TO THE POINT
Quick Takes on Health Care Policy and Practice

State Efforts to Protect Consumers from Balance Billing

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Health insurance rates for working-age Americans have improved over the past decade. But not everyone with health insurance today has adequate financial protection. About one-fourth of insured Americans are underinsured because they have significant coverage gaps or high out-of-pocket costs. And all consumers are vulnerable to surprise medical bills, or balance bills for out-of-network care. These balance bills arise when insurance covers out-of-network care, but the provider bills the consumer for amounts beyond what the insurer pays and beyond cost-sharing, as well as in situations where out-of-network care is not normally covered but the selection of provider is outside the consumer's control.

Consumers are most likely to receive surprise medical bills from health providers outside their insurance plan's network after receiving emergency care or medical procedures at in-network facilities. In the latter cases, for example, consumers may select a surgeon and facility in network, but discover that other providers, such as an anesthesiologist or surgical assistant, are out of network. These unexpected medical bills are a major concern for Americans, with two-thirds saying they are "very worried" or "somewhat worried" that they or a family member will receive a surprise bill. In fact, these bills are the most-cited concern related to health care costs and other household expenses.

While employers and insurers may voluntarily protect employees or enrollees from some types of balance billing, no federal law regulates charges submitted by out-of-network providers. States can help protect enrollees from unexpected balance bills. 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.

Despite Recent State Activity, Consumers in Most States Are Not Protected from Balance Billing

We conducted a study, published in June 2017, that found that 21 states had laws offering consumers at least some protections in a balance billing situation. But only six of those states — California, Connecticut, Florida, Illinois, Maryland, and New York — had laws meeting our standard for "comprehensive" protections.

The Commonwealth Fund

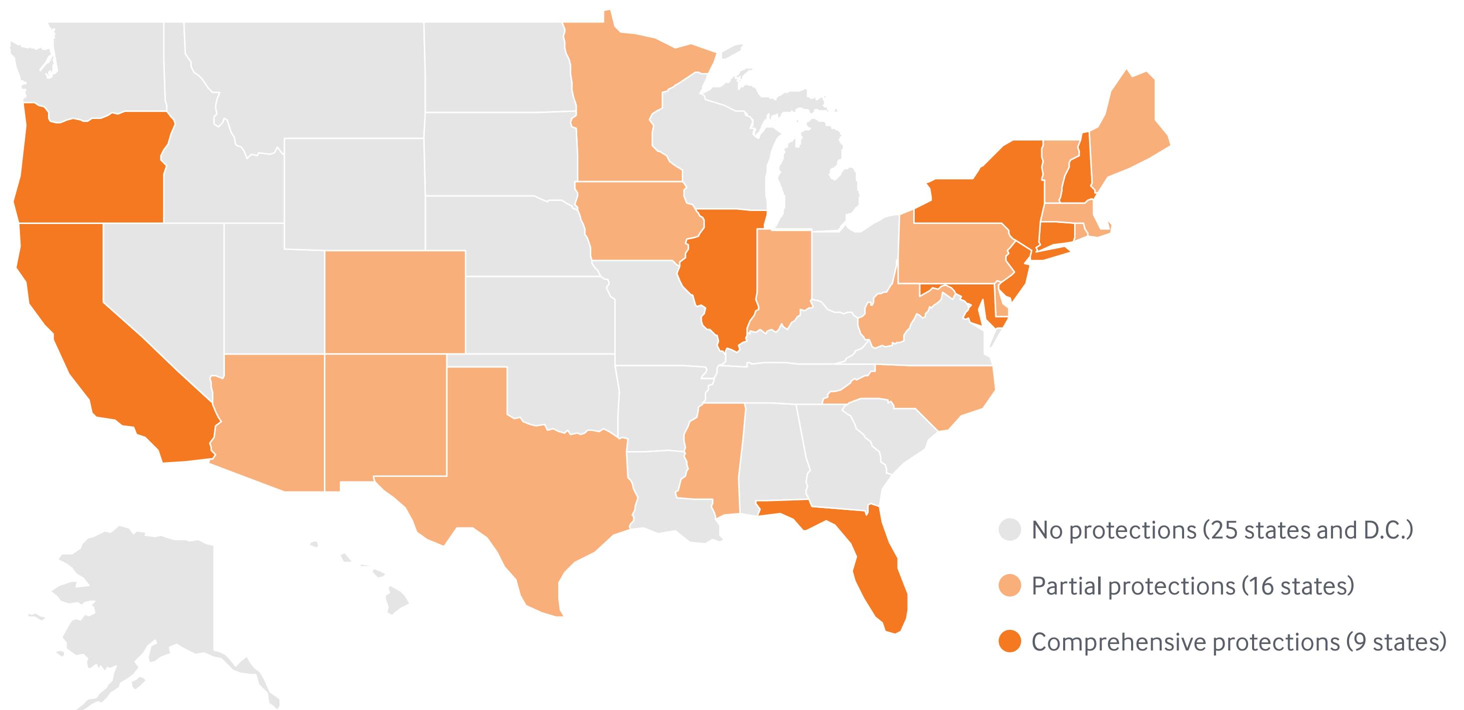
In 2017 and 2018, states continued taking steps to protect consumers. Four states — Arizona, Maine, Minnesota, and Oregon — created balance-billing consumer protections for the first time, and two states — New Hampshire and New Jersey — substantially expanded existing protections. We now classify New Hampshire, New Jersey, and Oregon as states offering comprehensive protections against balance billing. As of December 2018, 25 states have laws offering some balance-billing protection to their residents, and nine of them offer comprehensive protections.

New Jersey has met our criteria for comprehensive protection by creating a strong dispute-resolution process to establish a payment amount for the out-of-network service. Other states have recently acted to protect consumers from balance billing in a more limited way that does not meet our criteria. For example, Missouri's protections against balance billing apply only if the provider and insurer voluntarily agree to participate in the process.

Critical elements of state laws that offer "comprehensive" protections against balance billing:

- Extend protections to both emergency department and in-network hospital settings
- Apply laws to all types of insurance, including both HMOs and PPOs
- Protect consumers both by holding them harmless from extra provider charges — meaning they are not responsible for the charges — and prohibiting providers from balance billing, and
- Adopt an adequate payment standard — a rule to determine how much the insurer pays the provider — or a dispute-resolution process to resolve payment disputes between providers and insurers.

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



Data collection and analysis as of January 2019 by researchers at the Center on Health Insurance Reforms, Georgetown University Health Policy Institute.

Interest in a Federal Solution to Balance Billing

At the same time, interest has grown in federal measures, in part, because only federal legislation can protect those in self-funded insurance plans that are exempt from state regulation. During the 115th Congress, proposals were released by Senator Bill Cassidy (R–La.), Senator Maggie Hassan (D–N.H.), Representative Lloyd Doggett (D–Texas), and Representative Michelle Lujan Grisham (D–N.M.). The Cassidy proposal has bipartisan support, with three Democrats and two other Republicans as cosponsors.

Federal approaches vary along some of the same lines as state laws. For example, the Hassan bill relies most heavily on a dispute-resolution approach. By contrast, the Cassidy proposal relies on a payment standard that is the greater of a) the median in-network rate paid by the insurer or b) 125 percent of the average allowed amount across payers. Several federal proposals make protections contingent on failure of providers to notify the consumer that they could be billed by an out-of-network provider. States that have enacted protections have mostly viewed such contingent protections as an insufficient means of protecting consumers. Federal proposals also vary in the degree to which they allow a state role in implementing protections.

Some federal proposals, like some state laws, have potential gaps. For example, some address balance bills only from hospital-based physicians such as anesthesiologists and radiologists. Also, state laws and federal proposals mostly do not address ground or air emergency transport providers.

Looking Forward

The bipartisan interest in the surprise billing issue offers the potential for federal action in the new Congress. States are frustrated by their inability to address all insurance plans. And states without laws have often faced opposition from stakeholder groups, even when there is a consensus around protecting consumers. A federal solution could offer a more comprehensive approach, while giving states appropriate flexibility to seek an approach fitting their particular market environments.

State Balance Billing Protections

State	Setting		Type of managed care plan		Type of protection		State-specific method for payment	
	Emergency department	Nonemergency care in network hospital	HMO	PPO	Hold harmless	Provider prohibition	Payment standard	Dispute resolution process
Comprehensive approach (9 states)								
California	✓	✓	✓	✓ (a)	✓	✓	✓ (m)	(n)
Connecticut	✓	✓	✓	✓	✓	✓	✓	
Florida	✓	✓	✓	✓	✓	✓	✓ (b)	✓
Illinois	✓	✓	✓	✓	✓ (c)	✓ (d)		✓
Maryland	✓	✓	✓	✓	✓ (e)	✓ (d)	✓ (e)	
New Hampshire	✓ (k)	✓	✓	✓		✓		✓
New Jersey	✓	✓	✓	✓	✓	✓		✓ (o)
New York	✓	✓	✓	✓	✓	✓ (d)		✓ (p)
Oregon	✓ (k)	✓	✓	✓		✓	✓	
Limited approach (16 states)								
Arizona	✓ (k)	✓ (s)	✓ (t)	✓ (q)	✓	(r)		(l)
Colorado	✓	✓	✓	✓	✓			
Delaware	✓ (f)		✓	✓	✓	✓		✓
Indiana	✓		✓		✓	✓		
Iowa	✓		✓	✓	✓			
Maine		✓ (i)	✓	✓	✓	✓	✓	
Massachusetts		✓	✓	✓	✓			
Minnesota		✓ (j)	✓	✓	✓			✓
Mississippi	✓	✓	✓	✓	✓	✓ (d)		
New Mexico	✓		✓	✓	✓			
North Carolina	✓		✓	✓	✓			
Pennsylvania	✓		✓	✓ (g)	✓			
Rhode Island	✓	✓	✓		✓			
Texas	✓	✓	✓ (h)		✓			(l)
Vermont	✓		✓	✓	✓			
West Virginia	✓		✓		✓			

Notes: (a) In California, balance-billing protections in the emergency department setting apply only to those plans regulated by the California Department of Managed Care, which includes HMOs and most PPOs. (b) In Florida, payment standards apply to PPOs, but for HMOs they apply only for nonnetwork providers of emergency services. (c) In Illinois, protections apply only to facility-based providers. (d) In Illinois, Maryland, and Mississippi, balance-billing protections attach when the consumer assigns the benefit to the provider. The linkages to assignment apply to PPOs in Maryland only. In New York, assignment of benefits is required only in nonemergency cases in in-network hospitals in New York, but not in any other settings. (e) In Maryland the 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) In Delaware, balance-billing protections in the emergency department setting also apply to services originated in a hospital emergency facility or comparable facility following treatment or stabilization of an emergency medical condition as approved by the insurer with respect to services performed by nonnetwork providers, provided that the insurer is required to approve or disapprove coverage of poststabilization care. (g) In Pennsylvania, emergency service balance-billing protections apply only to HMOs and PPOs that require gatekeepers. (h) In Texas, HMO and EPO members must be held harmless, but those in PPOs may be balance-billed. State law requires PPOs to disclose the possibility of balance billing to consumers and allows consumers to pursue dispute resolution for amounts of $500 or greater. Also, 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 the use of balance billing. (i) In Maine, the protection does not include a bill for health care services received by an enrollee when a network provider was available to render the services and the enrollee knowingly elected to obtain the services from another provider who was out of network. (j) In Minnesota, the protection applies when the service is provided because of unavailability of a participating provider or without the enrollee's knowledge or because of the need for unforeseen services arising at the time the service is rendered. (k) In Arizona, New Hampshire, and Oregon, the protection applies only for emergency services provided by a nonparticipating provider in a network hospital. (l) In Arizona and Texas, a dispute-resolution process is available for claims exceeding a specified amount. (m) In California, the payment standard is less specific in situations involving emergency services. (n) California has available a dispute-resolution process for out-of-network care at network facilities if the regular process for applying the payment standard fails in some way. The state also has a voluntary, nonbinding dispute-resolution process for emergency services, but it has never been used. (o) In New Jersey, there is a $1,000 threshold for invoking the dispute-resolution process, but the consumer is held harmless even if dispute resolution is not used. (p) In New York, certain emergency services (specified by CPT codes) are exempt from the independent dispute-resolution process if the bill does not exceed 120 percent of the usual and customary cost and the fee disputed is $672.01 (adjusted annually for inflation rates) or less after any applicable coinsurance, copayment, and deductible. The consumer is held harmless for emergency services even if dispute resolution is not used. (q) In Arizona, protections apply only to health plans that cover out-of-network care. (r) In Arizona, providers are not prohibited from balance billing PPO members. But in cases where a dispute-resolution process is used, a balance bill cannot be submitted after the arbitrator has made a decision. (s) In Arizona, protection in nonemergency situations is contingent on disclosure to the consumer. But if the consumer declines to agree to the disclosure, the protections still apply. (t) According to state interpretation, the Arizona protection covers enrollees in HMOs.