Surprise Balance Billing: The New Fight for Consumer Protection in Health Care

A Texas high school teacher recently made headlines after getting a $108,951 bill when a heart attack sent him to an out-of-network hospital. The ambulance rushed Drew Calver to the nearest emergency center, which his insurance did not cover, leaving him with an astronomical surprise medical bill. Unfortunately, surprise medical bills are becoming a ubiquitous part of health care in America. The question is: why?

Most people have insurance, but insurance doesn't cover everything. So when Calver was treated at an out-of-network facility, his insurance paid only $55,840 towards the $164,941 that was due. The responsibility for the remainder fell to Calver in what's called a surprise balance bill. A surprise bill is simply a bill the patient was not expecting, while a balance bill is what the patient owes to a provider after his insurance pays a portion. Most health plans will pay the majority of the provider's fee, leaving the patient with a balance bill for a nominal amount, sometimes called the cost sharing amount.[1] Surprise balance billing occurs when a patient receives care he expects his insurance will cover fully, but his plan actually only covers a portion, leaving the unsuspecting patient to pay the balance left on the provider's bill.

Emergencies like Calver's are more likely to make the news, but surprise balance bills are actually more common in non-emergency situations. Planned surgery is a common cause of surprise balance billing, even as patients carefully schedule their surgery with a covered surgeon at an in-network hospital. Surgeons often bring in out-of-network surgical assistants, and health plans only pay a small fraction of the assistant's bill. Thus, patients who did everything possible to stay in network can be billed an average of $12,000 for out-of-network surgical assistants who were brought in while the patient was unconscious on the operating table.

As surprise balance billing can be financially disastrous, states are attacking both

the source of the problem and its effects. The problem stems from overly narrow networks. When health plan networks are inadequate, providers have to reach beyond the confines of fellow contracting providers to get the patient the care and treatment she needs. Health plans with narrow networks have inexpensive premiums, but patients can wind up paying thousands of dollars in surprise balance bills which don't count towards their deductibles. Recently, Humana made the news when it removed dozens of anesthesiologists from its network, making surprise balance bills from anesthesiologists much more likely. In response, Texas issued a network adequacy fine specifically because it would lead to an increase in surprise balance billing, which signals that more states are taking notice of the relationship between the two.

While many states have network adequacy laws, which attempt to ensure all of the patient's needs can be met by in-network providers, most of these laws have been on the books for over a decade and don't seem entirely solve the problem, particularly without adequate enforcement. The new approach is to directly regulate the practice of balance billing and its effects in addition to network adequacy.[2] For example, California enacted a comprehensive surprise balance billing law in 2016, modeled after New York's similar successful laws. The statute requires all health plans and insurers to cover out-of-network costs by reimbursing non-contracting providers a rate set by the Department of Managed Health Care. The patient only has to pay the out-of-pocket costs for which they would be responsible if they had received the same care from an in-network provider. Also, patients are taken out of the equation as the providers and health plans have to use a binding independent dispute resolution process if they have a dispute over the payment amount. Additionally, to use an out-of-network provider, the patient must consent in writing and be given a binding written estimate of the cost 24 hours in advance, so patients are never surprised with a balance bill.

More recently, other states have followed in California's footsteps to combat surprise balance billing. In the latest legislative session, New Hampshire passed legislation which limits the amount patients can be responsible to pay if they receive care from an out-of-network provider, and Missouri enacted a new law which protects patients who receive emergency care. Additionally, Pennsylvania is considering a law which would protect patients in emergency situations, and Illinois

is debating a more sweeping legislation which would apply even to planned care.

Even the federal government is paying attention to the problem, as last month a bipartisan group of Senators proposed legislation targeting the practice of surprise balance billing. A federal solution is particularly important, as even the best state protections don't apply to approximately thirty percent of Americans who get their health insurance through self-funded employer plans because they are governed by the federal Employee Retirement Income Security Act (ERISA), which preempts state law protections for balance billing. As the issue continues to get more attention, we hope to see more comprehensive legislation, and perhaps some more creative solutions.

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[1] If you're confused about the terms used to describe the different type of health care bills, you can consult the CMS glossary for definitions of balance billing, cost sharing, deductible, premium, and any other health care terms.

[2] For a more detailed look at the policy implications of the relationship between network adequacy and surprise balance billing, check out the white paper written by Mark Hall and Paul Ginsburg for the USC-Brookings Schaeffer Initiative for Health Policy.