Balance Billing and Surprise Billing in the United States: A Look to the Past and the Future

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Balance billing and surprise billing have taken a front seat in the battle over healthcare dollars in the United States. The first step to understanding this complex issue is understanding the terms. Surprise billing occurs when a patient receives an unexpected bill. Typically the surprise bills come from out of network providers. In addition, most surprise bills come from providers who have limited contact with patients. Generally, these bills have come from emergency providers, anesthesiologists, radiologists, pathologists, first assists, and their respective facilities that may also bill for technical services (i.e. an imaging facility billing for the MRI while a radiologist bills for the interpretation). Balance billing occurs when an out of network provider (also known as non-participating provider) receives payment from the insurance company and patient that, when combined, is less than the billed charge from the provider. Since the provider does not hold a contract with the insurance company, the provider has the legal right to bill the patient for the balance of the remainder due.

An example of balanced billing is as follows. Imagine a patient presents to an in network emergency facility and receives a bill for the facility as well as physician fees. The facility is a major hospital and in network with the insurance network. The insurance company is billed by the emergency facility for services provided, which are then contractually reduced based upon the facility's pre-negotiated contract for those services. The patient would then have some form of potential copay, deductible, and/or coinsurance provided they have not reached their out of pocket maximum for the year. The patient also receives a bill for the professional services of the emergency room physician, who is not employed by the emergency room, but is instead contracted by the emergency room to provide these services. This provider is not participating in the insurance network and is therefore out of network and has no contractual agreement. The provider bills the insurance company for his or her services. The insurance company will then pay according to their insurance plan's agreement with the purchaser of the insurance plan (typically the patient’s employer is the purchaser of the plan). In some cases, this might be 100% of billed charges, but in many cases, it will be significantly less. At that point, the insurance company will pay their portion of the fees and the patient will pay their eligible copay, deductible, and/or coinsurance. If the billed charges from the emergency room provider were $1,000 and the insurance company agreed to $250 based on their negotiations with the provider as well as based on their insurance plan agreement, there is still an outstanding balance of $750. The emergency room provider can accept the $250 as full and final payment or they have the option of “balance billing” the remaining $750 to the patient. While this example shows a balance bill of $750, there are reports of balance bills in excess of $100,000 in some cases. It should be noted that many out of network providers elect to not balance bill, instead attempting to negotiate with the insurance carrier for a fair and reasonable payment for the services provided. Of note, this scenario described above could also be construed as a “surprise bill” as the amount and balance bill was surprising to the patient who anticipated that they would not be responsible for this larger amount out of pocket.

If balance billing has been legal for decades, why are we just now hearing about it? This seems to be related to a few factors that have increased over the last decade. First, insurance companies are working towards “narrow networks” in many markets. A patient may or may not even know they have purchased a narrow network until they attempt to utilize services. Narrow networks simply mean that the insurance company significantly reduces the number of providers that they are willing to contract with, and typically do so at a significant reduction in
reimbursement to those providers. Providers may opt to take these lower reimbursements to provide a service to a community, even at a loss, or based on a belief or promise of access to a higher volume of patients. Insurers use narrow networks to reduce costs, typically passing on some of these savings to patients by way of lower premiums. HMO plans could be seen as a narrow network in many ways. Typically state put restrictions on the narrow networks to be “adequate”, but this definition is open to interpretation. Reducing the number of in network providers necessarily means an increase in out of network providers. More out of network providers means more opportunities for balance billing to occur. The second driving force is simple economics. The amount physicians and providers are paid for their services, both in absolute dollar terms and in comparison to inflation, has decreased dramatically over the last several decades. Meanwhile, insurers continue to see record profits since the institution of the Affordable Care Act (ACA), more commonly known as Obamacare. United Healthcare saw over 700% increase in stock value from 2010 to 2018 (approximately 500% when accounting for dividends), the first 8 years since the ACA was enacted. Meanwhile, from 2006 to 2017, the Medicare Physician Fee Schedule, upon which nearly all insurance contracts are based, increased less than 5%. Inflation during that time increased nearly 23%. As physician reimbursements diminish across the board and are significantly less than inflation and cost of living increases year-over-year while expenses continue to increase, physicians have elected to go out-of-network to protect their continued diminishing income. Finally, in an effort to improve profits as well as improve predictability of expenses, insurance companies have increasingly pushed more responsibility to patients through dramatically increased copays, deductibles, and coinsurance. From 2006 to 2016, average deductibles increased from $303 on average to over $1200. Deductibles only accounted for 28.8% of cost-sharing in 2006 but now account for over 50% of cost-sharing paid by patients. As patients have higher out-of-pocket expenses, they are receiving higher bills. This may lead to more consumer awareness of the bills paid to providers, including any balance billing.

As articles and complaints began to increase over the last 10 years, states began to look into addressing these issues. The driving issue was the emergency patient who has little to no choice over where they go (they need emergent care). These patients would present to an ER by ambulance or private vehicle, seek services, and find out later that they owed significant amounts to an out of network emergency provider. California was actually the first state to look into and address the issue. Under Governor Schwarzenegger, executive order S-13-06 when into place. It declared that balance billing for the provision of emergency services was unfair. This applied to both providers and hospitals. It was subsequently upheld in a Supreme Court Case in California the next year. While this addressed care in the emergency room for emergency issues, there were gaps. California legislature then passed AB 1203. This prohibited non-contracting hospitals from billing the patient for post-stabilization care after emergency care except applicable copayment, coinsurance and deductibles with some exceptions. This law only applied to Department of Managed Health Care (DMHC) plans regulated by the state and didn’t apply to federally regulated plan or those regulated by the California Department of Insurance (CDI). California attempted several more times to pass legislation, but was unable to do so until nearly a decade later.

Landmark legislation was then passed by New York in March of 2014 (implemented in 2015). There were several unique components to this law. The first was the incorporation of both non-emergent care as well as emergent care in protections from balance billing. Second, they established a new definition of reasonable fee, which was based, in part, on a Fair Health type database (there are actually 6 criteria, of which the usual and customary cost determined by this database is only one). Third, the patient was held harmless except their in-network copay, coinsurance, and deductible. Finally, the insurance and provider would be able to utilize a “baseball style” arbitration process to come to a resolution of the amount to be paid. In this type of arbitration, the arbitrator determines which number (the charged amount from the provider or the amount paid by the insurer) is closer to the reasonable fee, and awards this
amount. For instance, if the billed charges were $5,000 and the paid amount was $1,000 from insurance, the arbitrator would determine where they feel the reasonable fee resided. If this fee was felt to be over $3,000, then the provider would be paid the full $5,000. If this fee was felt to be less than $3,000, then $1,000 amount would be full and final payment.

In 2016, both California and Florida passed further legislation. California’s bill (AB 72) was designed to address the gap for non-emergency services. They followed suit with New York in limiting out of pocket costs to in-network cost sharing amounts but also required an immediate payment of 125% of medicare or the 50th percentile of the in network reimbursement for similar services in the same area under that insurance company. A dispute resolution system was also included, but the definition of what to consider in the process was less well defined. California also forced both parties to participate in the dispute resolution whereas previously insurance companies could opt out. Florida’s bill (HB 221) also sought to reduce both emergent and non-emergent balance billing. There was already a dispute resolution system in place (Maximus), which has been voluntary, and the ultimate payment from insurance would be determined through this system. Usual and customary was not clearly defined and was not tied to a database.

Florida’s tie to the dispute resolution system was important compared to prior bills introduced in previous legislative sessions in Florida, which typically capped payment to a set percentage of Medicare. Tying to a percentage of Medicare was particularly problematic from a legal standpoint related to prior case law. In Merkel v Health Options (2006), the court found that HMOs cannot reimburse based on Medicare reimbursement rate. In Baker County Medical Services v Aetna Health Mgt, LLC (2010), the judge found that using Medicare as a benchmark was not “reasonable” and stated that “in determining the fair market value of the services, it is appropriate to consider the amounts billed and the amounts accepted by providers with one exception. The reimbursement rates for Medicare and Medicaid are set by government agencies and cannot be said to be ‘arm’s length’”.

In 2019, Texas passed legislation (SB 1264) that very closely mirrored the New York legislation five years prior with some changes. First, Texas added in imaging facilities and laboratories to the list of providers subject to the laws. Second, facilities were included but put into a mediation process, not arbitration, and only in cases of emergency care, laboratory services, and diagnostic services. Third, the definition of surprise billing was expanded to include any referral from an in-network provider to an out-of-network provider. The bill also addressed prompt payment in a slightly different way, requiring insurance companies to pay their allowed amount within 30 days of a electronic clean claim and 45 days of a non-electronic clean claim. Finally, Texas legislators included a clause stating that nonemergency providers could obtain consent from a patient in advance of services being provided to allow the provider to balance bill. Texas did include arbitration language that closely reflects the New York language and is also baseball style. Of note, the cost of arbitration in Texas is split evenly between the insurer and the provider whereas in New York, the losing party pays the costs. As the law just passed, the actual enactment of the law is still to be determined.

With the momentum seen at the state level and a request from President Trump, congress has a renewed interest in passing federal legislation. All of the discussion so far on state laws pertains to health plans that are under the purview of the state governments. In 1974, the Employee Retirement Income Security Act (ERISA) was passed. This act was designed to provide protections to as well as setting rules for employer-sponsored health insurance plans. After this legislation was passed, the regulations regarding ERISA plans, including anything related to balance billing, were now under federal control, not state control. As a significant portion of the insurance market is provided by employer-sponsored health insurance, the state laws have limited impact. Federal legislation would close one of the few remaining gaps in balance billing.
There are several bills currently proposed in both chambers. The one currently receiving the most attention is coming from the Senate HELP committee from Senators Alexander (R-TN) and Murray (D-WA) entitled the Lower Health Care Costs Act of 2019. This is in draft form and addresses surprise medical bills, prescription drug pricing, price transparency, health record access, and cost of delivery. Specific to the balance billing component, the bill provided three alternatives for how to address the ultimate dispute in payment amount between the provider and the insurance company. The first approach is network-matching. In this model, the health care facility would guarantee in any contractual arrangement with an insurance that every practitioner, lab or diagnostic service provided in their facility will be under contract with respect to all services provided at their facility. It also provided an alternative for providers to be considered in-network if they agreed to have their reimbursement included as part of the facility payment and not to separately bill the insurance company or patient. Option two involves an independent dispute resolution process similar to that of the state plans. The plan does not elaborate much on how the dispute resolution should come to a conclusion other than to state that it shall consider relevant factors including the median contracted rate for the same or similar services in the same region. The proposal assigns costs of this dispute process to the losing party. The final option considered is benchmark payments. The benchmark in this option is determined based again not the median contracted rate for the same or similar services offered by the group health plan or health insurance issuer in that geographic region.

Another alternative has been proposed by Senator Cassidy (R-LA) and others in the STOP Surprise Medical Bills Act. In this bill, an automatic payment from the insurance plan would occur for the median in-network rate under the plan or coverage. The provider may negotiate an alternative amount and/or may pursue and independent dispute resolution (IDR). In the IDR, both parties submit their final offer. The IDR then determines which of the two final offers is more reasonable. This bill does more specifically outline relevant factors including “commercially reasonable rates” (not defined other than to take into consideration in-network rates); level of training, education, experience, quality, and outcomes; circumstances and complexity; market share of the provider; demonstration of good faith efforts to contract; and relevant economic aspects in the same geographic area.

The House Energy and Commerce Committee has released draft legislation from Representatives Pallone (D-NJ) and Walden (R-OR). As in all other drafts discussed, this draft eliminates balance billing and limits out of pocket amounts for the patient to their in-network cost-sharing amounts. This bill subscribes to the benchmarking plan previously discussed in the HELP committee bill. The rate would be set at 100% of the current median in-network rates for that geographic area with no dispute resolution.

There are other bills currently under proposal as well. Representatives Ruiz (D-CA) and Roe (R-TN) have proposed a bill very similar to the Cassidy bill with a set payment up front followed by an IDR if the original payment is not satisfactory. Representative Doggett (D-TX) has also reintroduced legislation focused on requiring disclosures and only limiting balance billing in the case of emergency services or noncompliance with disclosures.

In the absence of a consensus, one must look to the data. In May of 2019, the Robert Wood Johnson Foundation in conjunction with the Georgetown University Health Policy Institute Center on Health Insurance Reforms looked at the effectiveness of the New York bill over the roughly four years of use. As part of this white paper, the group interviewed all interested parties, including state regulators, consumer advocates, insurance company representatives, physician and hospital representatives, and expert observes between January and March of 2019. The arbitration clause was found to be the key to passage of the bill allowing all of the stakeholders to have some middle ground. Not surprisingly, the insurance companies were the
most concerned at the outset. The major takeaway is that consumers have been protected from surprise balance bills. One regulator was even quoted as saying that consumer complaints about balance billing went from “one of the biggest” issues to “barely and issue”. The results of the IDR were mixed. On an overall basis, the decisions are nearly 50-50 in regards to in favor of insurance vs in favor of providers. When broken down into emergent and non-emergent IDR results, the insurance companies won the majority of emergency cases while the providers won the majority of non-emergent cases. The threat of the IDR process has pushed both sides to the table with experts stating that the number of cases actually going to the IDR process is just a “tip of the iceberg” compared to the number of disputes that occur. Physicians have found the process fair. Insurers have noted that they are now incentivized to have larger networks and have provided better and more numerous in network contracts, a win for network adequacy concerns of consumers. The process has led to a 34% drop in out-of-network billing as well, again an intended outcome of this bill. While all of this progress has occurred, insurance rates have neither increased nor decreased in this time according to the report. The authors did identify three main issues still remaining to be addressed or modified. The first is the lack of ERISA plan protections, for which federal legislation is needed. The second is misinformation from both the provider office as well as the insurance plan as to whether or not the provider is in network. The final component is that the New York law left out hospital facilities that are out-of-network. At the end of the day, the insurance company and provider both have wins and losses while the patients have clearly won with the implementation of this legislation.

The Congressional Budget Office has also weighed in on the matter. The HELP draft and Cassidy bill were both scored. The HELP draft legislation was scored at $25 Billion in savings for the benchmark model, $20 Billion for arbitration, and $9 Billion for network matching. The Cassidy bill came in at $17 Billion for their arbitration model.

The path forward seems to be therefore clear. California, Florida, Texas, New York, and New Jersey have all implemented laws that utilize a dispute resolution system. New York’s law being the longest and best studied, has shown significant promise for a baseball-style arbitration with the arbitrator instructed to look at many factors, some of which are positive for providers while others are better for insurance plans. The parties involved seem to be happy with the process to date and the consumers have clearly won in the process. It is interesting that Texas, a traditionally “red state”, and New York, a traditionally “blue state”, have both agreed upon a path forward. This is a rare win in today’s hyper-partisan politics. Texas passed its legislation with near unanimous agreement. Florida, a swing state, and California, another “blue state”, have also implemented dispute resolution systems, although less sophisticated and less defined than the New York and Texas bills.

It should be noted that while this is a discussion of how to appropriately handle balance billing and surprise billing, the outcomes of these bills will significantly impact the ability of providers to adequately negotiate contracts with insurance carriers. In all negotiations currently, the provider has the option of going out-of-network and receiving, typically, higher payments. The reasons for doing so are multiple, but it allows for a check and balance with the insurance companies. If an artificial ceiling is introduced through legislation by placing a cap on the maximum amount of payment, particularly if that cap is based on insurance contracts, there is no check and balance to insurance companies continuing to increase profits while driving down reimbursements to the providers. As discussed above, insurance companies are already making record profits while providers continue to see declining reimbursement in relationship to inflation and cost of living.

Hopefully this outline is helpful in understanding the various complexities of this decision making process and also help provide a way forward. The New York and Texas bills appear to
be excellent road maps to a path that can provide protections for consumers while still keeping both providers and insurance companies in check.