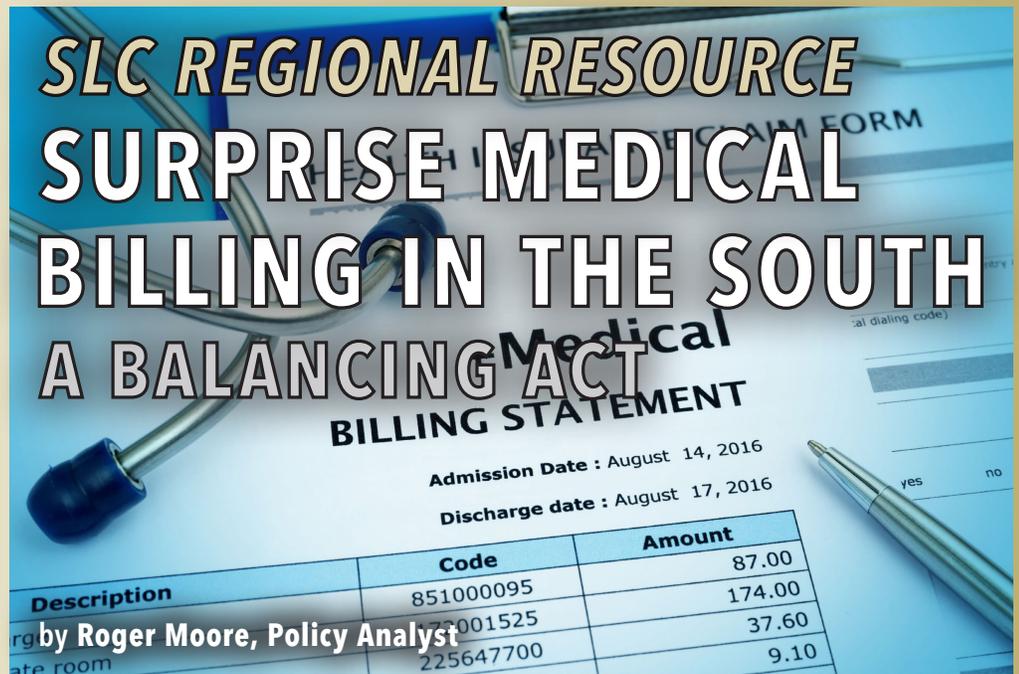


**Southern
Office of
The Council
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Governments**

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Introduction

Balance billing is a common practice that occurs when a medically insured patient receives treatment from an out-of-network healthcare provider,* either intentionally or inadvertently, and subsequently is billed the difference between the insurance company’s reimbursement rate and the amount charged by the provider. Not bound by contractual, in-network rate agreements with insurers, out-of-network providers are permitted to bill patients the remaining balance for services rendered after deductibles, copayments and coinsurance obligations have been paid. In most cases, the amount charged by a provider and the insurer’s reimbursement rate are significantly different, resulting in a confusing and/or financially distressful medical bill that must be settled or resolved by the patient.†

As healthcare costs in the United States continue to climb, often forcing consumers to pay higher premiums and

* In this *SLC Regional Resource*, “provider” is defined as a physician, specialist or facility that administers healthcare to patients. For brevity, the three are referred to as “providers” unless noted otherwise.

† Patients’ out-of-network obligations vary based on the type of health insurance plan that covers them. Health maintenance organization (HMO) plans, for instance, generally do not provide much, if any, support for out-of-network care. Preferred provider organization (PPO) plans may cover some out-of-network care, but patients usually are liable for a higher share of the costs than they would be for comparable in-network care.

deductibles for care, balance billing has become a controversial and confounding policy issue involving insurers, healthcare providers, consumer advocate organizations and regulators at both the state and federal levels. Balance billing most frequently occurs after patients unintentionally receive care outside their insurance network, either during emergencies or other situations when options to choose providers are restricted. Bills for these services, often referred to as “surprise medical bills” because patients are not fully aware of their provider’s network status when they receive care, can amount to hundreds or even thousands of dollars. In extreme cases, they have surpassed \$100,000.¹

There is general agreement that patients should be protected from balance billing practices after receiving care from out-of-network providers. However, finding a comprehensive solution that satisfies all stakeholders involved has proven elusive. The major parties responsible for administering care—providers and insurers—invariably disagree on appropriate payment levels for healthcare services. Providers assert that insurers have restricted their networks in recent years to cut costs, while offering low, unsustainable reimbursement rates for patient treatment. Meanwhile, insurers contend that providers demand excessively high reimbursement for their services and, in some cases, take advantage of unsuspecting patients for financial gain.

This *SLC Regional Resource* provides an overview of balance billing practices and presents examples of various

actions that Southern states have taken or considered to address the prevalence of surprise medical bills. Several states in the region have passed legislation to protect patients from balance billing in specified situations, but the scope of legislation inherently is limited due to federal restrictions. Thus, even though states have an important role to play in resolving balance billing practices, changes in federal regulations are essential to precipitate further action at the state level.

Understanding Balance Billing

Balance billing is a prevalent practice in the American healthcare system, affecting millions of people each year. According to an August 2018 survey from the non-partisan National Opinion Research Center (NORC), an organization affiliated with the University of Chicago, 57 percent of respondents indicated they had been surprised by a medical bill they initially thought would be covered by their health insurance carrier. Among this group, 20 percent answered that the charges were the result of unknowingly receiving care from an out-of-network provider.² A related survey from the nonprofit Kaiser Family Foundation, also conducted in August 2018, found that 39 percent of insured adults under age 65 had received a medical bill within the previous 12 months that was unexpected or higher than anticipated. The Kaiser survey found that a quarter of those who received a surprise bill attributed it to a provider or hospital that was not in their insurance network.³

Balance billing generally occurs under two different scenarios. In the first instance, patients voluntarily receive care from an out-of-network provider with the understanding they will be responsible for paying the difference between the insurance company's allowed reimbursement rate and the amount charged by the out-of-network provider. Under such a scenario, the patient is aware of the financial repercussions of receiving care outside the insurer's network but still chooses to do so for personal or medical reasons. The second scenario—and the one most people refer to when discussing balance billing and surprise medical bills—occurs when a patient unintentionally receives

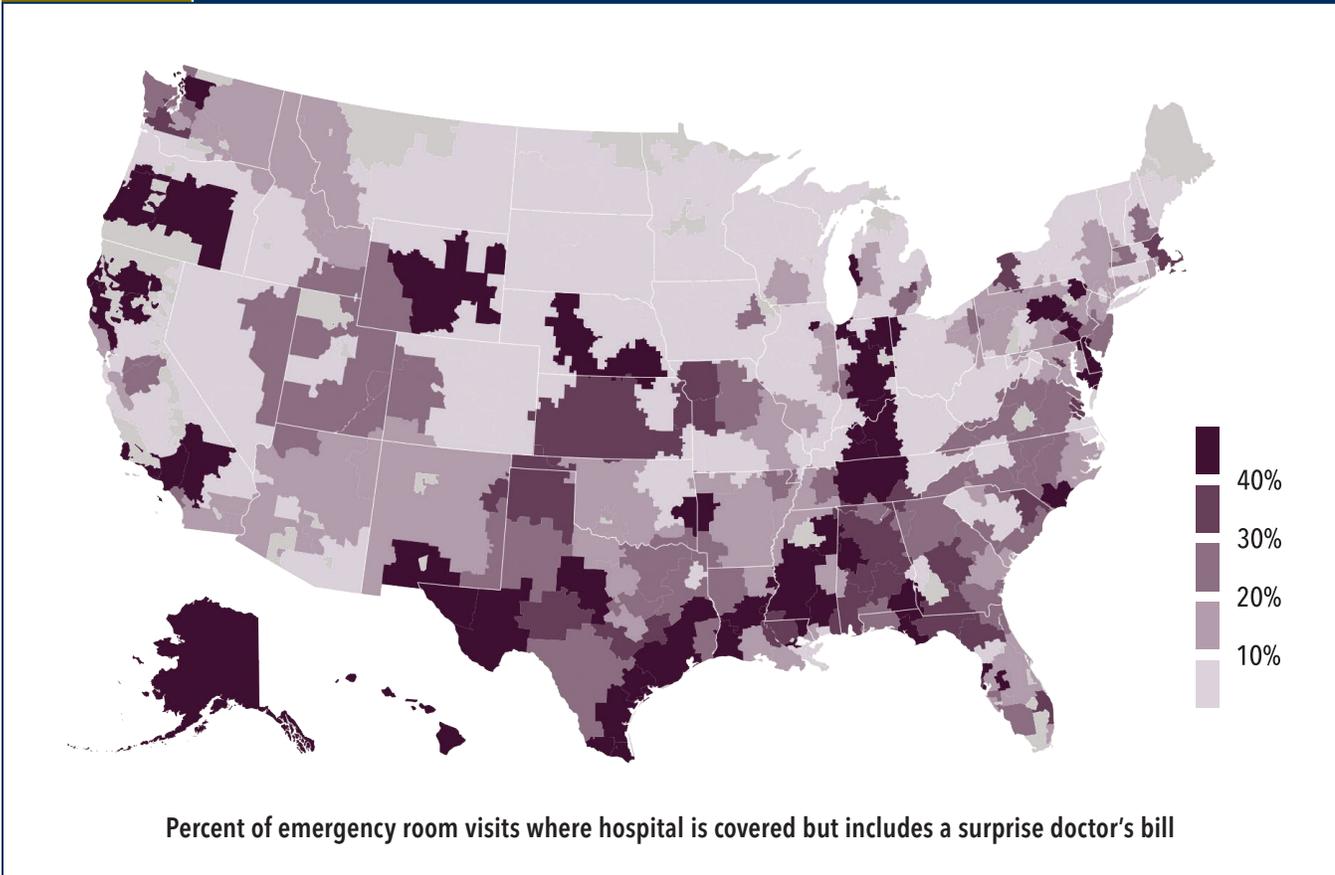
care from an out-of-network provider without a full understanding of the financial ramifications involved.

The practice of balance billing is most commonly triggered during emergency situations, when patients may be unable to decide where they receive care or discern whether the professionals providing treatment are part of their insurer's network. In many cases, hospitals use physician and medical specialist outsourcing firms, tasked with hiring providers to administer care at their facilities.* As contractors rather than employees, these medical personnel are not necessarily part of the same insurer networks as the facilities where they are assigned. Thus, many patients are treated at a hospital, emergency department or other facility that is part of their insurance network by a physician or specialist who is not. As a result, it is not uncommon for patients to be charged twice for the same medical event: one from the in-network facility, which will include a standard deductible, copayment or coinsurance obligation defined by the health plan, and another bill from the out-of-network providers contracted by that facility.⁴

In some cases, in-network hospitals may not have any in-network physicians assigned to their emergency departments, essentially guaranteeing that patients will be subjected to balance billing after receiving treatment.⁵ In January 2017, a study published in the journal *Health Affairs* found that 20 percent of inpatient admissions in emergency departments during 2014 led to surprise medical bills because one or more of the providers were not part of the patient's insurance network.⁶ A related study published in *The New England Journal of Medicine* found that 22 percent of patients at in-network emergency facilities were treated by out-of-network providers[†]

* Contracted staffing companies offer hospitals multiple benefits, including handling administrative tasks and finding physicians and specialists to fill vacant positions.

† The study found wide variations in out-of-network billing at hospitals. Fifty percent of hospitals have balance billing rates below two percent, while 15 percent have balance billing rates above 80 percent. At hospitals in McAllen, Texas, for example, the surprise billing rate was 89 percent, according to the study.

Figure 1**Percent of Emergency Room Visits Resulting in Surprise Medical Bills**

Note: Regions with fewer than 500 incidents are shown in light grey.
 Source: *The New York Times*, 2016.

in 2015.⁷ With the Centers for Disease Control and Prevention reporting approximately 137 million emergency department visits in 2015, a rough estimate would indicate that out-of-network emergency providers treated patients at in-network facilities on approximately 30 million occasions that year.⁸

Though less common, balance billing also occurs in non-emergency situations. Even when patients have identified in-network facilities and providers in advance of receiving treatment, there can be ancillary specialists participating in a patient's care regimen who are not part of the insurer's network. Prior to surgery, for instance, a patient may have assurances that the surgeon is part of their insurer's network; however, confirming whether other specialists also are in-network becomes more difficult, as most patients are unaware of the panoply of ancillary specialists needed to provide care. These additional personnel

can increase out-of-pocket costs by hundreds or thousands of dollars, and the associated charges only become known when a patient receives a bill.⁹ In some cases, the necessity of specialists may be indeterminable, or a basic service will be performed by an overly qualified individual who charges an additional amount for their time at a higher rate.¹⁰

Studies indicate balance billing is most likely to occur among specialists who are less likely to meet with patients prior to providing care or for those who are referred by in-network primary care providers to specialists who are out-of-network. A January 2017 study from researchers at Johns Hopkins University, published in the *Journal of the American Medical Association*, found that anesthesiologists, radiologists, emergency physicians, pathologists and neurosurgeons charge the highest for their services, on average, at four to six times greater than the average Medicare

reimbursement rate.* In some extreme cases, the amount charged for out-of-network care was nearly 800 percent of Medicare rates.¹¹ By comparison, providers seen most often by patients, such as general practice doctors, psychiatrists, allergists, immunologists, dermatologists and family practitioners, often charge less than twice the average Medicare rate.¹²

Ambulance services also are a major source of concern amid the broader balance billing debate. Privately operated ambulance companies have become increasingly common in cities across the United States, many of which cannot reach agreement with insurers on mutually acceptable reimbursement rates. As a result, many ambulance companies do not participate in insurer networks, instead charging patients by the mile and, in some instances, for each service provided during the transport. Ambulance companies also have to bear the costs of staffing emergency medical personnel around the clock, leading to disproportionate service charges, in some cases approaching \$1,000 per mile.¹³

Charges for air medical services can be even higher, with out-of-network patients receiving bills as high as \$50,000.¹⁴ Air ambulances, often operated by private companies, are particularly important for people living in rural areas, where reliable ground transportation and/or access to facilities may not be as accessible. In a 2017 report, *Consumer Reports* indicated that the expansion of for-profit air ambulance companies is driven, in part, by clinic and hospital closures in rural areas, making them the only viable option for some rural residents in need of emergency care in a timely manner.¹⁵

Dynamics of Balance Billing

Balance billing originates from disagreements over reasonable, fair and sustainable reimbursement for services provided to patients. This conundrum

* According to *Consumer Reports* (2017), Medicare fee schedules often are used as the benchmark when evaluating payment amounts because insurers use them as a reference point when calculating how much they reimburse for care. Overall, the average physician charges about 2.5 times the amount that Medicare pays.

consistently pits insurers against providers and hospitals, each trying to ensure continued viability within the complex and costly U.S. healthcare system.

Physician groups and other organizations affiliated with providers and hospitals assert that insurance companies are responsible for creating the balance billing issue. From the providers' perspective, health insurance networks have become narrowed in recent years as insurers try to reduce costs to maintain profit margins. Insurance companies, they argue, limit the pool of providers in their network to those who agree to contract at rates that often are below market value.¹⁶ Providers who do not assent to the insurer's preferred reimbursement rates remain out-of-network and, thus, required to bill insured patients to offset the costs of providing care.

Insurance companies assert that reimbursement rates already are at appropriate levels so as to keep patient costs in check. Insurers stress that if providers are reimbursed at the amounts requested, insurance premiums and deductibles would increase for their members. Insurers also argue that hospitals and providers—particularly those who work in emergency departments and are aware that patients are not always cognizant to determine a facility's or specialist's network status—have less incentive to join a network that could minimize their potential earnings.

There is an element of truth in both arguments. Insurers often have leverage when negotiating because it is in the interest of providers to remain part of a network to ensure a steady stream of insured patients. In many areas, it is difficult for physicians and specialists to maintain successful practices without joining insurance networks because most patients are not willing to shoulder the costs of visiting out-of-network providers.¹⁷ As such, insurers can negotiate reimbursement rate levels that are more fiscally aligned with their bottom lines, knowing that many providers will accept in-network rates to guarantee more patient visits.

This dynamic, however, does not apply to all facilities and providers. Emergency departments, and the

physicians and ancillary specialists who staff them, have lucrative out-of-network options unavailable to others. When confronted with an emergency, for instance, patients or their families will be more concerned with their immediate health than the network status of a specific facility or provider. Even if cognizant of insurance concerns, the option to select the treating physician and specialists may be neither expedient nor available. As a result, it may be in the providers' or hospitals' financial interests to stay outside a network because it allows for the billing of higher charges for services, recognizing that people always will need emergency care regardless of the costs. Previous studies found that this is the case for some emergency facilities; however, the majority do not have aggressive balance billing practices.

Finding a Solution

Identifying a comprehensive solution has proven difficult. Those that have been proposed often fail to satisfy both insurers and providers because a financial benefit for one often is a loss for the other. According to The Commonwealth Fund, a New York-based nonprofit organization that promotes comprehensive and accessible healthcare, there have been four state government approaches to resolve issues surrounding balance billing.¹⁸

1. **Insurer Hold Harmless Provisions:** Require insurers to pay in- and out-of-network providers their billed charges or another amount that is considered acceptable to the provider.
2. **Payment Standards:** Establish reimbursement rates for out-of-network providers, often set at a specified level above the average Medicare reimbursement or based on independent medical billing databases.
3. **Prohibitions on Provider Balance Billing:** Ban out-of-network providers from the practice of balance billing patients beyond the established cost-sharing amounts that are permitted by a patient's insurance plan.
4. **Dispute Resolution Processes:** Create an independent mediation process whereby providers and insurers negotiate a payment rate for services without involving the patient.

Disagreements to all four approaches exist. Hold harmless provisions frequently are opposed by insurance companies because they require payments that are acceptable to out-of-network providers which, in many cases, are higher than the insurer's preferred amount. These payments could lead to increased premiums for patients as insurance companies try to offset higher-than-anticipated reimbursement levels.¹⁹ Insurers also argue that payment standards disincentivize providers from joining health insurance networks, leading to higher costs for patients. For example, previously introduced and enacted legislation requires that reimbursement payments be tied to independently operated billing databases. Providers support these databases as an appropriate benchmark for determining costs of out-of-network care, though insurers argue they reflect pricing levels that are higher than negotiated network rates.

Meanwhile, most providers and hospitals strongly oppose prohibitions on balance billing and contend that they would be left with no recourse to recoup costs if an insurer's reimbursement rates are insufficient. Without other actions, prohibiting providers from employing balance billing places them at a significant disadvantage vis-à-vis insurance companies. On the other hand, dispute resolution mechanisms, while ostensibly providing an outlet for providers and insurers to negotiate a fair and reasonable price for a service without involving the patient, often are perceived as costly and cumbersome processes.²⁰

While providers, hospitals and insurers continue to blame each other for the practice of balance billing, the public holds all three accountable to some degree. According to NORC's August 2018 survey, 86 percent of respondents indicated that health insurance companies are very responsible or somewhat responsible for surprise medical bills, compared to 82 percent for hospitals and 71 percent for doctors. Almost one-fifth of respondents indicated that doctors are not at all responsible for balance billing, whereas less than 10 percent responded that was true for hospitals and insurance companies (See Table 1).²¹ Physician services, usage

Table 1

Survey: Who's Responsible for Balance Billing?

Percent of American adults who believe insurers and providers are responsible for surprise medical bills

	Very Responsible	Somewhat Responsible	Not at all Responsible
Health Insurance Companies	58	28	7
Doctors	24	47	19
Hospitals	45	37	9

Source: National Opinion Research Center, 2018.

of hospitals or other healthcare facilities, laboratory tests, imaging and prescription drugs all were listed as patients' primary reasons for receiving surprise medical bills.²²

Balance Billing Regulations in SLC States

State governments are at a disadvantage as it relates to addressing balance billing issues because they are prohibited from providing comprehensive protections for everyone. The Employee Retirement Income Security Act of 1947 (ERISA), a federal law that regulates all self-funded company and union health insurance plans, does not prohibit this practice. Under ERISA, employers with self-funded plans* are not considered insurance companies or engaged in selling insurance, thus precluding them from being governed by state insurance laws.²³ As a result, all state initiatives, to date, establishing protections from balance billing do not include self-funded plans and, thus, are limited in scope.²⁴ According to the Kaiser Family Foundation, 60 percent of workers nationally are insured through self-funded plans, meaning any balance billing protections that have been implemented do not apply to this population.²⁵ In the South, 64 percent of the population is in self-funded plans, slightly higher than the national average.[†]

* Self-funded plans pay claims out of their own funds, even though they may be administered by large insurance companies.

† The Kaiser Family Foundation uses U.S. Census Bureau definitions when aggregating regional data. The South, according to the Census Bureau, includes 14 of the 15 SLC states, as well as Delaware, Maryland and Washington, D.C.

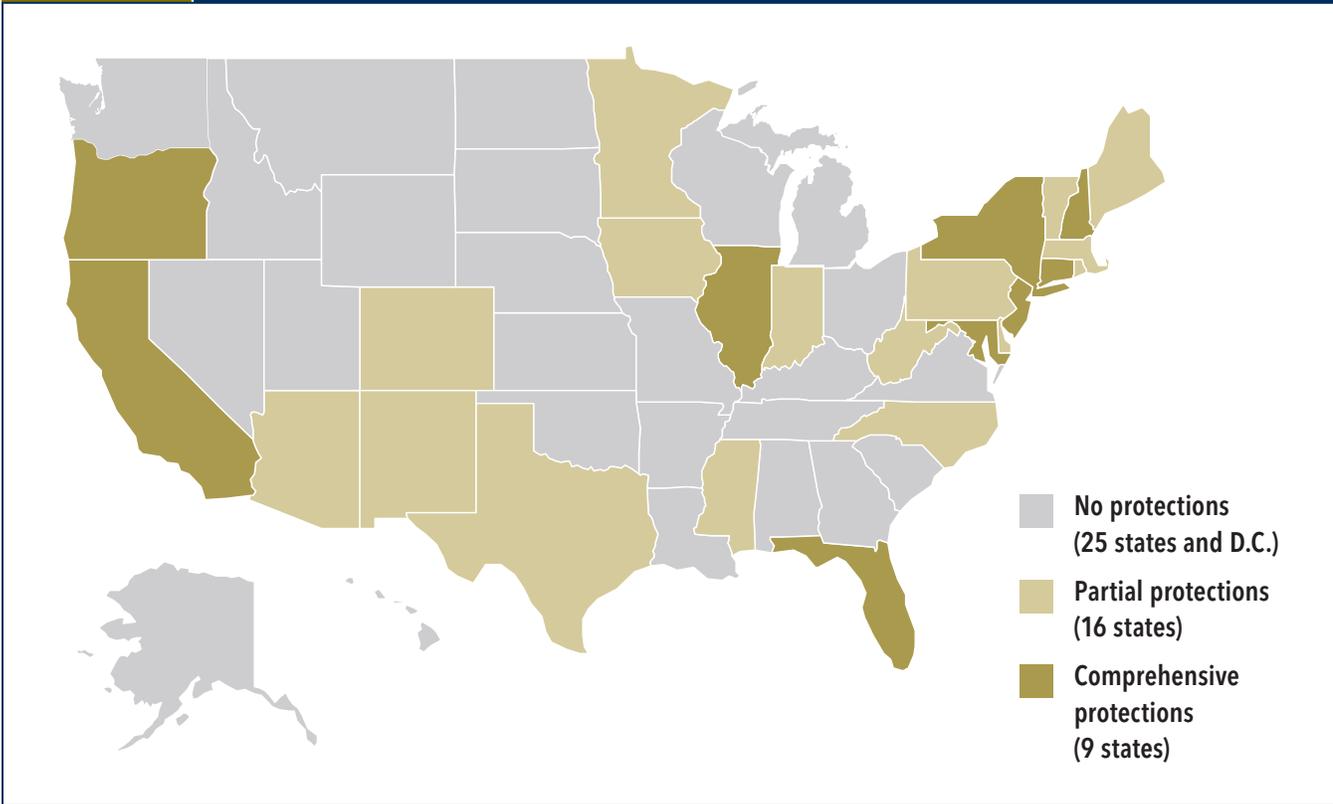
Nevertheless, several states in the SLC region have enacted, or at least considered, legislation to address balance billing issues for segments of the population that can be regulated. According to The Commonwealth Fund, Florida is the only Southern state that has implemented comprehensive protections against balance billing as of January 2019. Meanwhile, Mississippi, Missouri, North Carolina, Texas and West Virginia provide partial protections (See Figure 2).[‡] The remaining states in the region have no protections in place, though many, including Alabama, Georgia, Kentucky, Louisiana, Oklahoma, South Carolina, Tennessee and Virginia, have attempted to pass protections in recent years.

Enacted Legislation

Florida

In 2016, the Legislature passed House Bill 221 that protects consumers from balance billing in both emergency and non-emergency situations. The legislation prohibits out-of-network providers from billing insured patients for any excess amount beyond standard copayments, deductibles and coinsurance obligations defined by their health insurance plans. The prohibition only applies when an insured patient

[‡] The Commonwealth Fund identifies comprehensive protections as those that apply to both health maintenance organization and preferred provider organization plans during emergency and non-emergency situations. Comprehensive protections also protect consumers with hold harmless provisions and prohibitions on balance billing, as well as adopting adequate payment standards or dispute resolutions processes for unresolved reimbursement disputes between providers and insurers. Partial protections include some, but not all, of these provisions.

Figure 2**State Laws Protecting Patients from Balance Billing**

Note: According to the Commonwealth Fund, Missouri is excluded from the list of states with balance billing protections because they are applicable only if the provider and insurer voluntarily agree to participate in the dispute resolution process.

Source: The Commonwealth Fund, 2019.

does not have the ability or opportunity to choose an in-network provider. If an out-of-network provider requests reimbursement beyond the standard amount allowed by a patient’s health insurance plan, the insurer is liable for payment of fees. In the event the insurer and provider cannot agree on an amount, they must resolve the dispute in court or via a voluntary resolution process within a specified time frame.²⁶

Mississippi

Balance billing protections have been in place since 2013 after the passage of House Bill 374. The legislation prohibits providers from billing insured patients any excess amount above copayments, deductibles or coinsurance obligations defined by their health insurance plan.²⁷ If a provider accepts payment from an insurer—regardless of the amount—the bill is considered paid in full and the patient is not liable for any additional charges.²⁸ The legislation does not distinguish between emergency and non-emergency circumstances.

Missouri

In 2018, the General Assembly passed legislation making the state the latest in the South to offer balance billing protections. Senate Bill 982 protects patients from billing beyond standard copayments, deductibles and coinsurance obligations defined by their health insurance plan when they seek emergency care from an out-of-network provider at an in-network facility. The enacted legislation does not address balance billing in non-emergency situations. The legislation also establishes a comprehensive dispute resolution mechanism for insurers and providers to negotiate reimbursement payments. A provider submitting a claim to the insurer for unanticipated out-of-network care must send the claim to the patient within 180 days after rendering services. If the provider is unsatisfied with the insurer’s offer, the two parties have 60 days to negotiate reimbursement. Unresolved complaints following the 60-day period are settled in arbitration.²⁹

Table 2		Enacted Balance Billing Protections in SLC States				
State	Year Enacted	Enabling Legislation	Type of Protection	Medical Settings Covered	Additional Stipulations	Plans Covered
Florida	2016	HB 221	Consumer not liable for extra provider charges; balance billing prohibited	Any emergency; non-emergency at in-network facility	Defined insurer/provider dispute resolution process; standard payment rates for out-of-network care	HMO/PPO
Mississippi	2013	HB 374	Consumer not liable for extra provider charges; balance billing prohibited	Any emergency; non-emergency at in-network facility	-	HMO/PPO
Missouri	2018	SB 982	Consumer not liable for extra provider charges	Any emergency	Defined insurer/provider dispute resolution process	HMO/PPO
North Carolina	2007	HB 447	Consumer not liable for extra provider charges	Any emergency	-	HMO/PPO
Texas	2017	SB 507	Consumer not liable for extra provider charges	Any emergency; non-emergency at in-network facility	-	HMO
West Virginia	1996	HB 4511	Consumer not liable for extra provider charges	Any emergency	-	HMO

Source: The Commonwealth Fund, 2019; Missouri Senate Bill 982.

North Carolina

With the passage of House Bill 447 in 2007, the state became the second in the South, after West Virginia, to enact balance billing protections. According to the legislation, facility-based physicians and providers are prohibited from billing patients beyond the amount for standard copayments, deductibles and coinsurance obligations defined by a patient's health insurance plan. Out-of-network providers at in-network facilities cannot bill patients after payment is received from an insurer.³⁰ The bill does not distinguish between emergency and non-emergency settings.

Texas

In 2017, the Legislature passed Senate Bill 507 to expand mediation options for patients who receive unexpectedly high medical bills and facilitate billing mediation for all types of out-of-network care received at in-network facilities. Senate Bill 507 expands on a previous bill passed in 2009, Senate Bill 1731, which permitted mediation only for billing from anesthesiologists, pathologists, emergency department physicians, neonatologists and assistant

surgeons.³¹ Under Senate Bill 507, the mediation process is available for patients who receive bills in the amount of \$500 or more.³² Notably, the legislation does not prohibit balance billing; but instead, provides a mechanism for patients to resolve any bill they receive above \$500.

West Virginia

With the passage of House Bill 4511 in 1996, the state became the first in the South, and one of the first nationally, to offer partial protections from balance billing. Insurance companies are responsible for reimbursing providers for all out-of-network emergency care, exclusive of patients' standard deductibles, copayments and coinsurance obligations as defined by their plans, at prevailing rates for the services rendered.³³

West Virginia also had provisions codified in 1989, and updated in 1991, offering partial protections from balance billing. Specifically, healthcare providers are barred from billing patients who are covered by state-sponsored insurance plans in excess of standard

deductibles, copayments and coinsurance obligations as defined by their plan. The prohibitions are limited to emergency situations only, defined as those needed to resolve an imminent life-threatening medical or surgical emergency. Only after a patient is stabilized following an emergency can providers send bills to patients directly for services that are not covered by the plan.³⁴

Examples of Introduced Legislation*

Alabama

House Bill 11, introduced in 2019, prohibits providers from seeking compensation for services given to an insured patient in excess of standard deductibles, copayments and coinsurance obligations as defined by the patient's insurance plan. The bill states that compensation must be sought directly from the health insurance company. No distinctions are made between emergency and non-emergency situations.³⁵ As of April 5, 2019, the legislation still is under consideration.

Georgia

House Bill 84 and Senate Bill 56 were introduced during the 2019 legislative session to alleviate some of the concerns surrounding balance billing. House Bill 84, which failed to pass, stipulated that providers, upon request from a patient, would have been required to inform the patient of their network status and give the patient a list of the networks in which they participate. If outside the patient's insurance network, providers would have been required to provide notification, in writing, prior to the provision of non-emergency services, that the patient is entitled to see a bill for estimated expenses. Meanwhile, insurers would have been required to disclose whether a scheduled provider is within the insurer's network and, if not, disclose the amount that will be reimbursed for out-of-network care. The bill also would have established an arbitration process between the patient and provider.³⁶

* This *SLC Regional Resource* does not include an exhaustive list of all balance billing legislation that has been introduced in Southern states. However, it provides many examples that reflect states' efforts to address the rise in balance billing and surprise medical bills.

Senate Bill 56, along with including similar transparency rules as House Bill 84, prohibits billing in excess of the allowed amount the patient would pay for comparable service from an in-network provider when patients receive emergency treatment from an out-of-network provider. In addition, in the event an insured patient receives emergency treatment from an out-of-network provider, the insurer could arrange transportation to an in-network facility as soon as the patient is stabilized. The insurer is required to pay the entirety of charges for out-of-network care if they fail to transfer the patient. Senate Bill 56 also makes mediation available for patients who receive bills in excess of \$1,000 for non-emergency care.³⁷ The bill failed to pass during the 2019 legislative session, but may be reconsidered in 2020.

Kentucky

During the 2018 legislation session, Senate Bill 79 was introduced to prohibit balance billing by requiring providers administering unanticipated out-of-network care to send the bill directly to the insurer rather than the insured patient. The bill would have required insurers to reimburse providers no less than the usual and customary rates for services, after which providers would have been banned from sending any additional bills to patients in excess of standard copayments, deductibles and coinsurance obligations as defined by the insurance plan. In addition, Senate Bill 79 would have designated a nonprofit organization to maintain a database of billed charges submitted by providers, used as a benchmark for determining usual and customary rates for services. Insurers would have been required to submit all billed charges from both in-network and out-of-network providers, which would have been publicly available for consumers to view.³⁸

Louisiana

House Bill 369, which failed to pass during the 2018 session, proposed expanding mediation options for patients who receive bills in excess of \$500 for out-of-network care. If the legislation had been enacted, mediation would have been available for emergency care or any other service from an out-of-network provider at an in-network facility.³⁹ Similarly, in 2014,

House Bill 822 was introduced to prevent providers from billing patients in excess of standard copayments, deductibles or coinsurance obligations defined by the patient's health insurance plan. The prohibition on billing would have applied only if the provider received payment directly from an insurer for services provided.⁴⁰

Mississippi

House Bill 278, introduced during the 2019 session, aimed to increase balance billing protections in addition to the ones that already have been enacted. The bill, which did not pass, would have required reimbursement disputes between providers and patients to be resolved through binding arbitration, enforced by the attorney general's office.⁴¹ The bill was an effort to address complaints in the state that balance billing prohibitions often were violated by providers without consequence.⁴²

Oklahoma

In 2018, House Bill 3228, known as the "Patient Protection Act," would have prohibited out-of-network healthcare providers from billing patients if they agreed to accept the highest contracted reimbursement rate available from the insurer. No distinctions were made between emergency and non-emergency situations.⁴³

South Carolina

Senate Bill 226, introduced during the 2019 legislative session, specifically addresses balance billing for ambulatory services in the state. The bill, which is under consideration as of April 5, 2019, prohibits out-of-network EMS agencies from billing patients transported in ambulances in excess of standard deductibles, copayments and coinsurance obligations as defined by the patient's insurance plan if the insurer reimburses the agency at the same rate established for in-network services.⁴⁴

Tennessee

House Bill 2353, also known as the "Network Adequacy and Out-of-Network Balance Billing Transparency Act," was introduced during the 2018

legislative session. The bill would have mandated that insurance companies reimburse providers for out-of-network emergency care at the usual and customary rates for such services or the amount requested by the provider, whichever is less. According to the bill, "usual and customary rates" meant the 80th percentile of all submitted billed charges for a service in a specified geographic region. After receipt from the insurers, providers would have been prohibited from billing any additional amount in excess of standard deductibles, copayments or coinsurance obligations as defined by the patient's health plan. House Bill 2353 also included network requirements for insurers, outlining what qualifies as an adequate network and requiring insurers to submit an annual report to document compliance with network adequacy.⁴⁵

Texas

Senate Bill 1264, bipartisan legislation introduced during the 2019 session, bans out-of-network providers from billing patients for emergency care in excess of standard copayments, deductibles and coinsurance obligations as defined by a patient's health insurance plan. The bill requires insurers to reimburse out-of-network providers an amount that the insurers consider reasonable for the services, or at the agreed, contracted amount if the out-of-network provider performed a service at an in-network facility.⁴⁶ As of April 5, 2019, the legislation is under consideration.

Virginia

In 2018, the General Assembly introduced House Bill 1584, which would have protected patients from billing by out-of-network providers for ancillary services in excess of standard copayments, deductibles or coinsurance obligations defined by a patient's health insurance plan.⁴⁷ According to the bill, ancillary services were defined as screenings, diagnostics and laboratory services provided to an insured patient in connection with services received at an in-network facility. The bill stipulated that, in the event a patient received a bill from an out-of-network provider that did not exceed the allowed amount, the insurer would

have been required to pay the amount directly to the insured person, who would then reimburse the provider.⁴⁸

West Virginia

During the 2019 legislative session, the Legislature attempted, unsuccessfully, to reform the state's balance billing laws with the introduction of House Bill 2380. The bill would have required providers to disclose information to patients about their network status and hospital affiliations, as well as details of the financial consequences of receiving out-of-network care. Moreover, the bill would have required providers to give patients a full list of all specialists scheduled to treat the patient and information to help them determine each specialist's network status. The bill also required insurers to have a process that ensures all insured patients have access to in-network benefits at in-network pricing even if the patient visited an out-of-network provider. The bill also stipulated that patients, to be protected from surprise bills, sign an assignment of benefits form to enable a provider to seek payment directly from the patient's insurance carrier. Unresolved payment disputes between providers and insurers could have been addressed through an independent dispute resolution process established by the Commissioner of Insurance.⁴⁹

Federal Solutions to Resolve Balance Billing

There is bipartisan interest at both the state and federal levels to address balance billing practices. Due to the ERISA restrictions that prohibit states from regulating self-funded insurance plans, it generally is acknowledged that action at the federal level is a prerequisite for comprehensive protections from balance billing at the state level.

In September 2018, a bipartisan group of U.S. Senators unveiled draft legislation, known as the "Protecting Patients from Surprise Medical Bills Act," to address common concerns surrounding balance billing practices.⁵⁰ As written, the draft legislation includes three important provisions:

1. **Emergency services provided by an out-of-network provider in an out-of-network facility:** Ensures that patients treated for emergencies by an out-of-network provider at an out-of-network facility are required only to pay standard deductibles, copayments and coinsurance obligations defined by their insurance plan. Providers are prohibited from billing patients, and excess amounts are paid by insurance companies.
2. **Non-emergency services following an emergency service from an out-of-network facility:** Requires providers or facilities to inform patients or their designees following out-of-network emergency services that additional care will be more costly than receiving in-network service. A written acknowledgement of the notification is required. Patients or their designees have the option to move to an in-network facility following emergency services, though the legislation does not specify who is responsible for the costs of transportation.
3. **Non-emergency services performed by an out-of-network provider at an in-network facility:** Prohibits insurance companies and out-of-network providers from billing patients more than agreed, in-network rates for treatment by an out-of-network provider at an in-network facility. Excess amounts are paid by insurance companies.

Another U.S. Senate bill, known as the "No More Surprise Medical Bills Act of 2018," prohibits out-of-network providers from charging patients more than in-network rates for emergency services unless the patient has been notified of the potential charges and consents to them at least 24 hours in advance of receiving the care. The bill also establishes a dispute resolution mechanism whereby providers and insurers determine an appropriate payment level for services rendered.⁵¹

Absent successful legislation at the federal level, the Brookings Institution proposes amending ERISA to give states more flexibility in regulating payment rates from self-funded health insurance plans to providers. A formal ruling from the U.S. Department of Labor

could clarify that states are free to regulate healthcare providers as they wish, even when they receive payment from self-funded plans, leaving them with the ability to establish minimum and maximum billing rates.⁵² Other federal actions that could reduce the frequency of balance billing practices include mandating better notification standards regarding potential out-of-network care from employer-sponsored health plans, as well as requiring employer-sponsored plans to comply with dispute resolution processes.⁵³

Conclusion

Balance billing is a prevalent concern within the American healthcare system, one that affects millions of people. The September 2018 survey conducted by the Kaiser Family Foundation found that unexpected medical bills were the biggest healthcare concern among respondents, more important than other issues prominently featured in healthcare conversations, including rising premium costs, growing deductibles and exorbitant prescription drug prices.⁵⁴ In many ways, balance billing and surprise medical bills are a microcosm of the complex and tangled U.S. healthcare system that is difficult to navigate and can have far-reaching financial impacts, even for those who are well-insured. The difficulty of addressing balance billing practices is reflected in the numerous state regulations proposed in recent years that, ultimately, failed to be enacted.

There have been efforts at both the state and federal levels to introduce more transparency in healthcare pricing, an important component in reducing both the charges and numbers of surprise medical bills patients receive. Effective January 1, 2019, all hospitals operating in the United States are required to publicly list their standard charges for services provided at their facilities. The change, which follows similar actions at the state level, was mandated as part of a new rule from the Centers for Medicare and

Medicaid Services to give patients a more thorough understanding of healthcare pricing.⁵⁵ Though considered a strong first step in helping consumers learn more about complicated pricing methodologies, it is important to remember that listed prices may not always reflect actual charges. When providers and insurers have contracted network rates, they negotiate discounted charges that are below listed prices. Moreover, even when patients are not insured, providers frequently offer direct discounts to offset the high costs of services.⁵⁶

Federally mandated legislation that provides comprehensive protections from balance billing is the most appropriate solution at this time, whether in the form of modifying ERISA restrictions or providing more transparency in healthcare pricing. However, there are other legislative actions that states should explore in the meantime. More states in the region could enact legislation that provides protections for the segment of the population that is not impacted by the ERISA restrictions on self-funded insurance plans, just as Florida, Mississippi, Missouri, North Carolina, Texas and West Virginia already have done. States also have the option to require better pricing transparency for patients receiving care, or planning to do so, and provide access to mediation for patients who receive large, unexpected bills.

As is the case for most issues pertaining to the U.S. healthcare system, consumer education is of paramount importance and may serve as protection against large, unexpected medical bills. States have the ability to mandate that both providers and insurers provide as much information as possible to patients about the pricing of healthcare services, especially for out-of-network care. Providing more clarity about complex pricing models could benefit consumers and, hopefully, decrease the number of surprise medical bills in the future.

Endnotes

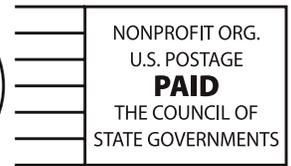
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This report was prepared by **Roger Moore**, policy analyst and committee liaison of the Human Services & Public Safety Committee of the Southern Legislative Conference, chaired by **Senator Katrina Shealy** of **South Carolina**. This report reflects the policy research made available to appointed and elected state officials by the **Southern Office of The Council of State Governments (CSG)**.

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