

# Protecting Patients from Surprise Medical Bills



**At least 1 in 5 Americans** will receive a surprise medical bill from a doctor they didn't – or couldn't – know was out of their health care coverage network.



**Most surprise medical bills are arbitrary**, come from select specialty doctors, and bear no relation to market rates or the actual cost of services provided.



**Federal legislation is necessary to protect patients** by prohibiting surprise medical bills and requiring a reimbursement to providers that is market-based and fair.

## How Surprise Medical Bills Affect Americans

Every year, Americans make about 137 million visits to emergency rooms in the United States.<sup>1</sup> For at least 1 in 5 patients covered by health insurance, they will receive a surprise bill from a doctor who treated them, even though the hospital itself is part of their coverage network.<sup>2</sup> The practice, referred to as “**surprise medical billing**” can break the bank for hardworking Americans, with bills totaling thousands of dollars.

Health insurance providers negotiate lower prices with in-network hospitals and doctors—and plans often cover a significant portion of these costs. But when a doctor is not part of a plan network—even if they separately contract with a hospital to treat patients there—they can charge much higher rates.

Under current law and practice, most states allow a doctor to bill a patient for any balance that may be outstanding after the health insurance provider pays the costs it is responsible for. But those charges become truly problematic for patients when out-of-network providers—who are not bound by contractual, in-network rate agreements with an insurance provider—bill patients for the entire remaining balance.

- **In-network provider:** An in-network provider is a physician, hospital, or other provider with whom the health insurance provider or plan has negotiated a payment amount for their services, usually identified by a billing code.
- **Out-of-network provider:** A health care provider who has no contract with the health insurance provider and is not required to accept a negotiated rate.

## How Many Are Affected

The likelihood of receiving a surprise medical bill varies depending on why a patient is in the hospital and how they were admitted:

- Researchers have found that 14 percent of all patients treated in an emergency room were likely to receive a surprise medical bill, as well as 9 percent of all admitted hospital patients.<sup>3</sup>
- The figure more than doubles to 20 percent among patients admitted via the emergency room.

There is substantial geographic variance in the likelihood of receiving a surprise medical bill, as certain specialists and ERs in some parts of the country are noticeably less likely to accept private insurance.

- For example, patients being treated in McAllen, Texas and St. Petersburg, Florida had an 89 percent and 62 percent chance, respectively, of receiving a surprise medical bill.
- In Boulder, Colorado and South Bend, Indiana, researchers found the rate of surprise medical bills to be nearly zero.<sup>4</sup>

The figures for ambulatory care are even starker:

- In 2014, 51 percent of ambulance rides nationwide were likely to result in a surprise medical bill.<sup>5</sup>

Even if you have never receive a surprise medical bill, you have paid for them in the form of higher premiums. A 2015 analysis of out-of-network charges in New Jersey highlights the impact on these charges on consumer premiums.<sup>6</sup> For example, for one insurer, out-of-network claims comprised 8 percent of their total commercial spending in 2013. If the plan were to pay these out-of-network claims at 150 percent of Medicare, rather than the billed charges, it would pay 52 percent less for out-of-network services, amounting a savings of \$497 million, which could result in a reduction of 4.3 percent in total commercial claims and consumers paying 9.5 percent less out-of-pocket.

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## CONCENTRATION IN CERTAIN SPECIALTIES

The problem of surprise medical bills tends to be concentrated among certain medical specialties where the providers are likely to (a) charge substantially more than their peers in other specialties and (b) not accept private insurance. Most studies on surprise medical bills have found that these bills are most likely to come from emergency medicine physicians, anesthesiologists, radiologists, and pathologists.

**5.8x** **Anesthesiologists** charge, on average, 5.8 times the Medicare reimbursement rate

**4x** **Emergency medicine physicians** charge 4 times the Medicare rate

**4.5x** **Radiologists** charge 4.5 times the Medicare rate

**4x** **Pathologists** charge 4 times Medicare<sup>7</sup>

- One study of emergency medicine physicians found that “out-of-network emergency physicians charged an average of 798 percent of Medicare rates.”<sup>8</sup>

Too often, an emergency department itself is part of a patient’s health plan network, but the physician staff independently contracts with the department and the providers do not accept insurance. When physicians charge excessive, unreasonable rates and refuse to participate in insurance plans that would protect patients from exorbitant costs, the patient is often left footing the bill.

## Health Care Networks Improve Quality and Affordability

Health insurance providers rely on networks to ensure patients have access to the care they need from doctors they choose and trust. They negotiate payment rates that fairly and reasonably compensate providers for their services and expertise, increasingly with models that reward doctors for delivering higher value care at lower costs. As a result, when doctors and hospitals join a network, patients have greater confidence that they will be protected from high costs when they get sick or injured, particularly in emergency situations.

Many, if not most, health insurance providers cover much of the cost for services performed by an out-of-network provider. However, because out-of-network providers are not in a contractual agreement with the health plan, there is nothing to stop the provider from sending bills to patients when a plan does not pay the full amount they charge. Our legislative recommendations directly address this concern.

Networks also help to ensure that consumers have access to high-quality and effective care. Health insurance providers evaluate doctors and hospitals for quality and safety performance before including them in a network. This involves ensuring that facilities and providers meet patient safety goals and credentialing standards.

In fact, performance on quality measures is the key part of criteria used for provider selection and inclusion in a plan’s network—including high-value network plans. In developing their networks, health insurance providers also make sure they have the variety of primary care doctors, specialists, hospitals, and other providers that consumers need and can access in a variety of locations. Health insurance providers periodically reevaluate the qualifications of the providers and their performance within their networks to make sure the consumers’ needs are met.

Developing strong provider networks that ensure patients have access to the care they need from providers they choose is not only a top priority for health insurance providers, it’s also the law. Most health insurance providers are required by law to meet either federal or state standards for network adequacy; many state standards are based on the National Association of Insurance Commissioners’ Managed Care Plan Network Adequacy Model Act. Although the standards vary between different states, they reflect the common theme that plans must provide options that minimize the distance a patient would have to travel for care. In other words, the law requires that private health plans have robust provider networks and also requires regular verification of their continued compliance.

# How to End Surprise Medical Bills

## CURRENT STATE LAW APPROACHES

Today, no federal law prohibits surprise medical bills, although some state laws address the issue. Existing law contains requirements for when emergency room care is covered and required that health insurance providers limit cost-sharing and reimburse providers following emergency services. In implementing these requirements, HHS established the “Greatest of Three” Rule, which limits the amount the health insurance provider is required to pay an out-of-network emergency services provider.<sup>9</sup> The insurance provider is required to pay the greatest of:

- the amount the insurance provider pays in-network providers for the same services;
- (2) the amount calculated by the insurance provider to be the “usual, customary, and reasonable charges” for such services; or
- (3) the amount that would be paid under Medicare for such services.

However, neither the law nor the implementing regulations prohibit the provider from billing the patient for the balance.

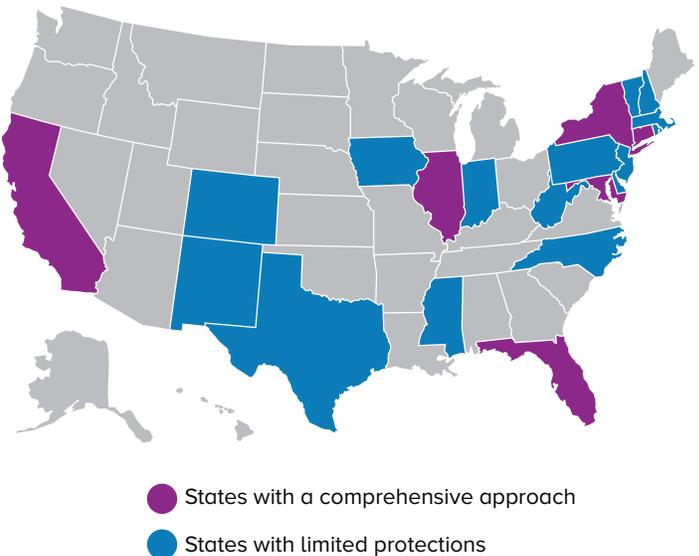
Currently, 21 states have laws that provide some level of protection from surprise medical bills, with 15 states having only limited protections.<sup>10</sup> The approaches in these states vary as follows:

- Eight states limit their regulation to the emergency department. Patients in these states cannot be balance billed for services at an out-of-network emergency department.
- Five states prohibit balance billing only for patients covered by a Health Maintenance Organization (HMO).
- Twelve states have “hold harmless” laws that require insurers to pay providers their billed charges or another amount the provider deems acceptable.
- Fourteen states have neither a payment standard (sometimes called a “benchmark”) nor an independent dispute resolution process for when providers and health plans disagree on what is a reasonable rate. As these are all “hold harmless” states, providers often use this ambiguity to charge high amounts to insurers, who must pay the entire bill so that the consumer is not liable, which results in higher costs for everyone.
- The other six states do have forms of comprehensive protection laws, which prohibit surprise medical bills both in emergency settings as well as non-emergency care at an in-network hospital, relying on either a payment benchmark or a dispute resolution process, or both.

## THE NEED FOR FEDERAL INVOLVEMENT

While states have taken varying approaches to addressing the issue of surprise medical bills, the problem has yet to be solved. This is in part because states lack the authority to impact the more than 100 million Americans enrolled in employer-provided coverage that is self-funded by their employer. Self-funded health plans are primarily governed by the Employee Retirement Income Security Act of 1974 (ERISA), which has a provision (referred to as state preemption) that precludes states from regulating these plans. Therefore, federal legislation is necessary. It is also with precedent, as ERISA has been amended to require mental health parity, establish out of network emergency room payment amounts, cover clinical trials, and prohibit annual and lifetime dollar maximums.

### *States with laws providing some level of protection from surprise medical bills*



## Recommendations

- **Prohibit surprise medical bills:** The law can ensure that patients not be financially penalized in cases when they receive out-of-network care through no fault of their own. In these circumstances, the law can prohibit providers from billing the patient for costs not covered by their health insurance provider.
- **Protect patients when they need treatment:** Legislation to prohibit surprise medical bills can apply to situations when patients require emergency medical treatment, ambulance services, or are treated by an out-of-network physician at an in-network hospital.
- **Establish a fair, market-based reimbursement standard:** Policy should encourage health insurance providers and doctors to collaborate by building networks that deliver high quality care and value. Federal policy should focus on ensuring that doctors are fairly compensated for their services, while encouraging them to participate in high-value networks. Policies that excessively pay out-of-network doctors raise premiums for everyone, undermine networks and care coordination - increasing health care and coverage costs while decreasing value for patients. In setting a standard, Congress should ensure that the method does not lead to increased health costs for either the individual consumer or the health care system.
- **Reach patients in all commercial health plans:** More than 100 million Americans are enrolled in self-funded health plans, and protecting those consumers requires federal action that reduces complexity while ensuring they cannot be surprise billed. Any federal standard for out-of-network payments should allow state flexibility for fully insured plans so long as a minimum federal threshold is achieved, but preserve ERISA's national, uniform rules for self-funded plans. Any federal standard for payments to out-of-network doctors should apply to self-funded ERISA health plans, as well as in states that don't enact their own standards for fully insured plans.
- **Keep patients informed:** Patients have a right to know about the costs of their treatment and options. They should receive complete information about whether facilities or providers do not participate in the patient's health plan and what that could mean for the patient's financial obligations.

AHIP has partnered with a broad coalition of consumer groups, employers, brokers, and others to lead the way in advocating for patient-centric legal solutions to the epidemic of surprise medical bills affecting millions of Americans.<sup>11</sup> We believe that federal reforms can help protect patients from these bills while also lowering costs for everyone and improving public confidence in our health care system.

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## Endnotes

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- 3 Garmon, C., & Chartock, B. (2017). One In Five Inpatient Emergency Department Cases May Lead To Surprise Bills. *Health Affairs*, 36(1), 177-181. [\\_jun\\_lucia\\_balance\\_billing\\_ib.pdf](#)
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- 6 Avalere Health (2015). "An Analysis of Policy Options for Involuntary Out-of-Network Charges in New Jersey." [http://avalere-health-production.s3.amazonaws.com/uploads/pdfs/1427291367\\_AH\\_Analysis\\_of\\_Policy\\_Options\\_WP\\_v3b2.pdf](http://avalere-health-production.s3.amazonaws.com/uploads/pdfs/1427291367_AH_Analysis_of_Policy_Options_WP_v3b2.pdf)
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- 9 Public Health Service Act Section 2719A and 29 CFR 2590.715-2719A
- 10 Lucia, K., Hoadley, J. & Williams, A. (2017). Balance Billing by Health Care Providers: Assessing Consumer Protections Across States. The Commonwealth Fund: [https://www.commonwealthfund.org/sites/default/files/documents/\\_media\\_files\\_publications\\_issue\\_brief\\_2017](https://www.commonwealthfund.org/sites/default/files/documents/_media_files_publications_issue_brief_2017)
- 11 <https://www.ahip.org/health-care-leaders-unite-to-protect-patients-against-surprise-medical-bills/>