



Out of Control

Patients Are Unwittingly Subjected to Enormous,
Unfair, Out-of-Network 'Balance Bills'

Acknowledgments

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Introduction

Excessive medical debt resulting from the provision of health care can cause families and individuals to spend down their savings, forego medical treatment, and even go without paying for food and heat.¹ In the United States, medical bills are the leading cause of individual and family bankruptcy. In 1981, only 8 percent of families filing for bankruptcy protection did so in the aftermath of receiving medical care.² However, by 2007, more than 62 percent of all bankruptcies were linked to a medical event, according to a study published in the *American Journal of Medicine*. And bankruptcy was not limited to the uninsured. To the contrary, the study reported that more than 75 percent of filers had health insurance.³

One driver of excessive health care bills is a practice known as “balance billing,” which refers to bills for the difference between the amount that an insurance company is willing to pay for treatment and a provider’s total charges. Providers who are not members of a patient’s insurance network have charged patients as much as 9,000 percent of what Medicare would have paid for the same procedure.⁴ In contrast, payment for in-network medical services is on average 123 percent of Medicare.⁵

Patients can be subjected to balance bills despite making their best efforts to avoid them. For instance, they might receive care at an in-network facility, only to find out later that an out-of-network doctor also provided medical services. This is because many doctors work *at* hospitals rather than *for* hospitals, and are not members of the same insurance network as the hospital.⁶

Solutions are possible at both the federal and state levels that would protect consumers from balance bills without unduly burdening providers or insurers, or upsetting the existing system of insurance networks. This paper outlines policies that have been implemented at each of these levels and proposes additional protections at the federal level.

¹ Susan Heavey, *Consumers Face Rising Medical Debt: Survey*, REUTERS (August 20, 2008), <http://reut.rs/1ocmx8M>.

² David U. Himmelstein, Deborah Thorne, Elizabeth Warren, and Steffie Woolhandler, *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 *American Journal of Medicine* 741, 741-746 (2009). <http://bit.ly/1fXkIXL>.

³ *Id.*, at 744.

⁴ AMERICA’S HEALTH INSURANCE PLANS, A HIDDEN THREAT TO AFFORDABILITY 3 (January 2013), <http://bit.ly/19YTqSA>.

⁵ MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 110 (March 2014) <http://1.usa.gov/1jbrJKn>.

⁶ Tara Siegal Bernard, *Out of Network, Not by Choice, and Facing Huge Health Bills*, NEW YORK TIMES (October 18, 2013), <http://nyti.ms/1k1i9Xi>.

I. Three Potential Balance Billing Scenarios

This section will briefly discuss three general scenarios through which patients might receive a balance bill.

In the first, a patient knowingly selects a provider that is outside of her network. For example, a family may choose an out-of-network pediatrician because the provider has a particularly good reputation or is more convenient to the patient's home or work. Or a patient might opt to continue seeing an out-of-network provider whom she initially began seeing when the doctor was in her network. The people in these examples have chosen to see physicians who are out of their networks and would have a reasonable expectation to receive balance bills. They do not need new protections.

Second, a patient might carefully select an *in-network* facility (such as a hospital) in which he or she will receive care, but in the course of treatment at this in-network facility, an *out-of-network* doctor provides some service to the patient. This may occur without the patient being aware that the provider is out-of-network or that the medical service even occurred at all. This could be something as simple as a pathologist analyzing tissue biopsy samples or a radiologist interpreting x-rays. Though they are often essential to care, these types of services are often done without the patient's knowledge and even without any interaction with the patient. Thus, even when a patient takes care to select an in-network hospital and an in-network doctor, he or she cannot anticipate the network status of secondary providers for a given procedure.⁷ Patients in these scenarios should be protected from receiving balance bills.

Third, a patient can receive balance bills as a result of receiving emergency care. Frequently, a patient needing emergency care is incapable of choosing an in-network hospital or in-network providers due to the seriousness of the injury. Patients who receive emergency care should be protected from receiving balance bills.

Balance billing reform requires a clear definition of what constitutes an emergency situation. The Emergency Medical Treatment and Labor Act ("EMTLA") defines a medical emergency as:

"[A] medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to pregnant women, the health of the woman or her unborn child) in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part; or with

⁷ NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES, AN UNWELCOME SURPRISE: HOW NEW YORKERS ARE GETTING STUCK WITH UNEXPECTED MEDICAL BILLS FROM OUT-OF-NETWORK PROVIDERS 6 (2012), <http://bit.ly/MrE0ve>.

respect to a pregnant woman who is having contractions—that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health and safety of the woman or unborn child.”⁸

In EMTLA, this definition of medical emergency is applied primarily to hospital emergency departments. However, patients can receive treatment for emergency conditions outside of hospital emergency departments. This definition of an emergency medical condition should be applied to future balance billing regulations.

How Often and How Much? Balance Billing in Context

A study conducted for the California Healthcare Foundation by Thomson Reuters found that in 2006, Californians with employer-based or other private insurance were treated by out-of-network providers about 11 percent of the time. The study analyzed the gap between potential in-network reimbursement rates and out-of-network charges to calculate what the average potential balance bill per patient would have been. For the 11 percent of Californians that received out-of-network care, the average potential balance bill would have totaled nearly \$1,300 (which includes charges by facilities, physicians, and other providers), in addition to an average of \$400 that patients would have paid in cost-sharing, which includes co-payments and deductibles.⁹ (The researchers did not have access to actual bills to confirm if their analysis was consistent with actual results.) A 2007 study by the California Association of Health Plans discovered that over two years, California policyholders were balance billed more than \$520 million by out-of-network providers.¹⁰

A 2011 study by America’s Health Insurance Plans (AHIP) concluded that 88 percent of insurance claims were for procedures performed by in-network providers, leaving 12 percent conducted by out-of-network providers.¹¹ The nature of payment and billing data makes it difficult to determine what percentage of out-of-network care occurred in emergency situations or by out-of-network providers at in-network facilities versus out-of-network care arising from conscious decisions by patients.

Out-of-network bills can be very expensive, particularly when compared to Medicare payment rates. In 2013, Dyckman & Associates conducted a study on behalf of AHIP that analyzed the maximum amount charged by an out-of-network provider and compared that

⁸ Emergency Medical Treatment and Labor Act 42 USC § 1395dd(e)(1).

⁹ Jack Hoadley, Kevin Lucia, and Sonya Schwartz, CALIFORNIA HEALTHCARE FOUNDATION, UNEXPECTED CHARGES: WHAT STATES ARE DOING ABOUT BALANCE BILLING 4 (April 2009), <http://bit.ly/LklVim>.

¹⁰ Chad Terhune, *Medical Bills You Shouldn’t Pay*, BLOOMBERG BUSINESSWEEK MAGAZINE (August 27, 2008), <http://buswk.co/1eQ2nPB>.

¹¹ AMERICA’S HEALTH INSURANCE PLANS, SURVEY OF CHARGES BILLED BY OUT-OF-NETWORK PROVIDERS 3 (January 2013), <http://bit.ly/1gnxKOG>.

amount to the corresponding Medicare fee for the same state. The study discovered that for 24 different standardized codes for medical procedures, out-of-network providers charged patients between 1,730 percent and 9,465 percent of the corresponding Medicare charge.¹² Data were collected for 30 states. A tissue exam by a pathologist had the highest cost discrepancy in 20 states and was among the top 10 in all 30 states.¹³ That procedure had an average rate of 4,000 percent of the Medicare charge.¹⁴ Moreover, this is exactly the type of procedure that is highly likely to result in a balance bill despite a patient's best attempts to avoid one; a pathologist is a provider that might not even interact with a patient, leaving the patient clueless as to whether that provider is in his or her network.

Impact on Individuals and Families

In 2013, the *New York Times* profiled the D'Andreas, a New York family whose nine-week old daughter required and underwent heart surgery.¹⁵ The daughter's primary surgeon was in-network, but the assistant surgeon, unbeknownst to the family, was out-of-network. Though the family was insured, it ended up receiving tens of thousands of dollars' worth of bills from out-of-network providers, including the assistant surgeon.¹⁶ In another case, also in New York, a patient arranged to have heart surgery. He confirmed that the hospital and primary surgeon were in-network, but was unaware that an assistant surgeon was out-of-network, resulting in a \$7,516 bill.¹⁷ New York law does not require providers to notify patients whether or not they are in-network prior to treating a patient.¹⁸

Patients are left particularly vulnerable to balance bills in emergency situations. In a complaint submitted to the New York State Department of Financial Services, a patient severed a finger with a table saw and was taken to an emergency room. Although he was treated at an in-network hospital, he was sent balance bills of \$83,000 and \$16,000 from an out-of-network plastic surgeon and an out-of-network assistant surgeon who reattached his finger.¹⁹ In another emergency situation, a New York patient was billed \$159,000 by an

¹² AMERICA'S HEALTH INSURANCE PLANS, A HIDDEN THREAT TO AFFORDABILITY 3 (January 2013), <http://bit.ly/19YTqSA>.

¹³ *Id.*, at 9-24.

¹⁴ *Id.*

¹⁵ Tara Siegal Bernard, *Out of Network, Not by Choice, and Facing Huge Health Bills*, NEW YORK TIMES (October 18, 2013), <http://nyti.ms/1k1i9Xi>.

¹⁶ *Id.*

¹⁷ NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES, AN UNWELCOME SURPRISE: HOW NEW YORKERS ARE GETTING STUCK WITH UNEXPECTED MEDICAL BILLS FROM OUT-OF-NETWORK PROVIDERS 2 (2012), <http://bit.ly/MrE0ve>.

¹⁸ *Id.*

¹⁹ *Id.*

out-of-network neurosurgeon. Medicare would have paid only \$8,493 for the provided services.²⁰

In 2008, a Las Vegas, Nev., man was taken to the emergency room with a fractured eye socket. Although he tried to confirm that he would be treated by in-network providers prior to receiving treatment, he was visited by an out-of-network doctor while under anesthesia. He was sent a balance bill for \$8,200.²¹ In 2014, Melinda Allen was taken to Fort Worth, Texas, emergency room after experiencing severe abdominal pain. The hospital was in her network, but the emergency room physician who treated her was not, and sent her a balance bill.²² Several weeks later, her husband ended up at the same hospital and was treated by the same doctor. Although he tried to refuse treatment from the out-of-network doctor, his objections were dismissed, he said. He was treated, and subsequently received a balance bill.²³

Sometimes, patients receive prior approval from their insurance company to visit an out-of-network provider, yet still receive a balance bill from that provider.²⁴ This was the case for a Virginia family, which, in 2003, received permission from its insurance company to visit an out-of-network provider in order to have that provider perform an operation on their newborn son.²⁵ The family was required by its insurance company to obtain a letter from their in-network provider indicating that going out of network was essential for the health of the child. The family obtained the letter and received a response from their insurance company indicating that it would pay the new surgeon based on “in-network plan benefits.”²⁶ The family assumed — incorrectly — that it would not have to pay more than \$3,000 for the surgery, the maximum annual out-of-pocket cost under their individually purchased insurance plan. But, the out-of-network providers charged the family \$159,000. The insurance company agreed to pay \$74,000 (the in-network payment rate), leaving the family responsible for paying \$85,000.²⁷

²⁰ *Id.*

²¹ Anna Wilde Matthews, *Surprise Health Bills Make People See Red*, WALL STREET JOURNAL (December 4, 2008), <http://on.wsj.com/1gwEZ6q>.

²² Deanna Dewberry, *In-Network Emergency Room, Out-of-Network Doctor Could Equal a Big Bill*, NBC-DFW (February 4, 2014), <http://bit.ly/N48G6D>.

²³ Deanna Dewberry, *New Rules Empower Patients Fighting Surprise Medical Bills*, NBC-DFW (February 5, 2014), <http://bit.ly/1ct4zXo>.

²⁴ Jordan Rau, *Insurer Okayed Out-of-Network Care for Heart Patient but Family Faces Huge Bill*, WASHINGTON POST and KAISER HEALTH NEWS (January 19, 2010), <http://wapo.st/1fE71b6>.

²⁵ *Id.*

²⁶ *Id.*

²⁷ *Id.*

II. Existing Protections and Regulations

The authority to regulate insurance varies significantly. Federal laws and regulations govern Medicare, Medicaid, and insurance plans for which employers accept the liability. (These plans are often called self-insured plans and are governed by the federal Employee Retirement Income Security Act, or ERISA.) States have the authority to regulate plans in which employers or individuals purchase insurance coverage from private companies. Within their areas of authority, states and the federal government have tried to protect some, but not nearly all, consumers from receiving balance bills for circumstances beyond their control.

Existing State Based Protections

States can protect patients from balance billing in several ways. First, states can regulate whether those who are members of certain types of insurance plans may be liable for receiving balance bills. At least 12 states protect members of health maintenance organizations (“HMOs”) from receiving balance bills from out-of-network providers under certain circumstances.²⁸ Some states provide protections only for emergency situations, while other states prevent balance billing for all services covered by the beneficiary’s insurance contract. Balance billing protections are extended in eight of these 12 states to members of a preferred provider organization (“PPO”).²⁹ These states are listed in Table 1.

Forty-nine states and the District of Columbia ban subjecting HMO beneficiaries to balance bills for care provided by an in-network provider. (Alaska is the only state that does not have such a ban.)³⁰ Twenty-seven states have a similar ban for PPOs.³¹ Protections from balance bills for care given by in-network HMO and PPO providers would seem to be redundant because in-network providers presumably have agreed to accept their insurance networks’ payment rates.

²⁸ *State Restriction Against Providers Balance Billing Managed Care Enrollees*, KAISER FAMILY FOUNDATION (viewed February 7, 2014), <http://bit.ly/1cbHpEE>.

²⁹ *Id.*

³⁰ *Id.*

³¹ A preferred provider organization (PPO) is a health plan that establishes contracts with health care providers to create a network providers. When patients use a provider that is in that patient’s network, the patient will typically pay less than if they used a doctor outside the network. See *Preferred Provider Organization*, HEALTHCARE.GOV (viewed February 25, 2014), <http://1.usa.gov/1fRkuzV>.

Table 1: State Balance Billing Protections

State	Scope of Protection	Type of Protection
California	HMOs and PPOs	HMO: ER services (except ambulance services) PPO: ER services (except ambulance services)
Delaware	HMOs only	ER services and certain other situations related to network adequacy
Florida	HMOs and PPOs	HMO: Any other service covered and authorized by HMO and when the provider knows the HMO is liable PPO: Any other service covered and authorized by PPO and when the provider knows the PPO is liable
Illinois	HMOs only	Ambulance services
Maryland	HMOs and PPOs	HMO: Covered benefits PPO: Covered benefits
Minnesota	HMOs and PPOs	HMO: Certain covered services PPO: Certain covered services
New Jersey	HMOs and PPOs	HMO: Emergency and urgent care services PPO: Emergency and urgent care services
New York	HMOs and PPOs	HMO: Ambulance services and acute care facilities for end of life cancer care PPO: Ambulance services
Pennsylvania	HMOs and PPOs	HMO: Emergency services PPO: Emergency services
Rhode Island	HMOs only	Covered services provided and or made available by HMO
Utah	HMOs and PPOs	HMO: Rural areas for specified covered services PPO: Rural areas for specified covered services
West Virginia	HMOs only	Emergency services

Source: *State Restriction Against Providers Balance Billing Managed Care Enrollees*, KAISER FAMILY FOUNDATION (viewed February 7, 2014), <http://bit.ly/1cbHpEE>.

When states protect consumers from balance bills, they may go about it in different ways. In 2006, Colorado passed a law that required consumers to be “held harmless,” which meant that patients would be protected from receiving bills from out-of-network providers when they were treated by those providers at an in-network facility.³² Under those circumstances, the burden would fall on the insurance company to pay the full balance of the bill.³³ This law was repealed in 2010 through a sunset provision written into the original legislation.

Alternatively, states may establish a payment standard that limits how much providers may bill out-of-network patients. For example, in 2007, the California legislature passed legislation that would have capped payments to out-of-network physicians at 250 percent of the Medicare payment rate. This bill would have applied only to emergency care and care provided by emergency room physicians, which would have *excluded* care provided by

³² Jordan Rau, *Insurer Okayed Out-of-Network Care for Heart Patient but Family Faces Huge Bill*, WASHINGTON POST and KAISER HEALTH NEWS (January 19, 2010), <http://wapo.st/1fE71b6>.

³³ *Id.*

specialists, even if that care was provided in the emergency room. The measure was vetoed by Gov. Arnold Schwarzenegger (R).³⁴

Similarly, in 2002, Maryland, limited the payment rate for covered services provided by non-network physicians to HMO members.³⁵ In Maryland, HMOs will pay the greater figure of 125 percent of the rate it would pay to an in-network provider in the same geographic area *or* the rate an HMO would have paid to a non-network provider for the same procedure in 2000.³⁶ For a patient who is treated at a trauma center, a provider is paid by the HMO at the greater amount of either 140 percent the rate that Medicare would pay to a similar provider *or* the rate paid in 2001 by the HMO in the same geographic area for the same procedure.³⁷

Existing Federal Protections

The federal government regulates health insurance received by patients enrolled in Medicare, Medicaid, and self-funded employer-based insurance. Federal regulators are also responsible for guaranteeing that certain minimum standards are met by private plans and plans offered through federal and state exchanges, which were established by the Patient Protection and Affordable Care Act.

Medicare and Medicaid Regulations

Balance billing of Medicare enrollees is very rare. In 1984, Medicare instituted a participating physician program. The program would pay providers who joined a baseline rate in exchange for a guarantee by those providers to always accept assignment for Medicare patients.³⁸ Assignment refers to a provider agreeing not to charge patients more than what Medicare has approved as payment. Providers who did not join the program would be paid at 95 percent of the baseline rate paid to participating providers.³⁹

Later, in 1989, Congress overhauled Medicare's payment structure such that a provider's total bill could not exceed 115 percent of what the provider would receive from Medicare.⁴⁰ For example, if a patient went to a non-participating provider for a procedure, and the

³⁴ Jack Hoadley, Kevin Lucia, and Sonya Schwartz, CALIFORNIA HEALTHCARE FOUNDATION, UNEXPECTED CHARGES: WHAT STATES ARE DOING ABOUT BALANCE BILLING 10 (April 2009), <http://bit.ly/LklVim>.

³⁵ *Id.* at 8.

³⁶ MARYLAND HEALTH CARE COMMISSION, STUDY OF THE BALANCE BILLING PROVISION IN MARYLAND 27 (March 2013), <http://1.usa.gov/1eqkR97>.

³⁷ *Id.* at 26-27.

³⁸ Robin McKnight, *Medicare Balance Billing Restrictions: Impacts on Physicians and Beneficiaries*, 26 *Journal of Health Economics* 328, 326-341 (2007).

³⁹ David C. Colby, Thomas Rice et al, *Balance Billing Under Medicare: Protecting Beneficiaries and Preserving Physician Participation*, 20 *Journal of Health Politics, Policy and Law* 52, 49-74 (Spring 1995).

⁴⁰ *Id.*

provider's listed fee was \$150 and Medicare's fee for the service was \$100, the provider would only be paid \$95 by Medicare (reflecting a 5 percent penalty for not participating in the participating physician program). Without the protections implemented in 1989, the provider could have sent a \$55 bill to the patient to cover the difference between its rate and what Medicare paid. But the new rule would limit the provider to sending the patient a bill for \$14.25, which is 15 percent of the \$95 that the provider would be paid by Medicare. Thus, the total payment to the provider would be \$109.25 (\$95 plus \$14.25).⁴¹

By 2011, 99.3 percent of all Medicare bills were paid on assignment, leaving only 0.7 percent of all claims eligible for balance bills, effectively eliminating balance billing for Medicare patients.⁴²

There is evidence to suggest that Medicare has been successful in providing a consistent level of patient care while eliminating balance billing. When Medicare implemented its balancing billing reform in 1989, many speculated that putting a price ceiling on payments to physicians could depress access to physicians and the overall quality of care received by patients.⁴³ But a study subsequently found that not only did patients save an average of \$140 per year (in 1999 dollars) due to the reform, there was no corresponding decrease in access to providers.⁴⁴ Even among specialties that billed the highest percentage of Medicare payment rates prior to the 1989 policy change, there was no observable decrease in access to providers.⁴⁵ Finally, Medicare's balance billing regulation had no significant impact on the length of visits, suggesting that doctors were not compensating for smaller payments by shuttling patients in and out more rapidly in order to maximize the number of patients treated.⁴⁶

Medicaid enrollees are also protected from balance billing. Providers that participate in Medicaid are required to accept whatever payment is authorized by the state's Medicaid agency.⁴⁷ Even if a Medicaid patient seeks emergency or hospital care outside of his or her state of residence, the provider is still barred from issuing a balance bill and must accept whatever payment the state agency provides.⁴⁸

⁴¹ Jack Hoadley, Kevin Lucia, and Sonya Schwartz, CALIFORNIA HEALTHCARE FOUNDATION, UNEXPECTED CHARGES: WHAT STATES ARE DOING ABOUT BALANCE BILLING 17 (April 2009), <http://bit.ly/LkIVim>.

⁴² MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 104 (March 2014) <http://1.usa.gov/1jbrJKn>

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ *Billing Disputes in Medicaid*, FAMILIES USA (viewed February 7, 2014), <http://bit.ly/1fFPZOR>.

⁴⁸ *Id.*

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (“ACA”) took several steps towards controlling health care costs for consumers, particularly out-of-pocket expenses. However, its balance billing protections are minimal. The ACA requires most plans to pay out-of-network providers at the in-network rate, but only for emergency services. The only protection this seems to provide is against an insurance company refusing to pay *anything* toward a bill received by a patient when she is treated by an out-of-network provider under emergency circumstances. Though this provides *some* protection to patients by guaranteeing at least the in-network rate, they can still be billed to cover the difference between the in-network rate and what the provider charges, which could result in significant charges for which the patient is liable to pay.⁴⁹

III. Proposed Policy Solutions

Currently, about 48 percent of Americans are insured through their employer, 31 percent through Medicare, Medicaid, or another government program, and 5 percent through privately purchased insurance. Fifteen percent have no insurance.⁵⁰ Of those that received employer-based insurance, 61 percent receive health insurance by a self-insured employer.⁵¹ The remaining 39 percent who receive employer-based insurance have plans that are primarily regulated by state law, but with certain minimum standards established by the federal government.⁵²

Under self-insured plans, the employer is responsible for paying claims instead of an insurance company.⁵³ These plans are regulated by the Employee Retirement Income Security Act (ERISA) of 1974.⁵⁴ Unlike conventional health insurance, for which regulatory authority has traditionally been granted to the states, ERISA is primarily regulated by

⁴⁹ *State Restriction Against Providers Balance Billing Managed Care Enrollees*, KAISER FAMILY FOUNDATION (viewed February 7, 2014), <http://bit.ly/1cbHpEE>. See also *FAQ: Grandfathered Health Plans*, KAISER HEALTH NEWS (viewed February 10, 2014), <http://bit.ly/1kvQ0u6>.

⁵⁰ *Health Insurance Coverage of the Total Population*, KAISER FAMILY FOUNDATION (viewed February 10, 2014), <http://bit.ly/1dD1jlu>.

⁵¹ KAISER FAMILY FOUNDATION AND HEALTH RESEARCH AND EDUCATIONAL TRUST, *EMPLOYER HEALTH BENEFITS: 2013 ANNUAL SURVEY 178* (August 2013), <http://bit.ly/1dj0I5H>.

⁵² SARAH ROSENBAUM, JOEL TEITELBAUM, AND KATHERINE HAYES, *THE COMMONWEALTH FUND, REALIZING HEALTH REFORM’S POTENTIAL 2* (March 2011), <http://bit.ly/1exduax>.

⁵³ KAISER FAMILY FOUNDATION AND HEALTH RESEARCH AND EDUCATIONAL TRUST, *EMPLOYER HEALTH BENEFITS: 2013 ANNUAL SURVEY 176* (August 2013), <http://bit.ly/1dj0I5H>.

⁵⁴ *ERISA—Employer Sponsored Self-Funded Health Benefit Plans*, COLORADO DEPARTMENT OF REGULATORY AGENCIES, DIVISION OF INSURANCE (viewed February 6, 2014), <http://1.usa.gov/1eCbodj>.

federal law, leaving very limited oversight authority to states.⁵⁵ Therefore, a policy that would protect people in these ERISA plans would require a change to ERISA law.

This paper recommends three types of reform to ERISA law to protect patients. We also recommend that states enact similar reforms to protect patients governed by state-regulated insurance plans.

Of the following reforms, **Reform 1** (transparency and disclosure reform) should apply in all circumstances, whereas **Reform 2** and **Reform 3** should apply to emergency situations and treatment by out-of-network providers at in-network facilities. Together, these reforms would effectively eliminate the ability of providers to send balance bills to patients in the applicable situations.

Reform 1. Right to Know Your Charges: Transparency and Disclosure

ERISA and state laws should be amended to include provisions that provide the greatest possible amount of transparency and disclosure of a provider's network status before the patient receives medical services. Prior to receiving non-emergency medical services from any provider at any facility, patients — or their legally authorized representatives — should be fully informed about the provider's network status and the potential balance billing charges that would be incurred if they receive those services from an out-of-network provider. This can be accomplished in three steps.

First, insurance companies should be compelled to maintain up-to-date and accurate lists of the providers in their networks. This will give patients the ability to seek out in-network providers prior to receiving care. The U.S. Department of Health and Human Services should create a Web site to house lists for ERISA plans and should ensure the administrators of such plans, which often are insurance companies, comply with the law.⁵⁶ State health or insurance agencies would be responsible for housing lists of non-ERISA plans, as well as ensuring compliance.

Second, when a patient arrives at any facility where medical care is provided, the facility should be responsible for informing the patient that he or she could receive medical services from both in-network and out-of-network providers at that facility. When a patient requires medical services from a physician that will not interact directly with the patient (for example, a pathologist or radiologist), the facility must make the patient aware of which providers might provide medical services and the network status of those providers.

⁵⁵ Employee Retirement Income Security Act, 29 U.S.C.1144, <http://bit.ly/1lz0VEM>.

⁵⁶ WILLIAM C. HSIAO, STEVEN KAPPEL AND JONATHAN GRUBER, ACT 128 HEALTH SYSTEM REFORM DESIGN ACHIEVING AFFORDABLE UNIVERSAL HEALTH CARE IN VERMONT 15 (2011), <http://bit.ly/10bE9q3>

Third, facilities should develop the capability for patients to search for in-network providers once they have been admitted to the hospital. This could be done electronically through tablet computers, such as iPads. This is a particularly important step, as it will allow patients to search for providers that are within their network. Patients should be informed that if they receive treatment from out-of-network providers, they might receive a balance bill.

However, modified procedures will be needed to protect patients who require emergency care. The Emergency Treatment and Medical Labor Act prohibits emergency room physicians in Medicare participating hospitals from delaying treatment to inquire about the insurance status of patients and must provide a specific standard of care for all patients equally regardless of insurance status.⁵⁷ However, once a patient is stabilized, the above disclosure steps should be implemented for subsequent care.⁵⁸

Reform 2. Patient Billing Protection Reform

ERISA and state laws should be amended to include a “hold harmless” provision for covered medical services provided by an out-of-network provider either in an emergency situation or at an in-network medical facility. Under this scenario, when a patient receives medical services from an out-of-network provider, the managed care organization (typically an HMO or PPO, which combine to account for 71 percent of all private insurance plans) would be required to guarantee that the patient will incur no out-of-pocket costs that exceed what he or she would have paid using an in-network provider for covered services.⁵⁹ Covered services include procedures that are included in contract established between the beneficiary and the insurance company.

ERISA and state laws also should be modified to include a related protection that would prohibit providers from sending balance bills directly to patients. With this protection, if a patient receives covered medical services from an out-of-network provider, any bills issued by the provider shall be sent to the insurer instead of to the patient. Without this protection, providers could still send invoices to patients for amounts for which patients would not be liable, potentially deceiving patients into paying bills they do not owe. This

⁵⁷ *Emergency Treatment and Medical Labor Act*, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS (viewed February 11, 2014), <http://bit.ly/1aQX2Gz>.

⁵⁸ The Emergency Treatment and Medical Labor Act defines the term “to stabilize” as “to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.” See Emergency Medical Treatment and Labor Act 42 USC § 1395dd(e)(3).

⁵⁹ Jack Hoadley, Kevin Lucia, and Sonya Schwartz, CALIFORNIA HEALTHCARE FOUNDATION, UNEXPECTED CHARGES: WHAT STATES ARE DOING ABOUT BALANCE BILLING 7 (April 2009), <http://bit.ly/LklVim>. See also KAISER FAMILY FOUNDATION AND HEALTH RESEARCH AND EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS: 2013 ANNUAL SURVEY 65 (August 2013), <http://bit.ly/1dj0J5H>.

reform would not prevent providers from continuing to collect deductibles, co-insurance, co-payments, or other cost sharing requirements as specifically provided in the beneficiary's contract with the insurance company. Providers will still be permitted to send bills for non-covered services directly to patients.

Reform 3. Payment Standard for Out-of-Network Claims

A third change to ERISA and state laws should include a payment standard for instances in which a patient receives medical services from out-of-network providers either in an emergency situation or at an in-network medical facility. When an insurance company receives a bill from a provider who has treated an out-of-network patient, the company would be required to pay providers 200 percent of the Medicare Fee Schedule for the services rendered or the provider's charge, whichever is less. The provider would be legally obligated to accept this payment as payment-in-full for covered services. However, patients would still be responsible for cost-sharing provisions, such as deductibles, copayments, and coinsurance. Regardless of which amount is used, the patient would not be responsible for paying any portion of the amount above the in-network rate. One distinct advantage of using the Medicare Fee Schedule rather than other benchmarks is its underlying relative value scale ("RVS").⁶⁰ The RVS sets a constant cost for all procedures relative to one another, but the multiplier used to calculate the fee itself varies by geographic location and payer.⁶¹

In 2012, Medicare payments averaged 81 percent of PPO rates.⁶² Thus, the typical private insurance payment rate was about 123 percent of Medicare payment rates. Our proposal of capping payments of balance bills to qualifying patients at 200 percent of Medicare's payment rate would allow providers treating out-of-network patients in emergency circumstances or at in-network hospitals to receive payments of about 162 percent of the normal rate for treating in-network patients. We selected 200 percent because it maintains the integrity of insurance networks and provides physicians with adequate compensation for treating patients who are outside of their network(s).

⁶⁰ *Id.*, at 10.

⁶¹ *Id.*

⁶² MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 110 (March 2014) <http://1.usa.gov/1jbrJKn>.

Conclusion

Merely being insured does not necessarily protect a patient from excessive and potentially financially crippling bills. Patients should be protected from being unfairly billed for care they unwittingly or unavoidably received from out-of-network providers. Medicare and Medicaid already protect elderly, low-income, and disabled individuals and families, and many states have taken a proactive approach to reduce the incidence of balance billing. But for the tens of millions of Americans, protections are almost nonexistent. Congress should take the actions this paper proposes to afford those protections by amending ERISA, and the states should follow suit for state-regulated insurance plans. This would prevent out-of-network providers from sticking unsuspecting patients with massive balance bills.