

# SURPRISE MEDICAL BILLS

## Policymakers Seek Solutions to Protect Consumers

Surprise medical bills, also referred to as “balance billing” or unexpected medical bills, are charges that arise when a person with private health insurance unknowingly receives care from an out-of-network (OON) provider resulting in higher than expected (surprise!) out-of-pocket costs.

This may occur when a patient goes to an in-network hospital or surgical center, but medical care, imaging or tests are provided by an OON provider working there. In these situations, the individual may subsequently receive a surprise medical bill from the OON provider. This may be because the OON provider charges higher rates than the patient’s insurance has agreed to pay, so the provider “balance bills” the patient for the difference. Or because the patient’s insurance requires them to pay a larger share of the cost of care received from OON providers through higher copays or deductibles. Either way the result is the same, the patient is responsible for more of the cost of their care.

### How Common are Surprise Medical Bills?

#### Inpatient Admissions

For inpatient admissions in 2016, Kansas had the second highest rate (24.0 percent) of inpatient admissions with an OON claim

Figure 1. Surprise Medical Bills/Balance Billing



Surprise medical bills are charges that arise when an individual with private health insurance coverage unknowingly receives care from an out-of-network provider that results in higher than expected out-of-pocket costs.

#### WHY DO SURPRISE BILLS HAPPEN?

##### FINDING A PROVIDER

The individual in need of care checks to make sure the provider or facility is in their insurer’s network and assumes all services will be covered.



##### IN THE NETWORK

Insurers build their provider networks by contracting with doctors, hospitals and labs to provide services for their individual enrollees and set the rules for how much their enrollees must pay out of pocket for those services.



##### BALANCE BILLING

But ... sometimes providers who work in a clinic or hospital are not participating in that facility’s network, so patients may be unaware that they have received care from an out-of-network specialist – say, a radiologist or anesthesiologist – or received services from an out-of-network lab, until they receive the “surprise” bill for those services from the out-of-network provider.



### KEY POINTS

- ✓ Surprise medical bills are charges that arise when an individual with private health insurance unknowingly receives care from a provider not covered by that insurance, resulting in higher than expected out-of-pocket costs for the patient.
- ✓ In 2016, the share of in-network hospital admissions in Kansas with at least one associated out-of-network claim was 24 percent.
- ✓ Nearly one out of every four (24 percent) emergency department visits by Kansans with insurance through a job with a large employer (generally more than 50 employees) had at least one out-of-network charge, higher than all but four other states.
- ✓ As of Sept. 16, 2020, 31 states – not including Kansas – have enacted laws to protect consumers from surprise medical bills.

among the 37 states and the District of Columbia included in a [March 2019 study](#). The share of in-network hospital admissions with at least one associated OON claim ranged from 1.7 percent in Minnesota to 26.3 percent in Florida, with an average of 14.5 percent. This means that despite obtaining care at an in-network hospital, about one in seven patients received a surprise medical bill for care provided during their hospitalization. Anesthesiology, emergency room care, and lab tests were among the common culprits.

## Emergency Services

[In a study published earlier this year](#), nearly one in five (18 percent) emergency visits by people with coverage from a large employer (generally more than 50 employees) resulted in at least one OON charge. In this study, the rate of OON billing for emergency visits varied from 4 percent in Alabama to 38 percent in Texas — and the rate in Kansas was 24 percent, higher than all but four of the other 50 states.

People with large employer coverage living in urban areas were more likely to have an emergency visit that resulted in at least one OON charge than those living in rural areas (18 percent compared to 14 percent). Emergency visits that lead to an inpatient admission were more likely to result in an OON charge than outpatient-only emergency visits (26 percent compared to 17 percent).

## State Action

As of Sept. 16, 2020, 31 states — not including Kansas — have enacted laws to protect consumers from surprise medical bills and balance billing (*Figure 2*, page 3). Of those states, 16 have enacted laws that take a comprehensive approach that includes:

- Holding consumers harmless by limiting their financial exposure to typical in-network cost sharing;
- Extending protections to both emergency department and in-network hospital settings;
- Applying to enrollees of health maintenance organizations and preferred provider organizations;
- Prohibiting providers from balance billing; and
- Adopting a specific payment standard or

process for resolving payment disputes between providers and insurers.

## Hold Harmless Protection

The hold harmless protection included in comprehensive state laws generally involves two types of requirements:

1. State regulated insurers are required to cover OON claims and apply their in-network level of cost sharing for surprise medical bills, and
2. OON providers are prohibited from balance billing patients covered by state regulated health plans and are limited to collecting no more than the applicable in-network cost sharing amount from patients.

Some state laws also include provisions that require insurers to provide written notice to consumers in their explanation of benefits statements and billing invoices about their rights and protections related to surprise medical bills.

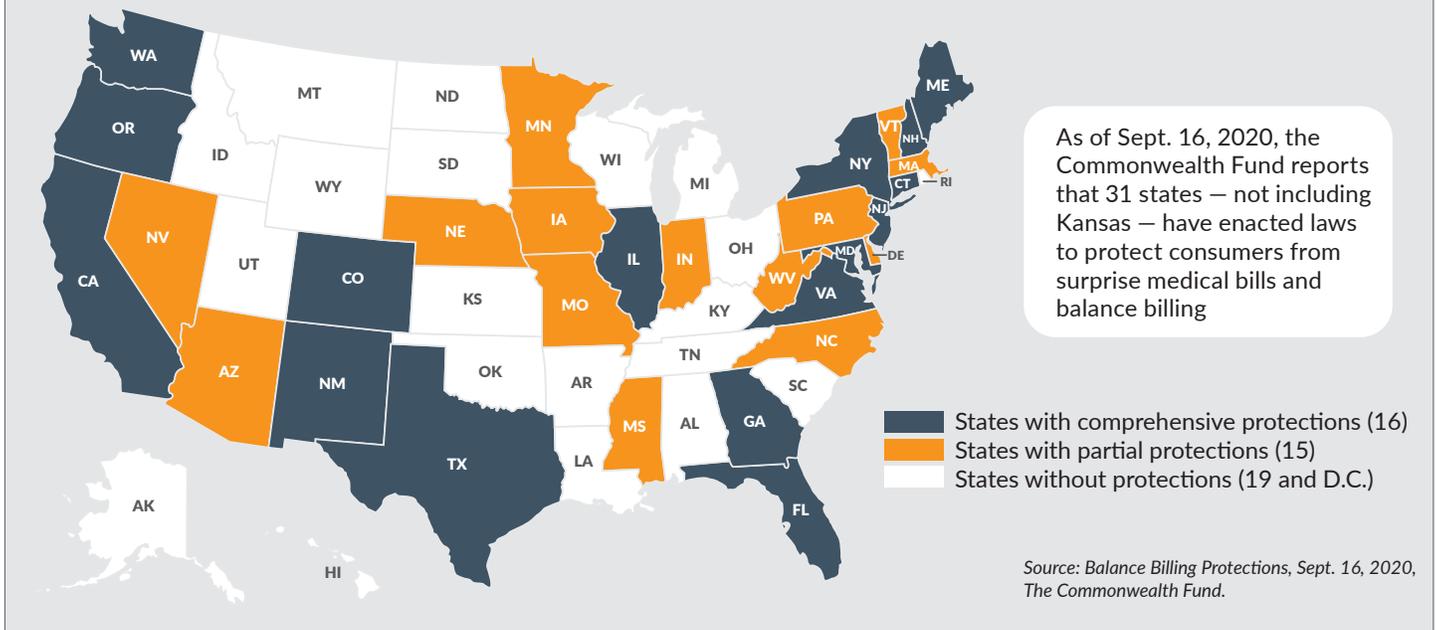
## Payment of Surprise Medical Bills

Approaches taken by states to determine the amount an OON provider will be paid by the insurer for surprise medical bills vary but generally involve adopting a payment standard or establishing a dispute resolution process that insurers and providers can use to reach agreement on the amount to be paid, with some states using a combination of both.

Some states require health insurers to pay OON providers a percentage of the amount Medicare fee-for-service would pay, or an average contracted amount that the plan pays for the same or similar service in the provider's geographic area.

Some states use a binding arbitration process, which sometimes requires the insurers and providers to first attempt to negotiate a payment amount before going to arbitration. If an agreement cannot be reached, the parties submit their best offer and the arbiter decides which offer wins. The losing party must pay the cost of the arbitration fee, which can run from \$300 to \$500. State regulators have reported that most surprise bills subject to these types of arbitration requirements are resolved through negotiations between the insurers and providers.

Figure 2. State Laws Protecting Consumers Against Balance Billing, Sept. 16, 2020



### Other Surprise Bill Protections

States that have enacted less comprehensive protections related to surprise medical bills have required that consumers be notified by their health plan or the hospital that they may encounter surprise bills, while others protect consumers from surprise bills associated with emergency care but not other care provided at in-network hospitals.

### Kansas Legislation

During the 2020 Kansas legislative session, one comprehensive bill, Senate Bill (SB) 357, related to surprise medical bills was introduced early in the session but did not receive a hearing. SB 357 would have prohibited health insurers and health care providers from engaging in balance billing practices for services provided in hospitals, ambulatory surgery centers and provider offices, and would have made insured individuals liable only for the in-network cost sharing provided in their health plan.

The bill also prohibited health benefit plans (such as those authorized under K.S.A. 40-4602 and 40-2209), insurers and providers from issuing surprise medical bills, and required health benefit plans and insurers to pay the median in-network rate under the covered person’s health insurance to the OON provider. However, if the provider did not accept that payment, the health benefit plan, insurer or

provider could negotiate an alternative amount or initiate independent dispute resolution, with certain limitations.

### Federal Legislation

Most large employers self-fund health insurance for their employees. Since federal law preempts state regulation of self-funded health plans, surprise billing laws enacted by states provide no protection for consumers covered by large employers with self-funded health plans.

Federal action would be required to protect consumers enrolled in those plans. Nationally, it is estimated that over 60 percent of workers who receive coverage through their jobs are covered under self-funded health plans.

On May 9, 2019, President Trump urged Congress to enact bipartisan legislation to outlaw surprise medical bills in all types of health insurance plans. Over the last year, four House and Senate committees — House Energy and Commerce Committee; Senate Health, Education, Labor, and Pension (HELP) Committee; House Ways and Means Committee; and House Education and Labor Committee — have drafted, marked up and voted on four bipartisan bills to prevent surprise medical bills.

The three bills still under consideration would ensure that consumers do not receive surprise bills

for cost-sharing beyond what they would pay for in-network providers (hold harmless protection), but differ in the way they establish what insurers will pay to OON providers. The Neal-Brady Bill (H.R. 5826), which is supported by hospitals and physician groups, provides a 30-day negotiation period, followed by independent dispute resolution if the parties do not reach an agreement. The Scott-Foxx Bill (H.R. 5800) and the Alexander-Murray Compromise Bill provide for a payment standard of the median in-network rate of the insurer for 2019 that would be inflated for future years and, for claims over \$750 (or \$25,000 for air ambulance cases), a binding independent dispute resolution process.

## **Special Protections During COVID-19**

The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) signed by President Trump on March 27, 2020, includes the Provider Relief Fund, which authorizes funds to be disbursed to physicians, hospitals and other providers to address the economic harm and impact on providers as a result of the pandemic. As a condition of receiving these funds, providers are required to (1) agree they will not seek to collect out-of-pocket payments from “presumptive or actual” COVID-19 patients that are more than what the patient would have paid for care from an in-network provider, and (2) are prohibited from balance billing for COVID-19 care. The CARES Act also includes language that ensures that OON lab providers will receive “fair payment” for COVID-19 testing by requiring commercial insurers to pay them an amount equal to the “cash price” for the service listed on the provider’s public website.

The Families First Coronavirus Response Act (FFCRA), signed by the President on March 18, requires “most private health plans to cover testing

for the coronavirus with no cost sharing during the emergency period,” including all group health plans and individual health insurance coverage. The cost-sharing provisions do not apply to short-term health insurance policies or coverage sold by organizations like the Kansas Farm Bureau or health care sharing ministries. FFCRA sunsets on December 31, 2020.

A few states also have enacted protections for COVID-19 patients similar to those in federal law. A Connecticut executive order prohibits surprise billing for any emergency services rendered to insured patients, requires insurers to pay OON providers their in-network rate and prohibits providers from billing uninsured COVID-19 patients more than the Medicare rate for the services provided. Massachusetts has mandated in-network coverage for services related to the treatment of COVID-19, prohibited providers from balance billing consumers for the cost of OON services, and required insurers to pay OON providers the in-network rate when the insurer has an existing agreement with the hospital where the OON provider is practicing, or 135 percent of the Medicare rate if no agreement exists.

## **Conclusion**

Although some states have taken action to protect consumers from surprise billing through state-regulated insurers, federal action would be required to protect those who are covered by large employer self-insured health plans exempt from state regulation. While the insurance industry, employers and health care providers all support legislation to protect patients from surprise medical bills, Congress is finding it difficult to balance the interests of consumers, insurers and providers when it comes to establishing how payments should be determined.

### **ABOUT THE ISSUE BRIEF**

This brief is based on work done by Linda J. Sheppard, J.D., and Sydney McClendon. It is available online at [khi.org/policy/article/20-48](https://khi.org/policy/article/20-48).

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