

The Crisis of COVID-19 Heightens the Need for Surprise Billing Protections

[Post Updated: April 20, 2020]

Earlier this year, the federal government appeared poised to address the problem of surprise billing,[\[1\]](#) but the coronavirus pandemic shifted policy priorities before Congress had a chance to act. While some lawmakers [may try to include](#) surprise billing protections in the next COVID-19 stimulus package, the pandemic and its ripple effects make action by lawmakers to address surprise billing critical.

Surprise bills, also known as balance bills, may occur when a patient unavoidably sees an out-of-network provider for an emergency situation or unexpectedly sees an out-of-network provider (e.g. an anesthesiologist or assistant surgeon) at an in-network facility. Nearly 2/3 of adults surveyed in [a poll by the Kaiser Family Foundation](#) expressed concern about surprise medical bills, topping the list of family budget concerns in February 2020. Even before the outbreak of COVID-19, 20-40% of visits to the emergency room resulted in surprise bills, although that percentage varied widely by state.[\[2\]](#)

The Outbreak of COVID-19 Amplifies the Issue of Surprise Billing

Furthermore, treatments costs for patients with COVID-19 may be very expensive, making the problem of surprise billing particularly acute. News reports detail examples where patients have received bills of \$10,000s for [testing](#) and [treatment](#) for COVID-19. Calculations by FAIR Health [estimate](#)

the total amount paid (insurer and patient cost-sharing) for a patient needing hospitalization for COVID-19 to be \$38,221, with uninsured patients and those seeking care from out-of-network facilities facing charges of over \$73,000 for the same treatment. While President Trump [announced](#) that he secured commitments from the largest private insurers to waive cost-sharing payments for treatment related to COVID-19 for plan members, and many large hospital systems have [said](#) they will not bill patients for COVID-19 related testing and treatment, those protections remain inadequate, especially during this time of crisis.

As healthcare workers and the healthcare system are stretched to respond to the virus, the coronavirus outbreak exacerbates existing problems in additional ways. Physician staffing shortages and specialized facilities that treat only COVID-19 patients increase the risk that patients will unwittingly see an out-of-network provider.[\[3\]](#) This increased risk applies both to patients with COVID-19 and those seeking treatment for other health issues. Perhaps the biggest problem with surprise billing during this pandemic is that just the fear of receiving a surprise bill could lead patients to delay seeking testing or treatment, unwittingly allowing them to pass the disease to others. As a result, the issue of surprise billing could extend the length and severity of the pandemic for all Americans.

Federal Protection for Surprise Billing During the COVID-19 Crisis

Lawmakers are aware of the issue but have not yet passed legislation to comprehensively address the problem. In the first comprehensive law responding to the coronavirus pandemic, the [Families First Coronavirus Response Act](#), Congress required insurers to cover any services or items provided during a medical visit that results in coronavirus

testing without any cost-sharing. In addition, Congress included appropriations to cover COVID-19 testing and related visits for uninsured patients through state Medicaid programs. The law, however, does not prohibit balance billing by the provider that administered the test, so a patient might still face a surprise bill from an out-of-network provider.[\[4\]](#) Early versions of the CARES Act in the House included provisions to prohibit surprise billing, but the final version contains only protections for COVID-19 testing.[\[5\]](#)

Nevertheless, federal officials mitigated some of the risk of getting a surprise bill for treatment of COVID-19. Specifically, the Department of Health and Human Services [required](#) any provider receiving a portion of the \$100 billion relief fund allocated in the CARES Act to “not to seek collection of out-of-pocket payments from a COVID-19 patient that are greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider.” While technically this policy allows providers to refuse the government aid and bill patients for any services received, it is hard to imagine any provider choosing to refuse assistance during this crisis. In addition, in the [terms and conditions](#) of the CARES Act Provider Relief Fund, the Secretary of HHS [broadly interprets](#) the definition of a COVID-19 patient to include presumptive cases. Some [news reports](#) suggest that because every current patient is a potential COVID-19 patient, this guidance could be interpreted to block all balance billing. Whether this broad interpretation, however, survives legal challenges remains untested. As a result, this policy should protect patients receiving treatment for COVID-19 or similar respiratory illness, but it may leave patients seeking treatment of other conditions unprotected even as this crisis increases the likelihood that they unwittingly see an out-of-network provider during this time.

Surprise Billing Protection from the States

While the debate in Congress about how best to address surprise bills persisted over the past years, many states acted to address this problem. A [report](#) from the Commonwealth Fund, predating the COVID-19 crisis, found that a majority of states enacted some form of protection from surprise bills, but only 13 of those states had “comprehensive” protections. Furthermore, even in states with comprehensive protections, residents who get their insurance through self-funded employers (approximately 2/3 of those with employer-sponsored coverage or approximately 1/3 of Americans) are left unprotected because the Employee Retirement Income Security Act (ERISA) prevents any state laws from applying to these plans. For example, California’s [AB 72](#) protects patients insured with plans regulated by the state Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI) from receiving surprise or balance bills if they inadvertently receive care from an out-of-network provider at an in-network hospital. In addition, [California regulations](#) protect patients with managed care plans from balance bills for emergency or subsequent stabilization care (see The Source [blog](#) for more detailed coverage).

In addition to existing state laws, some governors are issuing executive orders or directing state agencies to remind insurers of their obligations during a declared state of emergency, including additional requirements mandated by the [Families First Coronavirus Response Act](#). For example, in California, both [CDI](#) and [DMHC](#) issued letters to insurers regulated by those agencies. The letters require these insurers to cover all COVID-related testing costs with no cost-sharing and reminded insurers of their obligations to provide all medically necessary emergency care without prior authorization and to ensure adequate networks, including coverage for out-of-network care resulting from an increase in need for healthcare services. Similarly, in [Illinois](#), the

Department of Insurance reminded insurers of their obligation under state law to “impose no greater cost-sharing on an enrollee than their coverage provides at the in-network level... at a participating network hospital..., even if the specialists themselves are not participating providers... The enrollee must be held harmless from any of these providers’ charges that exceed the applicable cost-sharing for an in-network provider, regardless of whether the issuer and provider have agreed upon the overall charges.”

In other states, Governors and Departments of Insurance have used emergency powers to expand surprise billing protections during the declared emergency. In Ohio, for example, the Department of Insurance noted that “[w]hile many Insurers have network agreements with... hospitals, there may be some cases where an insured is directed to a hospital for treatment and testing that is out-of-network under their health plan’s coverage.” [\[6\]](#) As a result, the Department of Insurance requires that testing and treatment for COVID-19 must be covered without preauthorization and must be covered at the same cost-sharing level as if provided in-network. Furthermore, for all emergency care, insurers must pay “the greatest of the amount negotiated with in-network providers, the amount... the plan generally uses to determine payments for out-of-network services, or the amount that would be paid under Medicare. Additionally, health insuring corporations providing coverage in Ohio must ensure coverage for out-of-network emergency services without balance billing.” While this declaration from Ohio stops short of eliminating all surprise billing and ERISA preemption limits the application only to insurers licensed by the state (and not self-funded employer plans), it nonetheless implements important consumer protections during this time of crisis.

Similarly, the Governor of Connecticut issued an [executive order](#) to simplify existing surprise billing protections in Connecticut, to ensure that no uninsured patient receives a

bill for COVID-related treatment that exceeds Medicare rates, and to prevent billing *patients* for COVID-related treatment (i.e. for anything not covered by insurance) until the federal government distributes money that may cover these expenses. Finally, many states, including [Georgia](#), [New Hampshire](#) and [Louisiana](#), are requiring insurers licensed in the state to review their network adequacy to ensure that patients are not charged excessive cost-sharing if in-network access becomes limited due to the crisis.

While these state actions are important protections, it is important to note that the executive orders and guidances from state departments of insurance only offer protections during the declared state of emergency. Additional actions are needed to protect patients through the financial crisis expected to continue past the declared health emergencies.

Conclusion

As Americans are facing unprecedented financial hardships, policymakers at both the state and federal levels need to act to prevent high medical costs, or even the fear of high medical bills, from amplifying the health crisis. While tying federal relief funds to a prohibition on balance billing and orders by state officials to minimize balance billing are important steps during the declared emergency, more needs to be done to protect patients without COVID-19 who may receive surprise bills due to an overtaxed healthcare delivery system. When the initial health emergency subsides, policymakers may find themselves at a crossroad where they may have the ability to address some of the fundamental difficulties with the way healthcare is delivered in the U.S. Providers who put themselves at personal risk to care for patients deserve to be paid fairly for their work, but the government needs to ensure that compensation does not come at the risk of financial ruin for patients seeking necessary care. Whether that compensation

is set to a federal benchmark (like Medicare) or a requirement of binding arbitration between insurers and providers for out-of-network care, lawmakers need to ensure that the most vulnerable Americans are protected.

[1] See <https://www.nejm.org/doi/full/10.1056/NEJMp1916443>.

Four Congressional committees reported out bills this session: the Senate HELP/Commerce ([S. 1895](#)), the House Energy and Commerce Committee (Ruiz-Roe Bill [H.R. 3502](#)), House Ways and Means (Neal-Brady Bill [H.R. 5826](#)), House Education and Labor (Scott-Foxx Bill [H.R. 5800](#)).

[2] Eric C. Sun EC, Michelle M. Mello, Jasmin Moshfegh, Laurence C. Baker. Assessment of Out-of-Network Billing for Privately Insured Patients Receiving Care in In-Network Hospitals. *JAMA Intern Med*. 2019;179(11):1543–1550. <https://jamanetwork-com.ucsf.idm.oclc.org/journals/jamainternalmedicine/article-abstract/2740802>; Christopher Garmon and Benjamin Chartock. One in five inpatient emergency department cases may lead to surprise bills. *Health Aff (Millwood)* 2017;36:177-181. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0970?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%3dpubmed.

[3] Soleil Shah Suhas Gondi. Opinion: Why Covid-19 Could Trigger a Surprise Billing Crisis. *Undark*. March 2, 2020. <https://undark.org/2020/03/26/covid-19-surprise-billing/>

[4] Jack Hoadley, Kevin Lucia, Katie Keith. Keeping Surprise Billing Out Of Coronavirus Treatment. Health Affairs Blog. April 2, 2020. <https://www.healthaffairs.org/doi/10.1377/hblog20200330.353921/full/>.

[5] Rachel Cohrs. White House floated limited surprise billing proposal in COVID-19 talks. Modern Healthcare. April 3, 2020. <https://www.modernhealthcare.com/politics-policy/white-house-floated-limited-surprise-billing-proposal-covid-19-talks> and Paige Winfield Cunningham. The Health 202: Congress might ban surprise medical bills in the coronavirus stimulus effort. Washington Post. March 19, 2020. <https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2020/03/19/the-health-202-congress-might-ban-surprise-medical-bills-in-the-coronavirus-stimulus-effort/5e72680a88e0fa101a74cd8d/>

[6] Bulletin 2020-05 COVID Testing and Treatment: Out-of-Network Coverage. Ohio Department of Insurance. March 20, 2020. Available from: <https://iop-odi-content.s3.amazonaws.com/static/Legal/Bulletins/Documents/2020-05.pdf>