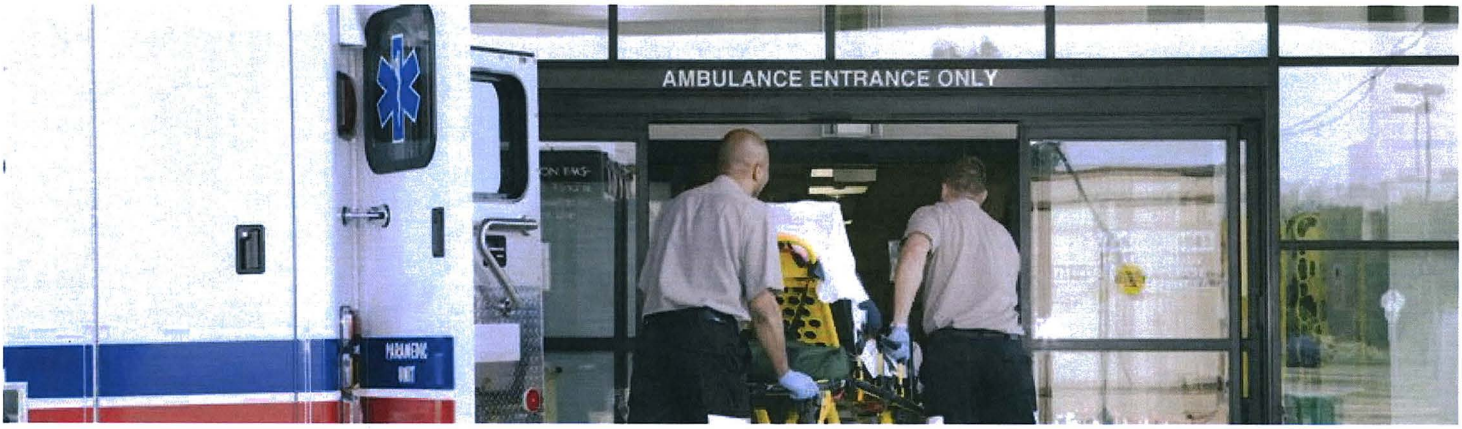

Balance Billing by Health Care Providers: Assessing Consumer Protections Across States

June 13, 2017

Authors

Kevin Lucia, Jack Hoadley, Ashley Williams

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Abstract

Issue: Privately insured consumers expect that if they pay premiums and use in-network providers, their insurer will cover the cost of medically necessary care beyond their cost-sharing. However, when obtaining care at emergency departments and in-network hospitals, patients treated by an out-of-network provider may receive an unexpected "balance bill" for an amount beyond what the insurer paid. With no explicit federal protections against balance billing, some states have stepped in to protect consumers from this costly and confusing practice.

Goal: To better understand the scope of state laws to protect consumers from balance billing.

Methods: Analysis of laws in all 50 states and the District of Columbia and interviews with officials in eight states.

Findings and Conclusions: Most states do not have laws that directly protect consumers from balance billing by an out-of-network provider for care delivered in an emergency department or in-network hospital. Of the 21 states offering protections, only six have a comprehensive approach to safeguarding consumers in both settings, and gaps remain even in these states. Because a federal policy solution might prove difficult, states may be better positioned in the short term to protect consumers.

Background

Consumers buy private health insurance coverage to protect themselves from the high cost of medical care. They expect that if they pay their premiums and use in-network providers, their insurer will cover the cost of medically necessary care beyond their specified copayments, coinsurance, and deductibles.

An in-network provider is a physician, hospital, or other health care provider with whom a health plan has negotiated a payment rate. As part of its contract with the plan and typically required by state law, the in-network provider agrees not to charge the plan or enrollee more than the negotiated rate. By contrast, an out-of-network provider has no contract with the health plan and thus no negotiated payment rate. When an enrollee is treated by an out-of-network provider, the health plan will often limit its payment to an amount that it determines is fair. When this happens, an enrollee may be billed by the out-of-network provider for the difference between what their health plan paid and what the provider charges. In some cases, enrollees face thousands of dollars in charges—referred to as "balance bills"—above their expected cost-sharing.[1](#/#1)

Even if enrollees research which providers are in network before seeking care, they may face balance billing in certain situations that are beyond their control, such as when they are treated by an out-of-network provider at an in-network emergency department (ED), hospital, or other facility. Indeed, many consumers who received unexpected bills report being surprised both by the bill and the fact that the provider who cared for them was not in network.[2](#/#2) These scenarios exclude situations when consumers elect to go out of network.

The incidence of balance billing is unclear because most data sources do not capture whether providers send their patients balance bills or seek to collect them. But many consumers are at significant risk for being balance billed because they use out-of-network providers. Researchers found that 14 percent of ED visits were likely to produce a surprise bill as were 9 percent of hospital stays. The risk is even greater for patients admitted to the hospital via the ED—20 percent of such patients were likely to receive a surprise bill.[3](#/#3)

When consumers feel very ill or experience a medical emergency, they usually do not have the time or presence of mind to determine whether a provider who treats them is out of network. Even if they know, they often have no opportunity to choose a network provider. For example, a man experiencing a heart attack who is rushed to the nearest emergency room or a woman in labor who needs an anesthesiologist will face difficulty in identifying the network status of the treating physician prior to receiving care.

While insurers may elect to protect their enrollees from some instances of balance billing, there are no federal protections that explicitly ban the practice.[4](#/#4) States can help protect enrollees from unexpected balance bills.[5](#/#5) 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](#/#6)

This issue brief documents current laws to protect consumers from balance billing for care provided in EDs and network hospitals. Our findings are based on analysis of health insurance laws, as of December 2016, in all 50 states and the District of Columbia, supplemented by interviews with insurance regulators and other officials in eight

states to explore the impact of varying approaches.[7](#/#7)

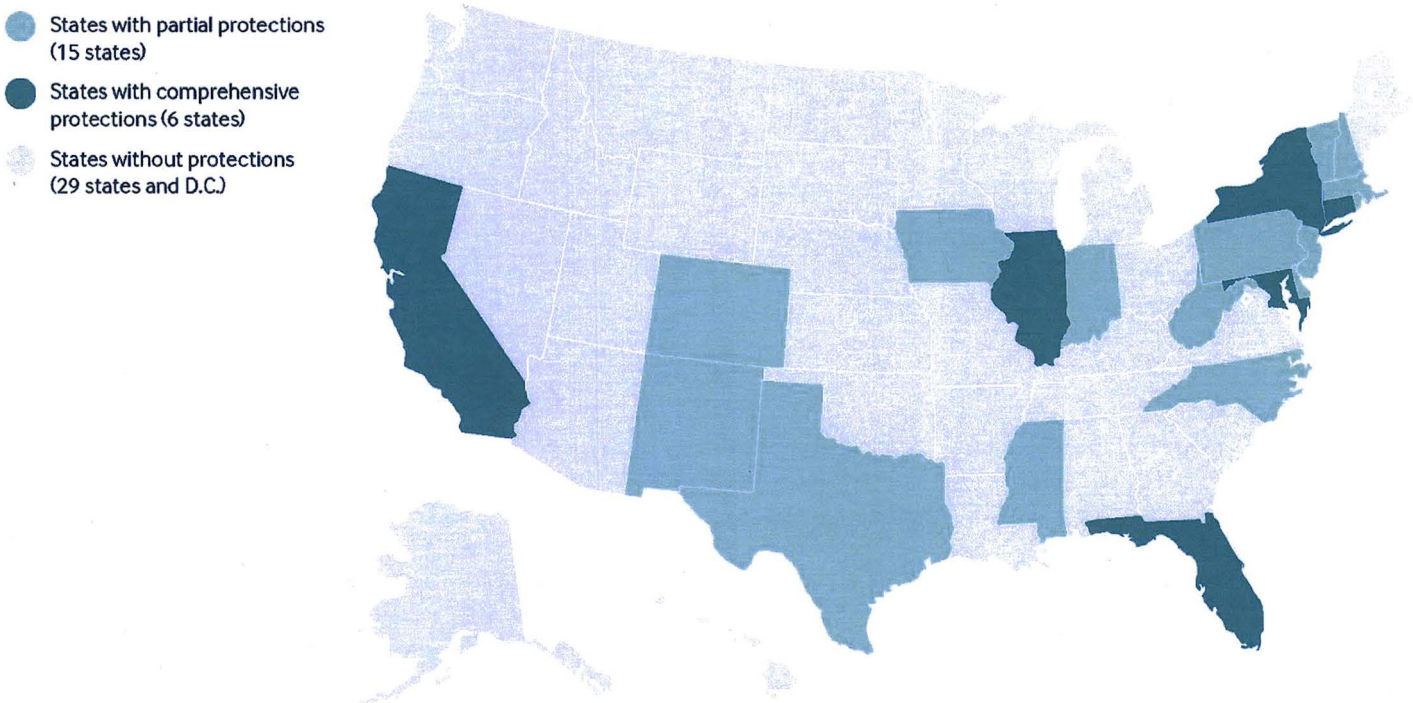
Key Findings

Only 21 States Protect Consumers from Balance Billing in EDs or In-Network Hospitals

Only 21 states have direct protections laid out in statute or regulations for consumers who would otherwise face balance billing for care by out-of-network providers in EDs or in-network hospitals (Exhibit 1).[8](#/#8) Other states typically rely on market forces to minimize balance billing or on regulators to pressure insurers or providers to mitigate its effects on consumers. Several additional states, including Tennessee and Washington, have consumer protections that are triggered in situations where provider networks are inadequate.

Exhibit 1

State Laws Protecting Against Balance Billing by Out-of-Network Providers in Emergency Departments or In-Network Hospitals



Source: Data collection and analysis as of January 2017 by researchers at the Center on Health Insurance Reforms, Health Policy Institute, McCourt School of Public Policy, Georgetown University.

Share

Some of the 21 states place significant limitations on them (described below). Most laws apply to all insurance markets (including individual and small- and large-group markets). Some apply to all types of managed care products, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs), but others

protect only HMO enrollees.

State laws also vary in their approach to restricting balance billing. Some *prohibit balance billing by providers,* others *require insurers to hold enrollees harmless* from balance-billing charges by paying the entire charge if necessary, and some do both. In states that have adopted both approaches, out-of-network providers are directly prohibited from balance billing consumers for additional charges beyond what the health plan pays. In addition, insurers must guarantee that the consumer is held harmless from, and is not liable for, balance-billing charges.

State Approaches to Balance Billing: A Guide to Terminology

Insurer hold harmless requirement	A requirement that insurers pay providers their billed charges or some lower amount that is acceptable to the provider.
Prohibition on provider balance billing	A requirement that out-of-network providers cannot bill insured patients beyond any allowed cost-sharing amounts.
Payment standard	A law or rule setting payment rates for out-of-network providers, such as 125 percent of the rate set by Medicare.
Dispute resolution process	An independent mediation or other process through which providers and insurers can negotiate or settle on a fair rate of payment for a claim.

Some laws include *payment standards* to ensure that providers are compensated fairly. Certain states, for example, require insurers to pay out-of-network providers at a set percentage of Medicare rates or at "usual and customary rates." Other states require providers and insurers to engage in a *dispute resolution process* for settling payment rate issues, with some requiring that the enrollee be held harmless. Most states that include dispute resolution processes find they are rarely used, though an incentive may be offered for parties to negotiate. Some state laws provide further protections: California prohibits out-of-network providers from sending a bill to consumers for anything beyond in-network cost-sharing and to provide refunds if a consumer inadvertently pays more.

The 21 states with direct protections in law do not protect consumers in all situations from balance billing (Exhibit 2). Some states limit protections to ED settings, certain types of managed care plans, or have other limits that leave consumers at risk.[9 (#/#9)] Only six states—California, Connecticut, Florida, Illinois, Maryland, and New York—have a comprehensive approach to protecting consumers.

Exhibit 2

State Balance-Billing Protections

Setting	Type of managed care plan	Type of protection	State-specific method for payment
Nonemergency		Hold	Dispute

	Emergency department	care in network hospital	HMO	PPO	harm-less	Provider prohibition	Payment standard	resolution process
States with a comprehensive approach								
California	✓	✓	✓	✓[a]	✓	✓	✓	✓
Connecticut	✓	✓	✓	✓	✓	✓	✓	
Florida	✓	✓	✓	✓	✓	✓	✓[b]	✓
Illinois	✓	✓	✓	✓	✓[c]	✓[d]		✓
Maryland	✓	✓	✓	✓	✓[e]	✓[d]	✓[e]	
New York	✓	✓	✓	✓	✓	✓[d]	✓	✓
States with a limited approach								
Colorado	✓	✓	✓	✓	✓			
Delaware	✓[f]		✓	✓	✓	✓		✓
Indiana	✓		✓		✓	✓		
Iowa	✓		✓	✓	✓			
Massachusetts		✓	✓	✓	✓			
Mississippi	✓	✓	✓	✓	✓	✓[d]		
New Hampshire	✓	✓	✓		✓			
New Jersey	✓	✓	✓	✓	✓			
New Mexico	✓		✓	✓	✓			
North Carolina	✓		✓	✓	✓			
Pennsylvania	✓		✓	✓[g]	✓			
Rhode Island	✓	✓	✓		✓			
Texas	✓	✓	✓[h]		✓			
Vermont	✓		✓	✓	✓			
West Virginia	✓		✓		✓			

Note: See A Guide to Terminology for full definitions of the terms used in the column headers.

[a] Protections in emergency department setting apply only to those plans regulated by the California Department of Managed Care, which includes HMOs and most PPOs.

[b] Payment standards apply only for nonnetwork providers of emergency services for HMOs.

[c] Protections apply only to facility-based providers.

[d] Protections attach when consumer assigns the benefit to provider. Linkages to assignment in Maryland apply only to PPOs and in New York only to in-network hospitals.

[e] Hold harmless and payment standards for PPOs apply only to on-call physicians and hospital-based physicians who obtain assignment of benefits; they apply to HMO providers in all situations.

[f] Protections for emergency department care also apply to services originating in hospital emergency facility or comparable facility following treatment or stabilization of emergency medical condition, as approved by insurer with respect to services performed by nonnetwork providers. Insurer is required to approve or disapprove coverage of poststabilization care.

[g] Emergency service balance-billing protections apply only to HMOs and PPOs that require gatekeepers.

[h] HMO members must be held harmless, but those in PPOs may be balance-billed. State law requires PPOs to disclose possibility of balance billing to consumers and allows consumers to pursue dispute resolution for amounts of $500 or greater. PPOs must base payments on usual and customary billed charges in emergency settings or those where no in-network provider is reasonably available. This minimum payment amount is designed to minimize use of balance billing.

Six States Have Comprehensive Protections Against Balance Billing

These six states incorporate a comprehensive approach by:

- extending protections to both ED and in-network hospital settings
- applying laws to both HMOs and PPOs
- protecting consumers both by holding them harmless from extra provider charges and prohibiting providers from balance billing, and
- adopting adequate payment standards or dispute resolution processes to resolve payment disputes between providers and insurers (Exhibit 2).

Although these states' approaches vary, discussions with insurance regulators suggest that these protections have been relatively successful in limiting balance billing in the emergency and in-network hospital settings.[10 (#/#10)] New York, one of the latest states to implement a comprehensive approach, recently reported that the law was "highly effective" in establishing consumer protections, although some gaps remain.[11 (#/#11)]

State laws vary most significantly with respect to how payment disputes are resolved between insurers and providers. For example, California requires that an insurer pay the greater of 125 percent of Medicare's rate or the average in-network rate paid by the insurer in a region.[12 (#/#12)] By contrast, Illinois has not adopted a standard for adequate payment. Health plans or providers may initiate binding arbitration using a state-sanctioned arbiter, but, in practice, regulators report that disputes are normally resolved without arbitration.

In New York, plans must establish a reasonable payment amount and disclose their method for determining it. Plans also must show how that amount compares to usual and customary rates, defined as the 80th percentile of all charges for a health care service made available by FAIR Health, an independent entity that maintains a medical bill database.[13 (#/#13)] Any party that is not satisfied with the amount paid can appeal through a state-created independent dispute resolution process.

Fifteen States Protect Consumers in Some Situations

Fifteen states have balance-billing laws that protect consumers in some, but not all, cases (Exhibit 2).

Limited to the ED setting. Eight states have balance-billing protections that apply only to services provided by out-of-network providers in ED settings—but not in in-network hospital settings, and one state law (Massachusetts) applies only in the in-network hospital setting. State officials acknowledge these gaps in consumer protections.

Limited to HMOs. Five states limit balance-billing protections to HMOs but not PPOs. For example, Texas holds consumers harmless for balance billing if they are in HMOs. For PPOs—the most popular product in Texas—state law requires insurers to disclose the possibility of balance billing to consumers and allows parties to pursue formal dispute resolution. Although the law does not require insurers to hold members harmless, it does set a high minimum payment standard with the goal of reducing the likelihood that PPO members will receive balance bills.

Limited to hold harmless provisions. In 12 states, balance-billing protections only require insurers to hold consumers harmless from the billed charges of providers but do not prohibit providers from sending bills. Because these states do not prohibit providers from balance billing, consumers may still receive a bill from a physician, hospital, or other provider. For example, in Colorado, despite a "hold harmless" protection, state regulators have reported that "members sometimes receive balance bills and may not understand their rights not to pay."[14 (#/#14)] Some providers apparently send balance bills in the hope that patients will complain to their insurer or state insurance department. In New Mexico, state regulators report that they have increased their educational efforts to help consumers understand their rights.

No fair payment standard or dispute resolution process. Fourteen states have neither a standard for adequate payment by a health plan to an out-of-network provider nor a dispute resolution process to resolve payment disagreements.[15 (#/#15)] Providers have used this lack of specificity to charge high amounts to insurers, who must pay the balance bill to avoid consumer liability, resulting in higher overall health costs. In New Jersey, for instance, the absence of a standard may encourage providers to remain out of network—by opting not to accept a discounted payment rate with an insurer—and then charge higher prices through balance billing, potentially contributing to the state's high hospital charges and high premiums.[16 (#/#16)]

Most States Lack Consumer Protection Laws for Balance Billing

In 29 states and the District of Columbia, there are no state laws or regulations that explicitly protect consumers from unexpected balance billing by out-of-network providers in EDs or in-network hospitals. In some of these states, insurance regulators reported taking informal approaches. They may act as an arbiter between a provider and an insurer to determine an acceptable payment level or encourage an insurer to pay billed charges to help consumers resolve billing disputes. Insurance regulators have reported some success with these approaches. For example, Oklahoma regulators report that, when the department of insurance gets involved, insurers or providers will often make adjustments to their respective payments or charges.

However, without direct statutory authority over insurers and limited or no jurisdiction over providers, informal approaches by state regulators are unlikely to be consistently effective. Nor do they offer a long-term solution as market conditions—such as insurer networks, plan payments, and provider billing practices—evolve.

Washington State insurance regulators reported a recent increase in the number of consumer complaints related to balance billing, even though it had not been an area of concern, given the state's robust network adequacy requirements. Regulators suggested that the increase resulted in part from the growth of narrow-network plans. Without a law that protects consumers from balance billing in these situations, one regulator noted "there isn't much you can do to force providers and insurers to resolve the dispute." The Washington State Office of the Insurance Commissioner now supports legislation with comprehensive standards to protect consumers against the possibility of balance billing for care in ED and in-network hospitals.[17 (#/#17)]

Discussion

Consumers expect that their health insurance will cover the cost of most medically necessary care beyond their cost-sharing amounts. But when emergencies or other unexpected circumstances expose them to out-of-network providers, balance billing can create financial burdens and undermine their confidence that health insurance will protect them from financial hardship.

Concerns about balance billing are not new but may be growing as the use of narrow provider networks becomes increasingly common. The fact that consumers are more likely to experience balance billing in situations where they have no control over which providers treat them suggests that additional state and federal policy solutions are needed to protect consumers fully and limit financial risk. Yet comprehensive policy solutions have been elusive, largely because of disagreements between insurers and providers concerning the appropriate levels of payment for medical services.

A federal solution would go farthest, since most individuals with private insurance are in employer-sponsored self-insured plans, which are regulated primarily under federal law. Indeed, as it considers legislation to amend or replace the Affordable Care Act, Congress could take steps to better protect consumers from balance billing.

In the meantime, some states, including Pennsylvania, are considering steps to strengthen consumer safeguards.[18](#/#18) New Mexico held a series of public forums with the goal of developing stronger protections.[19](#/#19) And a few states have claimed a leadership role in developing comprehensive solutions that balance the interests of consumers, providers, and insurers. The success of Maryland and New York, for example, demonstrates that it is possible to shield consumers from unexpected and burdensome balance-billing charges while facilitating a process for insurers and providers to determine acceptable payment levels.

Notes

[1] E. Rosenthal, "Costs Can Go Up Fast When E.R. Is in Network but the Doctors Are Not (https://www.nytimes.com/2014/09/29/us/costs-can-go-up-fast-when-er-is-in-network-but-the-doctors-are-not.html)," *New York Times,* Sept. 28, 2014. See also B. Herman, "Billing Squeeze: Hospitals in Middle as Insurers and Doctors Battle Over Out-of-Network Charges (http://www.modernhealthcare.com/article/20150829/MAGAZINE/308299987)," *Modern Healthcare,* Aug. 29, 2015.

[2] L. Hamel, M. Norton, K. Pollitz et al., *The Burden of Medical Debt: Results from The Kaiser Family Foundation/New York Times Medical Bill Survey (https://kaiserfamilyfoundation.files.wordpress.com/2016/01/8806-the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey.pdf)* (Henry J. Kaiser Family Foundation, Jan. 2016).

[3] C. Garmon and B. Chartock, "One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills (http://content.healthaffairs.org/content/early/2016/12/13/hlthaff.2016.0970)," *Health Affairs Web First,* published online Dec. 14, 2016.

[4] Federal officials have recognized state-level efforts to regulate balance billing, and federal law has protections for Medicare and Medicaid beneficiaries. See U.S. Department of Health and Human Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017; Final Rule (https://www.gpo.gov/fdsys/pkg/FR-2016-03-08/pdf/2016-04439.pdf)," *Federal Register,* March 8 2016 81(45):12204–352; referring back to U.S. Department of Health and Human Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017; Proposed Rule (https://www.gpo.gov/fdsys/pkg/FR-2015-12-02/pdf/2015-29884.pdf)," *Federal Register,* Dec. 2, 2015 80(231):75488–588.

[5] J. Hoadley, S. Ahn, and K. Lucia, *Balance Billing: How Are States Protecting Consumers from Unexpected Charges? (http://www.rwjf.org/en/library/research/2015/06/balance-billing--how-are-states-protecting-consumers-from-unexpe.html)* (Robert Wood Johnson Foundation, June 2015). In 2015, the National Association of Insurance Commissioners (NAIC) adopted revisions to its model law on network adequacy that offered limited relief for consumers in emergency and in-network hospital settings. See National Association of Insurance Commissioners, "Health Benefit Plan Network Access and Adequacy Model Act (http://www.naic.org/store/free/MDL-74.pdf)," #74 (NAIC, 2015). For a brief description of the NAIC model law, see K. Pollitz, *Surprise Medical Bills (http://www.kff.org/private-insurance/issue-brief/surprise-medical-bills/)* (Henry J. Kaiser Family Foundation, March 2016). It remains unclear how many states will adopt NAIC's approach, however.

[6] G. Claxton, M. Rae, M. Long et al., *2016 Employer Health Benefits Survey (http://www.kff.org/health-costs/report/2016-employer-health-benefits-survey/)* (Henry J. Kaiser Family Foundation, Sept. 2016).

[7] Semistructured interviews with insurance regulators and other officials were conducted in the following states: Florida, Illinois, New Mexico, New York, Oklahoma, Pennsylvania, and Washington. Connecticut regulators offered written responses to interview questions.

[8] States also may regulate balance billing in certain other situations, such as where networks are deemed inadequate.

[9] In addition to the limitations noted in this issue brief, such as setting, type of health plan, and balance billing approach, there may be other limits on protections. For example, a state protection may apply only to certain categories of providers.

[10] Based on communication with regulators in Illinois and New York. For Maryland, see J. Hoadley, S. Ahn, and K. Lucia, *Balance Billing: How Are States Protecting Consumers from Unexpected Charges? (http://www.rwjf.org/en/library/research/2015/06/balance-billing--how-are-states-protecting-consumers-from-unexpe.html)* (Robert Wood Johnson Foundation, June 2015).

[11] New York State Department of Financial Services, *Report of the Out-of-Network Reimbursement Rate Workgroup*, Jan. 26, 2017.

[12] Cal. Health & Safety Code § 1371.31(a)(1).

[13] N.Y. Fin. Serv. Law § 607. FAIR Health was created in 2009 after the state's attorney general uncovered potential conflicts of interest in the methods that health insurers were using to determine reimbursements to patients who received care from providers outside their health plans' networks. Settlement agreements with New York insurers focused on bringing fairness and transparency to the out-of-network reimbursement system. FAIR Health maintains a database of charge data for medical procedures and a website designed to help consumers estimate charges for health care services. Insurers use the data to help determine reimbursement rates for out-of-network claims.

[14] J. Hoadley, K. Lucia, and S. Schwartz, *Unexpected Charges: What States Are Doing About Balance Billing (http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20U/PDF%20UnexpectedChargesStatesAndBalanceBilling.pdf)* (California Health Care Foundation, April 2009).

[15] For this purpose, we do not count a state, per Indiana, that simply uses a usual and customary rate that does not further define the standard.

[16] Avalere Health LLC, *An Analysis of Policy Options for Involuntary Out-of-Network Charges in New Jersey (https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwjg8sG15r_RAhXIKyYKHWk6As4QFggaMAA&url=http%3A%2F%2Favalere-health-production.s3.amazonaws.com%2Fuploads%2Fpdfs%2F1427291367_AH_Analysis_of_Policy_Options__WP_v3b2.pdf&usg=AFQjCNFm9imv7K2Oz4oOx4KzWKMJqYpNTA&sig2=kztu5OvkiamBJVA96nTqmg)* (Avalere, March 2015).

[17] Washington State Office of the Insurance Commissioner, *Surprise Medical Billing (https://www.insurance.wa.gov/surprise-medical-billing)* (Jan. 2, 2017).

[18] Pennsylvania Insurance Department, "Insurance Commissioner Testifies Before Pennsylvania State Banking and Insurance Committee on Surprise Balance Billing (http://www.media.pa.gov/Pages/Insurance-Details.aspx?newsid=198)," Pennsylvania Pressroom, Oct. 19, 2016.

[19] New Mexico Office of Superintendent of Insurance, "Surprise Medical Bills Cause Confusion and Stress for Patients and Providers Alike; Superintendent of Insurance Wants to Hear from New Mexico (http://www.osi.state.nm.us/docs/Surprise%20Medical%20Bills.pdf)," March 1, 2016.

Acknowledgments

The authors thank the state insurance regulators and state officials who shared their time and valuable insights with us. Thanks also to Sandy Ahn, Paul Ginsburg, Justin Giovannelli, Katie Keith, and Karen Pollitz for their thoughtful review.

March 23, 2018

VIA EMAIL
Representative Ivy Spohnholz
Chair, House Health & Social Services
Representative.Ivy.Spohnholz@akleg.gov

Re: Proposed Substitute for HB 193

Dear Chair Spohmholz:

We are writing to support the proposed committee substitute to HB 193. Banning balance billing poses a serious threat to the healthcare safety net unless the bill also establishes an appropriate minimum benefit standard. At minimum, we urge you to maintain the minimum benefit standard currently in place in Alaska for out-of-network care. Since 2004, the 80th Percentile rule has protected Alaskan patients by making sure that insurers contribute their fair share for out-of-network care, including emergency care.

The Emergency Department Practice Management Association (EDPMA) is one of the nation's largest professional physician trade associations focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation's emergency departments. **Together, EDPMA's members deliver (or directly support) health care for about half of the 141 million patients that visit U.S. emergency departments each year.** We work collectively and collaboratively to deliver essential healthcare services, often unmet elsewhere, to an underserved patient population who often has nowhere else to turn.

The 80th percentile rule protects the healthcare safety net, patients, providers and insurers. **Emergency departments are the nation's health safety net. Even though emergency physicians are only 4% of physicians, they provide 50% of all care given to Medicaid and CHIP patients and 67% of all care to uninsured patients.** They contribute far more than their share of uncompensated and undercompensated care. If emergency physicians are also undercompensated by private insurers in Alaska, fewer emergency physicians may choose to practice in the state, lines in emergency departments in Alaska would grow, and some emergency departments may even close down.

The 80th percentile standard helps patients. Patients shouldn't be responsible for all of the costs related to "covered" emergency care simply because it was provided by an out-of-network

provider. Emergency care is an "essential health benefit" that must be "covered" whether it be in-network or out-of-network care. Insurers should contribute their fair share.

Further, the 80th percentile standard encourages insurers to negotiate lower in-network rates, resulting in more in-network providers. Without the minimum benefit standard, there is no incentive for insurers to negotiate fair in-network rates with emergency providers because federal law (the Emergency Medical Treatment and Labor Act) requires those providers to treat everyone no matter the ability to pay. The 80th percentile standard requires providers to be paid the usual, customary and reasonable rate when the patient has insurance coverage. This, in turn, helps shore up the healthcare safety net and helps ensure access to emergency care, even in remote areas.

The standard also protects insurers by establishing a standard where the top 20% of charges are not considered in the calculation of the minimum benefit standard. Overly high charges – outliers - are not even part of the formula. So it is no surprise that the National Council of Insurance Legislators adopted model legislation in 2017 that defined "usual, customary, and reasonable rate" as 80th percentile of an unbiased charge database. Even in states where there is no minimum benefit standard, some private insurers typically pay the 80th percentile. For example, in its "Information on Payment of Out-of-Network Payments", UnitedHealthcare states "Affiliates of UnitedHealth Group frequently use the 80th percentile of the FAIR Health Benchmark Databases to calculate how much to pay for out-of-network services of health care professionals …"

And when CMS asked an outside contractor to look at what benchmarking database to use for the minimum payment standard for out-of-network emergency care, the National Opinion Research Center (NORC) at the University of Chicago recommended the FAIRHealth database ("Data Sources for Establishing Payment Rates for Out-of-Network Emergency Room Services" (2014)). NORC reiterated this in a similar report addressing a benchmarking databases for all out-of-network care ("Qualitative Assessment of Databases for Out-of-Network Physician Reimbursement" (2017)).

Thank you for considering our comments, we look forward to working with you on this issue. If you have any questions, please do not hesitate to contact Elizabeth Mundinger, Executive Director of EDPMA, at emundinger@edpma.org.

Sincerely,

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cc: Members of the House Health & Social Services

American College of Emergency Physicians®
ALASKA CHAPTER
ADVANCING EMERGENCY CARE

March 28, 2018

Representative Ivy Spohnholz, Chair
House Health and Social Services Committee
State Capitol, Room 421
Juneau, AK 99801

RE: HB 193 Letter of Support

Dear Representative Spohnholz:

Representing more than 80% of the emergency physicians providing emergency medical care to the people of our state, the Alaska Chapter of the American College of Emergency Physicians writes today to ***support HB193***.

HB 193 will protect patients and families across the state from the high costs and sticker shock that can come from "surprise medical bills." Both doctors and patients support this important measure, which will provide consumer protections for patients, strengthen access to care, and put an end once and for all to surprise bills.

As emergency physicians in Alaska, we know firsthand about the gaps in patient healthcare coverage that can cause patients to postpone or avoid treatment until it's too late. According to a national survey, 44% of people reported that they didn't seek treatment when they were sick or injured because of costs. At the same time, 35% of Americans would have trouble paying their regular bills if faced with a $400 health emergency. This is alarming, but not surprising, and we must work together to ensure that patients can safely access emergency care without worrying about going bankrupt.

What good is insurance if it fails us in an emergency? Insurance companies are shifting hundreds of millions of dollars in costs to patients and doctors each year through higher premiums, deductibles and cost-sharing requirements. At the same time, Alaska insurance companies are narrowing their networks – making them smaller through limiting access to doctors and care, which means fewer options and choices for patients and creating large coverage gaps where care patients thought would be covered, turns out not to be. These gaps are leading to surprise bills, adding even more costs for patients.

Alaska patients and families deserve better. Right now, the state has a regulation in place that requires insurance companies to cover these unexpected out of network costs during emergencies through fair and appropriate payments to doctors. But, Alaska insurance companies are working to undermine this regulation – and we need your help to ensure patients are protected in the long

run. We're working to support a new bill, HB 193, that will end surprise billing altogether and provide the protection patients need.

HB 193 is a comprehensive solution that protects patients and ends surprise bills by requiring insurers to cover unexpected, emergency out of network care, and limiting patient financial exposure. HB 193 will protect patients from receiving large bills that their insurance companies have refused to pay. By establishing an appropriate and fair reimbursement standard between insurers and doctors, the bill takes patients out of the middle and improves access to care.

HB 193 sets a fair minimum standard, the 80th percentile rule that has been working in Alaska since 2004, which insurers use as a benchmark to pay out-of-network physicians, providers or facilities for unexpected care. HB 193 bans balance billing, meaning no further bills would go to patients in these situations. Because doctors will be payed fairly, there is no need for additional bills.

Despite negative attention created by misleading information by insurance companies, patients support the 80th percentile rule, and want their insurance plans to fairly cover out-of-network emergency care. The 80th percentile rule relies on transparent market-based information that takes into account local market prices for services. They are based in market costs and not set by government or manipulated by insurance companies.

Although critics have claimed that providers with extremely large market share can impact prices under this standard, there's no evidence or report of foul play. ISER (UAA's Institute of Social and Economic Research) is currently looking at this issue for Alaska. Research in New York State has shown that a similar standard did <u>not</u> increase cost after its implementation there.

Without the 80th percentile rule in HB193, patients will be left unprotected as insurance companies shirk their responsibility to pay. In fact, insurance companies would be allowed to set any rates they wanted – with no regard for costs or impact on emergency room staffing or services.

Alaska patients and families need this full protection from surprise bills. This bill with strengthen the healthcare system, offering protection first and foremost to patients, and ensuring the doctors and emergency rooms can keep their doors open and keep staffed with needed specialists and providers to best treat patients in emergencies.

We hope we can count on your support for HB 193.

Thank you for your consideration,

Ben Shelton, MD, FACEP
President, Alaska ACEP