

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

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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.

KEY TAKEAWAYS

- ▶ With no explicit federal protections against “balance billing,” some states have stepped in to protect consumers from this costly and confusing practice
- ▶ Only six states have a comprehensive approach for protecting consumers, and another 15 states offer protections with some significant limitations



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

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 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

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 States can help protect enrollees from unexpected balance bills.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

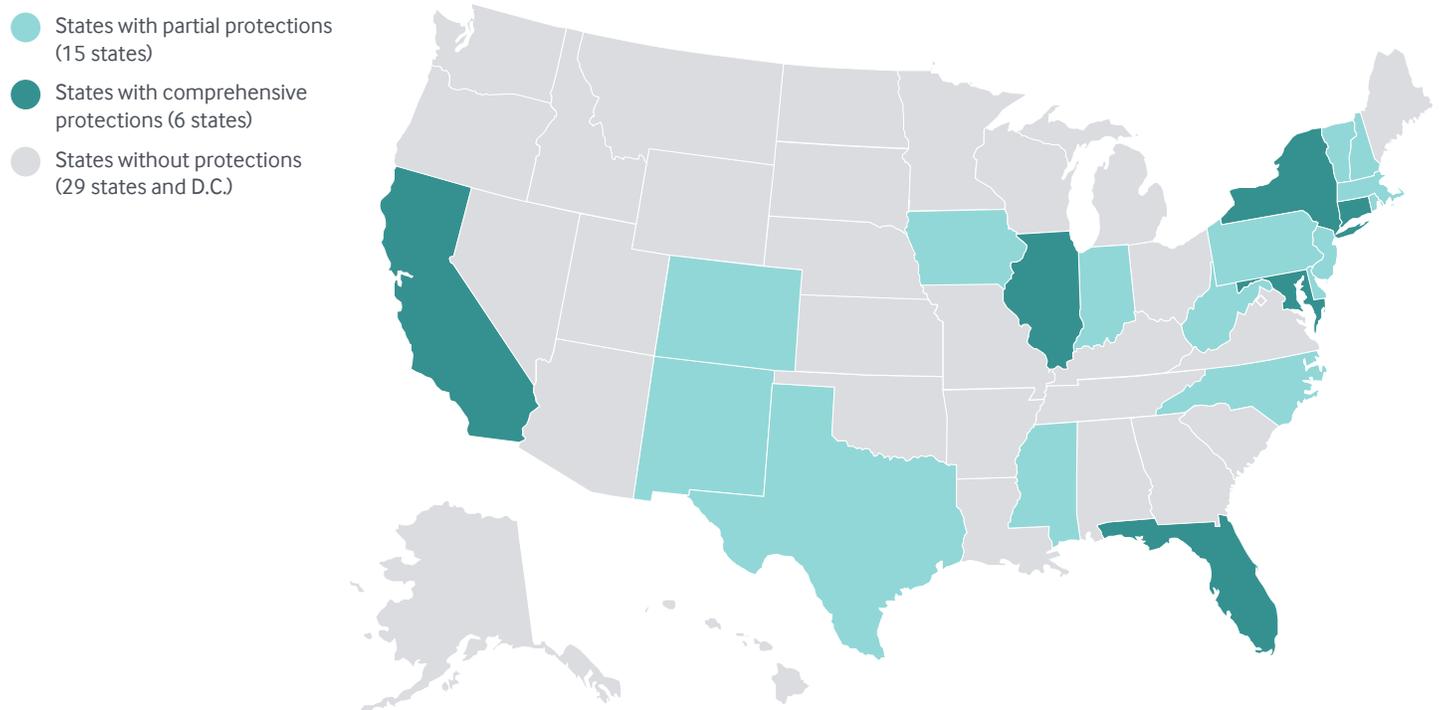
This issue brief documents current laws to protect consumers from balance billing for care provided in EDs and network hospitals. Our findings are based on analysis of health insurance laws, as of December 2016, in all 50 states and the District of Columbia, supplemented by interviews with insurance regulators and other officials in eight states to explore the impact of varying approaches.⁷

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 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.

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.

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.

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.

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 Only six states—California, Connecticut, Florida, Illinois, Maryland, and New York—have a comprehensive approach to protecting consumers.

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 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

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 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.¹⁵ 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

Exhibit 2. State Balance-Billing Protections

	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
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 [glossary](#) 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.

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 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 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

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

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 New Mexico held a series of public forums with the goal of developing stronger protections.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,” *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,” *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* (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,” *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,” *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,” *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?* (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,” #74 (NAIC, 2015). For a brief description of the NAIC model law, see K. Pollitz, *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* (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?* (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* (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* (Avalere, March 2015).
- ¹⁷ Washington State Office of the Insurance Commissioner, *Surprise Medical Billing* (Jan. 2, 2017).
- ¹⁸ Pennsylvania Insurance Department, "Insurance Commissioner Testifies Before Pennsylvania State Banking and Insurance Committee on Surprise Balance Billing," 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," March 1, 2016.

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