Policy At A Glance:
Surprise Out-of-Network Medical Bills

On February 5, 2019, six senators sent a letter to industry groups representing health care providers and health insurance plans. In this letter, the senators requested information necessary for a bipartisan legislation to protect patients from costly and unexpected out-of-network medical bills.

What is a Surprise Out-of-Network Medical Bill?

A surprise out-of-network medical bill can happen when an insured patient receives care from a health care provider who does not participate in their health plan’s contracted network. Surprise medical bills can occur when patients are unable to actively choose their medical provider and often involve out-of-network 1) hospital emergency rooms 2) ancillary physicians such as radiologists, anesthesiologists, and pathologists or 3) specialty groups such as ambulance or laboratory services. Although the patient’s health plan may cover a portion of the bill requested by the provider, out-of-network providers can collect the remaining balance directly from the patient (a process known as “balance billing”).

Even when a patient seeks emergency care at an in-network hospital, the physician working in the emergency room may not contract with the same health insurer as the hospital, resulting in an unexpected bill to the patient. Research suggests that one in five emergency room admissions lead to a surprise medical bill.¹

Relevant Federal & State Legislation

<table>
<thead>
<tr>
<th>Date</th>
<th>Legislation</th>
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<tbody>
<tr>
<td>9/2/1974</td>
<td>The Employee Retirement Income Security Act (ERISA) of 1974 enacted</td>
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<td>9/23/2016</td>
<td>Assembly Bill 72 (Health Care Coverage: Out-of-Network Coverage) becomes law</td>
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<td>9/18/2018</td>
<td>The Protecting Patients from Surprise Medical Bills Act introduced by Senator Bill Cassidy (R-LA)</td>
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<tr>
<td>10/12/2018</td>
<td>The No More Surprise Medical Bills Act introduced by Senator Maggie Hassan (D-NH)</td>
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According to survey results released by the University of Chicago in 2018, 57 percent of Americans have received an unexpected medical bill in the past. Survey respondents identified the following as the source of their surprise medical bill:

- Physician services (53 percent)
- Laboratory tests (51 percent)
- Hospital or other health care facility charges (43 percent)
- Imaging (35 percent)
- Prescription drugs (29 percent)

In a nation where 20 percent of insured individuals still have trouble paying their medical bills, the issue of surprise medical bills is prompting state and federal lawmakers to protect patients from its financial ramification.

State Level Efforts to Address Surprise Medical Bills

Surprise medical billing rates vary widely by state. In McAllen, Texas and St. Petersburg, Florida, surprise medical billing rates are at 89 and 62 percent, respectively. In other parts of the country, such as Boulder, Colorado and South Bend, Indiana, surprise-billing rates are almost zero.

As of June 2017, only 21 states have laws that protect their residents from surprise medical bills. Of those, 15 states offer partial protection (Colorado, Delaware, Indiana, Iowa, Massachusetts, Mississippi, New Hampshire, New Jersey, New Mexico, North Carolina, Pennsylvania, Rhode Island, Texas, Vermont, and West Virginia) while six states (California, Connecticut, Florida, Illinois, Maryland, and New York) offer comprehensive protections.

State laws that address surprise billing does one of the following:

- Cap or limit charges for services that are delivered out-of-network
- Improve cost transparency in service costs and/or provider networks
- Set up an arbitration process to resolve surprise bills
- Establish committees to study the impact of surprise billing on consumers

Surprise Medical Bill Legislation in California

Effective July 1, 2017, Assembly Bill (AB) 72 caps the charges patients have to pay for medical surprise bills. Under AB 72, privately insured patients will only be responsible for the in-network share of the cost if the patient sees an out-of-network provider at an in-network facility. AB 72 only applies to roughly 70 percent of state’s private health insurance plans and does not apply to “self-insured plans.” Self-insured plans are employer-sponsored plans in which companies pay for health insurance claims out of their own funds.
Federal Protection against Surprise Bills

Currently, there is no federal protection for patients against surprise out-of-network medical bills and existing state-level policies that address unexpected medical bills cannot protect patients enrolled in self-insured plans. This is because a federal law, the Employee Retirement Income Security Act (ERISA) of 1974, prevents states from regulating these plans. Self-insured plans are commonly found among large employers and while they cover 61 percent of privately insured employees in the nation, many employees do not know if they are enrolled in such a plan as companies hire well-known insurers to administer their self-funded plans. To address these concerns, senators introduced two draft bills in the fall of 2018; these senate bills are the Protecting Patients from Surprise Medical Bills Act and the No More Surprise Medical Bills Act and are modeled after state regulations on the same issue.

The Protecting Patients from Surprise Medical Bills Act was introduced in September 2018 and applies to individuals in both the insured and self-insured plans. This bill proposes to limit patient cost sharing, set payments that insurers can owe out-of-network providers, and ban providers from balance billing patients. The bill further focuses on care received at an out-of-network emergency care and treatment provided by out-of-network providers in an in-network facility. The No More Surprise Medical Bills Act was introduced in October 2018 and instead of capping the charges for services that are delivered out-of-network, this bill sets up an arbitration process between the health plan and provider to resolve surprise bills. Both bills seek to take the patient out of the billing dispute and reduce the financial liability of insured patients.

What is the Employee Retirement Income Security Act (ERISA) of 1974?

Commonly known as ERISA, this federal law is administered and enforced by the Labor Department’s Employee Benefits Security Administration, the Treasury Department’s Internal Revenue Service, and the Pension Benefit Guaranty Corporation. Its major role is to protect the interests of employees and their dependents by setting minimum standards for most voluntarily established retirement and health plans in private industry. ERISA does not require any employer to establish a retirement or health plan; rather, it only requires that those who establish plans must meet certain minimum standards.
Next Steps for Surprise Medical Bills

The majority of states in the United States have not enacted comprehensive legislation to protect insured patients against unexpected out-of-network medical bills. Even states that offer comprehensive protections are limited because state laws cannot apply to self-insured health plans regulated under ERISA. Therefore, broad and extensive federal action is necessary to protect employees covered under self-insured plans as well as residents of states that offer little or no protection against medical surprise billing.

References