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Balance Bill (n): An unexpected bill sent by a hospital, doctor, or clinic for an amount beyond that paid by the patient's insurance.

Balance Billing: How Are States Protecting Consumers from Unexpected Charges?

How seven states—California, Colorado, Florida, Maryland, New Mexico, New York, and Texas—have approached protecting consumers from certain types of balance billing.

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Introduction

Large bills from an out-of-network health care provider can be an unexpected surprise to consumers who did not knowingly decide to obtain health care outside the plan's provider network. As health plans embrace tighter networks as a tool for improving quality or reducing premiums, the potential for such bills may grow. Although insurers may protect their plan members in some cases, there is no broad protection from these types of bills in federal law or in most states. Several states have acted to protect consumers from the need to pay

balance bills, at least in emergency situations. New York started implementation of expanded protections in April, providing a test of what may be the most comprehensive state approach to date. But even these states have struggled with how to implement protections while balancing legitimate interests of health plans and health care providers. This issue brief summarizes and compares seven state approaches to protecting consumers from balance billing.

What is a Balance Bill?

Americans purchase health insurance to protect themselves against the cost of care for a significant illness or health condition. In doing so, they hope to protect themselves against large and unaffordable bills from health care providers. Yet even with insurance, some consumers face bills for the difference between an insurer's payment to the provider and the provider's charges, often referred to as balance bills or surprise bills.¹ These bills occur most often when consumers receive covered services from out-of-network providers.² Large balance bills are often stressful for consumers and are a significant source of medical debt.³

Most health insurance plans for working-age Americans today involve a provider network.⁴ Networks can take the form of a closed network in many health maintenance organizations (HMOs) or exclusive provider organizations (EPOs), in which the plan normally pays only for care delivered by a network provider. Under an open network, such as a preferred provider organization (PPO) or other point-of-service plans, the plan typically covers out-of-network care, but imposes higher cost sharing or a higher deductible when using out-of-network providers. PPOs are the most common insurance choice, at least for those with employer-based coverage.⁵ Some consumers elect to enroll in plans with more restricted networks, most often when these plans are available at lower premiums. For other consumers, especially those who value their existing relationships with providers, easier access to providers outside the network may be preferable.

Typically, when a consumer uses a network provider, the consumer is held harmless; in other words, the consumer does not have to pay the difference between the insurer's coverage and the provider's billed charges. This assurance is based on the network contract between the plan and the provider and on state laws regulating these relationships. But when a consumer uses a non-network provider, there is often no contractual relationship to prevent the provider from balance billing the consumer regardless of whether the health plan makes no payment (e.g., closed-network HMO) or partial payment (e.g., open-network PPO).

Provider networks involve a set of agreements among the plan, the health care provider, and the plan enrollee. Network providers agree to accept a payment rate that may be less than they would charge on the open market, but in return they expect to get a higher share of business from the plan's enrollees. The plan selects providers based on providers' willingness to accept these lower rates, the plan's need to have adequate providers to serve their policyholders, and the goal of maintaining high-quality care. Consumers, in selecting a plan, may consider the tradeoffs between broader networks and lower premiums. But in selecting a plan, they should understand the financial consequences of obtaining care outside the network. Network negotiations and thus the ultimate costs—premiums and other cost sharing—borne by plan enrollees are influenced by factors such as the market concentration of providers and health plans.

Scenarios for Balance Billing

Consumers receive care from non-network providers in a variety of scenarios. Depending on the scenario, the legal and financial consequences differ.

- *Scenario 1: Informed Use of Non-Network Providers.* In the simplest and probably most common scenario, the consumer makes a voluntary, informed decision to go out of network for a particular service. For example, he or she may want to receive a surgical procedure from a particular surgeon who does not participate in the plan's network. The consumer is aware that he or she will be responsible either for the entire bill (if enrolled in a closed-network plan) or will pay both higher cost sharing and a balance bill for the amount by which the provider's charge exceeds the health plan's payment for out-of-network care.
- *Scenario 2: Emergency Settings.* In this scenario, the consumer has some type of medical emergency and is taken to a hospital for emergency care.⁶ Even if the consumer makes sure to go to a network hospital, there is no certainty that the emergency department (ED) is staffed by network providers. In these situations, the consumer has little or no ability to choose a network or non-network provider. Most consumers probably assume that the network hospital is staffed by network physicians and other health professionals. In reality, this is not always the case. Data are not widely available to track how often these situations arise. But a recent study of networks for the three largest insurers in Texas found that at least one of five in-network hospitals had no in-network emergency department physicians (for one of these insurers, over half of the network hospitals had no in-network ED physicians).⁷ In some emergency situations in which the consumer is treated by a non-network provider, the health plan may agree to reimburse the provider at a certain level, but a provider can balance bill the consumer for any additional charges since there is no contractual obligation to accept the health plan's payment as payment in full.
- *Scenario 3: Surprise Billing Situations in a Network Hospital.* Beyond the emergency context, consumers may still find themselves in scenarios in which they are treated unexpectedly by a non-network provider.

One common situation occurs when the consumer makes sure to identify an in-network hospital and providers to perform a procedure or service, but still encounters non-network providers in other roles. This could occur when a woman arranges to have her baby delivered by a network obstetrician and hospital, but the anesthesiologist is not part of her health plan's network. Or it could occur when an individual arranges for knee replacement surgery with a network surgeon but the assistant surgeon or surgical assistant helping with the surgery and the radiologist performing the MRI are not in network. Another scenario arises following an emergency department encounter when the patient is stabilized and no longer in emergency care. Follow-up care during the hospital stay may be provided by an out-of-network cardiologist, infectious disease specialist, or physical therapist. The non-network providers in these situations can bill the patient, and there is no guarantee how much the insurer will pay (if at all) for coverage for these types of "surprise bills."

- *Scenario 4: Consultations or Services Outside the Network.* While the above scenarios are the most common, situations may also arise in which the consumer needs a consultation with or services from a specialist not in a health plan's network. This could occur when there are gaps in the plan's network or when network directories are inaccurate. In theory, this situation allows all parties involved more time to identify the possibility of an uncovered charge than in emergency or surprise bill scenarios.

There are few sources of data that document how frequently these situations occur, although a study of 2004 claims data found that out-of-network care represented 10 percent to 13 percent of charges in PPOs or similar plans.⁸ According to a survey-based analysis conducted in 2011, 8 percent of consumers used an out-of-network physician, most frequently in the emergency department. About 40 percent of those consumers (3 percent of the overall sample) went out of network involuntarily at least once over a 12-month period—more frequently in inpatient or ED settings.⁹ Decisions by health plans to offer narrower networks could increase the potential for balance billing.¹⁰

Protecting Consumers

Federal law does not currently protect consumers from balance billing or surprise billing in these scenarios. The Affordable Care Act (ACA) only guarantees that the health plan must provide coverage for emergency services even if the providers are out of network (Scenario 2).¹¹ Specifically, the plan must pay these out-of-network providers the greatest of the plan's median payment amount for in-network providers, a payment based on the methods the plan generally uses to determine payments for other out-of-network services (e.g., a percentage of usual and customary fees), or the amount that Medicare would pay for the service.¹² When providers are paid adequately, they are less likely to balance bill. But some providers may not consider these amounts adequate, and the ACA neither prohibits balance billing nor requires the plan to hold the consumer harmless. Furthermore, ACA rules do not apply to situations in which a consumer unknowingly receives care from an out-of-network provider (Scenario 3) or in which in-network providers are unavailable (Scenario 4).

States take various approaches to protecting consumers from balance billing. Nearly all states require HMO contracts to hold consumers harmless when they go to in-network providers; a smaller share apply the same protections for PPOs.¹³ Thus providers participating in a health plan's network are obligated under their contracts with insurers to hold consumers harmless by forgoing balance bills.

Although most states have no provisions that address billing for care received from out-of-network providers, about one-fourth of states have elected to protect consumers against bills from non-network providers in at least some circumstances.¹⁴ Some of these state laws have a very narrow scope (e.g., one law applies only to ambulance services). Most state laws apply to emergency services received from non-network providers (Scenario 2) and less frequently in surprise billing situations (Scenario 3). Some states have limited these protections to a subset of insurance products; for example, more states apply protections to HMOs than to PPOs.¹⁵

Under federal law, employer-sponsored plans that are self-funded by the employer are generally exempt from state regulation.¹⁶ Thus, consumers with self-funded employer health plans must use network providers to avoid receiving balance bills. In practice, employer-sponsored

What Should Consumers Do To Prevent Unexpected Charges?

- When possible, use provider directories and other plan-provided information to locate in-network providers.
- When possible, ask providers whether they are in the plan's network. If providers are not in network, ask whether they will accept the plan's payment as payment in full.
- In cases where a provider sends a balance bill, review the health plan's explanation of benefits and any notices about consumer rights.
- Before paying a balance bill, contact both the health plan and the provider. Ask whether the plan is willing to pay the bill. If not, ask whether the provider will accept a lesser amount.
- Contact the state insurance department to see if any remedy is available under the state's laws.

plans may elect to take a similar approach as that offered by some states and protect policyholders from some balance bills.

In the absence of legal protections, consumers do not always face balance bills. Even if the plan design is a closed network, a plan may elect to provide coverage for selected services delivered by non-network providers. As noted above, health plan contracts may protect members who receive emergency services or when the network cannot meet a particular need. Plans may seek to negotiate a rate with providers in these situations, but often pay the full billed charges to ensure that their members are "kept out of the middle" and protected from a balance bill.¹⁷ These situations could be limited to requests by members or their providers, but in some cases plans may elect to use their discretion more broadly.

Alternatively, some providers elect to write off the unpaid amounts after insurers make a payment, either by not sending a balance bill or not making active efforts to collect payment from the patient. Providers may do so to preserve a good doctor-patient relationship. Some hospitals have sought to make sure that facility-based

physicians participate in the same networks that include the hospital. But narrower networks have made this more difficult, especially when excluded providers respond with

high charges. For example, United Healthcare in Missouri recently decided to stop paying the full charges of non-network emergency department physicians.¹⁸

Purpose of Study and Methodology

To protect consumers from balance billing, some states focus narrowly on making consumers aware of the potential financial consequences when going out of network. Other states focus on removing the consumer from payment disputes by regulating the amount of payments from the insurer to the out-of-network provider.

In an effort to determine how states are protecting consumers from balance billing, we analyzed the legal

framework in seven states: California, Colorado, Florida, Maryland, New Mexico, New York, and Texas. We chose these states because they represent a range of state approaches to balance billing protections. In addition to analyzing state laws, we conducted 19 interviews with state regulators, insurers, providers, and consumer advocates from our study states to gain a comprehensive understanding of how state laws are affecting consumers' experiences with surprise bills.

Specific Elements of Consumer Protection

Four key elements are highlighted in state approaches to protecting consumers from balance billing. The states in this study use a variety of these elements in different combinations, as described in the next section.

Disclosure and Transparency. Several states have taken steps to help make consumers aware that they may face balance bills in situations where they are unable to use network providers in emergencies (Scenario 2) or encounter out-of-network providers as part of a care team when they use network providers (Scenario 3). It is the standard in many states to require insurers to have language in notices and plan summaries about the financial consequences of going out of network. Some states go beyond that to require notices to consumers at the point of service describing the potential for seeing a non-network provider and receiving a balance bill. Other state provisions are aimed more broadly at bringing greater transparency to networks and medical bills by providing consumers with information on the composition of the plan's network, such as accurate provider directories. In addition, some states seek to make public specific information on the cost of using a non-network provider and summary information on how often network hospitals have non-network providers delivering care (e.g., non-network emergency physicians in a network hospital).

Balance Billing Prohibitions. Several states protect consumers more directly by prohibiting non-network providers from billing patients, beyond any allowed cost sharing, in certain situations. States are more likely to address the emergency setting (Scenario 2), but some states have also sought to address surprise billing (Scenario 3). In some states, the ban applies only if the non-network provider accepts payment for the claim directly from the insurer based on an assignment of benefits. Assignment of a claim means that the consumer transfers the right to reimbursement to the provider, who becomes entitled to direct payment from the insurer (even though there is no network relationship between the plan and provider). In states taking this approach, providers agree to accept the plan's payment as payment in full, and the consumer is liable only for applicable cost sharing. Physician groups often advocate for assignment in these situations, since it is easier to collect payments from insurers than from patients.

Hold Harmless Provisions. An alternative to a ban on balance billing is to require that insurers hold plan members harmless by paying providers their billed charges (or some lower amount that is acceptable to the provider) in situations such as emergency care. From the consumer's perspective, either a ban on balance billing or a hold harmless rule yields the same result, although practical matters may complicate the effectiveness of

both approaches. For example, hold harmless rules could require the consumer to be aware of their ability to pass the bill to the insurer rather than pay the billed amount. Also, the costs incurred by insurers will eventually be passed to consumers through higher premiums.

Adequate Payment. Although both balance billing prohibitions and hold harmless provisions achieve the goal of protecting the consumer, they may leave health plans and providers in conflict over the question of adequate payment. Some states have specific rules to set

payment rates for these situations, for example requiring that insurers pay non-network providers at the usual and customary rates they pay to network providers. Other states, instead of setting a specific rate, refer providers and insurers to an independent mediation or dispute resolution process to settle on a fair rate of payment. These mechanisms help to protect consumers because they allow both providers and health plans to know what they will pay or be paid, which in turn helps to address the conflicts over payment.

How States Use Elements of Consumer Protection

California takes a direct approach to protect consumers by prohibiting physicians from balance billing in emergency cases (Scenario 2). The policy, established by the Department of Managed Health Care (DMHC), treats all emergency department services as in network and applies only to plans under the jurisdiction of the DMHC, not the Department of Insurance.¹⁹ Generally HMOs and PPOs fall under DMHC jurisdiction, representing most of the market.^{20, 21}

As part of the rules, California requires that plans pay providers a “reasonable and customary” payment rate. It goes beyond “usual and customary” in that payment must be based on “statistically credible information that is updated at least annually” and must take into account factors such as the provider’s training and experience, the nature of the service provided, and fees usually charged by a provider.²² As one stakeholder reports, the provider and the plan “have to work it out,” but “no one thinks the standard is completely clear.” If providers are unhappy with the plan’s payment, they can use the state’s voluntary, non-binding independent dispute resolution process (IDRP).²³ Although disputes between plans and providers are common, respondents indicate that use of this voluntary process is limited.²⁴

California has no disclosure requirements beyond the standard information required at the point of service regarding the use of out-of-network providers. In the view of one stakeholder, disclosure may be valuable in principle, but it does not provide the type of consumer protection achieved by a state’s prohibition on balance billing.

Colorado takes a policy approach that differs from that used in California. The state treats covered services by

non-network providers at a network facility as if they are in network and requires health plans to hold their members harmless in both emergency and surprise billing situations (Scenarios 2 and 3) when patients are treated in network facilities, as well as for referrals when the plan’s network is deemed inadequate (Scenario 4).²⁵

The Colorado approach thus puts the burden on health plans to pay the provider’s billed charge or some other amount that is agreeable to the provider. Nevertheless, one insurer reports that the consumer protections are working well, although acknowledging that health plans typically must pay the provider’s full billed charges and rarely are able to negotiate rates. Another stakeholder suggests there is a gap in the protections for consumers with high-deductible health plans, in which the plan cannot pay if the member has not met the deductible.²⁶ In these situations, the member must challenge the provider on the amount billed in order to avoid paying full billed charges.

Florida has a statute that takes the same general approach as California by prohibiting balance billing for emergency services (Scenario 2), but only for HMO products. In these situations, plans are required to pay the lesser of the provider’s charges, the usual and customary charges for similar services in the community, or a charge mutually agreed to by the plan and the provider.²⁷ Florida also prohibits out-of-network providers from balance billing HMO patients for covered services that are authorized by the HMO.²⁸ Regulators interpret the statute as prohibiting balance billing for any ancillary services provided to a patient in an in-network hospital if admitted by an in-network physician, including services by non-network providers.

If disputes arise, the state has an independent dispute resolutions (IDR) process administered by a third party.²⁹ The IDR process is rarely used, in part because providers perceive that decisions tend to favor insurers or because providers would have to pay for the cost of the IDR if they are unsuccessful.

Maryland protections originally applied only to consumers enrolled in HMOs, and some balance billing protections were expanded in 2010 to PPO enrollees. Maryland prohibits providers from balance billing HMO consumers for covered services including but not limited to emergency services (Scenarios 2 and 3). HMOs must hold consumers harmless for covered services provided by out-of-network providers and pay at prescribed rates; for example, provider rates for emergency services are based on Medicare reimbursement rates.³⁰ The PPO law grants the protection against balance billing to patients who assign benefits to their physicians.³¹ For physicians who are not hospital-based or on-call, however, the prohibition on balance billing applies only if the patient assigns benefits to the physician and the out-of-network physician fails to disclose certain information to consumers prior to providing health care services, including an estimate of the cost of services and a statement that the physician can balance bill for covered services.³²

Stakeholders generally believe that the state's laws are working well for consumers, and a 2015 report by the Maryland Health Care Commission on the extension to PPOs concluded that "the law, generally, achieved its intended purpose."³³ One stakeholder characterizes the PPO law this way: "We are still seeing balance billing occur, but it's not as prevalent as it used to be." There are gaps, however. Several stakeholders note that there is currently no balance billing protection for costly air ambulance services and for services of non-physician providers (e.g., hospital-based surgical assistants).

Maryland's approach is distinctive in two respects. First, it does not incorporate a dispute resolution process. Second, Maryland has specific requirements for payment levels that must be met by health plans for different types of health services and different types of physicians.³⁴ For example, for services other than evaluation and management, an HMO must pay at least 125 percent of the average rate it paid during the previous calendar year.³⁵ A PPO must pay 140 percent of the average rate paid the previous year or the average rate paid in 2010 to an on-call physician.³⁶

New Mexico was included in this study to illustrate what happens in a state that has no specific state

legislation to address balance billing by out-of-network providers. Because we focused on a single state in this situation, we cannot say whether it is representative of other states without legislation. A stakeholder in New Mexico reports that the state has relatively few providers, and so health plans tend to have contracts with most providers in the state. As a result, legislation to protect consumers from balance billing situations has not been necessary because balance billing occurs infrequently. One stakeholder notes that at least one health plan often holds their members harmless when non-network providers are used, despite the absence of any requirement to do so. This includes paying the full-billed charges to protect their members if they cannot work out a lower payment with the provider. If the providers in these situations are unwilling to negotiate, the health plan apparently chooses to pay full billed charges to protect their members.

New York is the only state to combine various elements of consumer protection for Scenarios 2 and 3, including disclosure, transparency, and a process to resolve payment disputes. The new law, enacted in April 2014, went into effect starting April 1, 2015 for any new insurance contract or contracts renewed after March 31, 2015.³⁷ The law builds on some existing protections that applied to HMOs but not to other insured products. The stakeholders we interviewed generally agree with the principles enshrined in the law, and since enactment, the state has consulted closely with stakeholders to work through implementation details and guidance.

Under the new law, the state bans balance billing by providers in emergency situations. It extends that protection to surprise billing and other situations, as long as the consumer assigns the provider's claim to the insurer.³⁸ Thus, in surprise billing situations where assignment is in place, no balance bill can be charged to the consumer. The link to assignment may have helped garner support from physician groups, because it makes it easier for them to collect payments.

New York requires plans to establish a reasonable payment amount, and plans must disclose their methodology and how it compares to usual and customary rates, which are defined as the 80th percentile of the amounts made available by Fair Health, an independent entity created in 2009 to maintain a database of charges for medical procedures.³⁹ If the provider is not satisfied with the amount paid, the state has created an independent dispute resolution process. The IDR process uses licensed physicians in active practice; they can choose either the provider's original billed charge or the plan's original

payment—as opposed to any amount in the middle. In making a decision, the IDR must consider the patient’s characteristics, the doctor’s training and experience, and the usual and customary rate based on the Fair Health data. As an alternative, the parties can negotiate a settlement on their own and notify the IDR. The IDR can also direct the parties to negotiate a settlement.⁴⁰ The IDR system is designed to create incentives for providers and plans to set their charges and payments at more reasonable levels. Stakeholders express cautious optimism for the IDR process, although they will wait for some actual experience with the process before making any final assessments. Some issues remain. One insurer is concerned that physicians could distort the Fair Health data by increasing their charges, while a physician stakeholder worries that the IDR could be complex for smaller physician practices to navigate successfully.

In the new law, New York includes a more extensive set of disclosure requirements for health plans, hospitals, physicians, and other providers.⁴¹ The goal is to make it easier for consumers to look at out-of-network benefits when doing comparison shopping prior to selecting a plan and to understand the potential charges prior to using services from an out-of-network provider. One stakeholder describes the new rules as: “Each party will be responsible for disclosing the information about which it has knowledge.” For example, plans are required to maintain accurate and regularly updated provider directories, provide clear statements of how bills are calculated, and provide examples of out-of-pocket costs for frequently billed services.⁴² Hospitals are required to provide lists of their standard charges, the insurance plans with which they participate, and whether their employed or contracted physician groups participate in these insurance plans.⁴³ Physicians are required to make available their participation status with health plans and their “reasonably anticipated charges” (on request).⁴⁴ Also, if a doctor is scheduling a hospital service and that particular doctor knows who else is going to be providing additional services or “be in the room,” he or she must disclose whether those doctors participate with the patient’s insurance.⁴⁵

Texas provides varying protections for each of three product types. For HMOs, regulators interpret the law to hold consumers harmless for emergency services (Scenario 2) and when medically necessary covered services are not reasonably available from in-network providers, including some situations in Scenario 3. Some stakeholders report that the HMO law is confusing for consumers; regulators indicate that their current interpretation and practice will

be more clearly articulated in upcoming regulations.⁴⁶ Regulators believe that their current approach has resulted in few balance billing issues for HMO enrollees, but other stakeholders are concerned that the protections “may not always translate into practice.”⁴⁷ Similarly, Texas rules require EPOs to hold consumers harmless when they cannot reasonably use a preferred provider, including emergencies; regulators indicate that this approach also includes surprise billing situations.⁴⁸

For PPOs, its most popular product, Texas relies primarily on disclosure and mediation to help consumers, but does not guarantee that consumers are protected from balance billing. Pursuant to 2013 rules, PPO plans in Texas must provide up-to-date provider directories. Directories must identify hospitals that have agreed to facilitate the use of preferred providers and must disclose the percentage of out-of-network claims filed by providers at each contracted hospital, by provider type.⁴⁹ Directories must also identify all contracted providers at network facilities and specify those facilities without any contracts with a particular type of provider.⁵⁰ In order for a network to be adequate, at least one hospital must be available where all types of facility-based physicians are available in network. If there is a sudden decrease in the availability of a type of facility-based provider, plans must post this on their website.⁵¹

The state also requires that PPOs provide general disclosures informing consumers that they may receive care from out-of-network providers, but one stakeholder points out that consumers “have to know to ask” which providers are in network. PPO and EPO consumers can also receive information about their right to get estimates of the amounts the plan will pay, if they request this information from their health plan.⁵² In addition, the state collects information from insurers on frequently used services, including charges and actual paid amounts in and out of network. The state then publishes the information on a website that identifies costs for out-of-network care. One stakeholder, however, told us that there have been problems with inconsistencies in the cost data that are reported, resulting in a recent proposal by the department of insurance to refine its data collection. Another believes the state is “making progress,” but found it “not so clear that [state efforts have] made a difference.” On the other hand, regulators believe improvements will be seen as the recent rules begin to have an impact.

When out-of-network services are provided in an emergency or inadequate network situation, Texas law requires that PPOs pay at least the usual and customary rate for the services in the area. It has also established

a mediation process and allows consumers to initiate mediation if the balance bill from a single out-of-network provider based at a facility exceeds \$1,000 (bills from multiple providers involved in one service may not be combined).⁵⁴ Providers must inform consumers of their right to mediation when balance billing, and insurers must do so in the explanation of benefits. The mediation evaluates whether the provider's charge is excessive and whether the amount the insurer paid meets the usual and customary standard. Stakeholders report that few consumers use the process; many cases never go to

mediation because the parties settle on a payment amount (some suggest that insurers often pay the full charges). Of the 900 cases filed in 2014, only one went to actual mediation, which regulators indicate was the first case for mediation. Other stakeholders suggest that the \$1,000 threshold limits the availability of mediation, and that consumers (despite being notified) may not be aware of their right. A bill to decrease the threshold to \$500 has passed the legislature and is awaiting action by the governor.

Summary of State Approaches

Our seven study state approaches are summarized in Table 1.

Table 1. Summary of Laws and Regulations Affecting Out-of-Network Balance Billing in Study States

	California	Colorado	Florida	Maryland	New Mexico	New York	Texas
Hold harmless or provider prohibition on balance billing in emergency situations (Scenario 2)	Yes, for HMOs and some PPOs	Yes	Yes, for HMO plans	Yes, for HMOs and tied to assignment for PPOs ^{c,d}	No	Yes	Yes, for HMOs and EPOs ^f
Hold harmless or provider prohibition on balance billing in surprise bills (Scenario 3)	No	Yes	Yes, for HMOs ^b	Yes, for HMOs and tied to assignment for PPOs ^{c,d}	No	Yes, tied to assignment ^d	Yes, for HMOs and EPOs ^f
Hold harmless or provider prohibition on balance billing in other situations (Scenario 4)	No ^a	Yes	No	Yes, for HMOs and tied to assignment for PPOs ^{c,d}	No	Yes, tied to assignment ^d	Yes, for HMOs and EPOs ^g
State mediation or dispute resolution process	Yes, not much used	No	Yes, not much used	No	No	Yes	Yes, if more than \$1,000
Disclosure rules beyond standard notices	No	No	No	Yes ^e	No	Yes	Yes

Sources: Cal. Code Regs. tit. 28, § 1300.71.39; Colo. Rev. Stat. § 10-16-704 (3)(a)(1); Fla. Stat. Ann. § 641.513; Fla. Stat. Ann. § 641.3154; Fla. Admin. Code r. 59A-12.030; MD. Code Ann. Health-Gen. §§ 19-710(p), 19-710.1 and 19-712.5; MD. Code Ann. Insurance §§ 14-205.2 and 14-205.3; N.Y. Fin. Services Law §§ 601 to 608; N.Y. Comp. Codes R. & Regs. tit. 23 § 200; N.Y. Pub. Health Law § 24 and Insur. Law § 3217-a; Tex. Insur. Code Ann. §§ 1271.055, 1271.155, 1467.051; 28 Tex. Admin. Code §§ 3.3725; 3.3705; 3.3708; 22 Tex. Admin. Code §§ 187.85 to 187.89; proposed regulation 28 Tex. Admin. Code § 11.1611(e).

^a Per California's Knox-Keene Act, regulators indicate that if there is a network gap for medically necessary treatment, plan members may be protected. See Ca. Health & Safety Code § 1367 and 1367.03. Also, regulators indicate that if consumers relied upon an inaccurate provider directory, he/she can appeal to the Department of Managed Health Care's Help Center.

^b Under Fl. Stat. Ann. § 641.3154, out-of-network providers are prohibited from balance billing for ancillary services when the HMO has authorized the covered service. Regulators also interpret the statute as prohibiting balance billing for ancillary services when an in-network physician admits the patients to an in-network hospital.

^c For PPOs, protection against balance billing does not apply for physicians other than hospital-based or on-call if these other physicians disclose, prior to delivering services, information on estimated costs and the fact that a balance bill is possible.

^d Assignment means that the consumer transfers the right to reimbursement from the health plan directly to the provider so that the health plan can pay the provider directly.

^e Maryland's pre-disclosure requirements do not apply to hospital-based or on-call physicians and only apply to other out-of-network physicians prior to providing a service if they want to balance bill.

^f Texas regulators indicate that their current interpretation requires HMOs to hold consumers harmless when they receive ER services or when in-network providers are unavailable for medically necessary covered services; proposed HMO regulations reflect this interpretation. Tex. Insur. Code §§ 1271.055 and 1271.155; see proposed regulation 28 Tex. Admin. Code § 11.1611(e). For EPOs, Texas rules require the EPO to hold the enrollee harmless when an insured cannot reasonably use a preferred provider; regulators interpret this to include surprise billing situations. 28 Tex. Admin. Code § 3.3725.

^g Texas requires PPOs and EPOs to have a disclosure stating that consumers may be entitled to have their services paid at in-network rates if their reliance on an inaccurate provider directory causes them to go out of network. For EPOs, the disclosure statement states that if a consumer goes out of network because an in-network provider is unavailable or the consumer received out-of-network ER care, "the insurer, must, in most cases resolve the non preferred provider's bill." Tex. Admin. Code § 3.3705 (f)(1) and (f)(2). Texas rules further require the EPO to hold the enrollee harmless when an insured cannot reasonably use a preferred provider. 28 Tex. Admin. Code § 3.3725.

Cross-Cutting Issues

Several issues arise out of the experiences observed in the seven study states. These provide potential lessons for other states that may be considering regulatory approaches.

Protecting Consumers. Other than in Texas, stakeholders report that state balance billing legislation has been reasonably effective in keeping consumers out of the middle of disputes between non-network providers and health plans over the correct level of payments. While protections exist in Texas, there has been disagreement among stakeholders over the effectiveness of the protection. Also because Texas law has neither a ban on balance billing nor a hold harmless provision for PPOs, it does not offer consumers the same degree of protection as provided in other states. By contrast, in New Mexico, which lacks a balance billing statute, consumers have been protected because of market dynamics that have generally encouraged broad networks and insurer practices that include paying full billed charges when necessary. The steps taken recently by United Healthcare in Missouri, however, show the limits of private actions to protect consumers.⁵⁵

Even in the states with laws in place, however, there are noteworthy gaps. As noted, some states have segments of the insurance market (e.g., PPOs in Florida or some PPOs in California) in which the rules do not apply. And no state has the ability to address coverage that is self-funded by employers or unions because these insurance arrangements are regulated exclusively under federal law.

Emergency Versus Surprise Billing Settings.

There appears to be a greater consensus about protecting consumers from balance bills in emergency situations (Scenario 2) than for other surprise billing situations (Scenario 3). This result is not unexpected since consumers have the least control in medical emergencies. Even if the consumer goes to the emergency department of a network hospital,⁵⁶ he or she has essentially no control over whether the physicians or other providers who provide treatment in the emergency department are in the plan's network. The surprise bill settings identified in Scenario 3, however, are starting to attract more attention from policymakers. Legislation in New York specifically addresses surprise billing situations, and California legislators are considering an extension of protections to these situations.⁵⁷

Both Maryland and New York have created a linkage between assignment of insurance benefits and restrictions on balance billing (applying to any surprise billing situations in New York and to some PPO billing disputes in Maryland). In part, this was a political compromise whereby physicians obtained an easier means of payment through assignment in exchange for agreeing not to balance bill, while insurers consented to assignment to help protect their members from getting caught in the middle of a billing dispute. Maryland stakeholders are generally satisfied with how this limited protection has worked to date, and New York stakeholders seem cautiously optimistic.

Balancing Interests of Insurers and Providers.

The difference between a direct ban on balance billing by providers and requirements on insurers to hold their plan members harmless mainly revolves around which stakeholders are at financial risk. Under hold harmless rules, the insurer is at risk for paying whatever the provider charges. Under balance billing bans, the provider is at risk for accepting an amount less than the amount billed—or even an amount the provider considers reasonable. To the extent that either stakeholder is dissatisfied with the process, there is a greater chance that consumers can get caught in the middle despite the protections built into law.

To balance the interests of all stakeholders, several states have either incorporated stronger approaches to setting rates or included a dispute resolution process. A state requirement that plans pay based on their own usual and customary rates, without more specific rules, leaves the insurers with greater leverage. The Maryland approach provides enough specificity so that most stakeholders believe that the system works well enough. Providers had previously raised concerns that insurers sometimes took advantage of loopholes to keep payments low, but they have been alleviated somewhat by statutory adjustments to the payment formula. Maryland's reliance in part on historical payment rates may sometimes disadvantage certain insurers, but these situations seem uncommon.

One Maryland insurer reports a clear preference for having a set rate for payment rather than the uncertainty that may occur under New York's greater reliance on dispute resolution. But New York stakeholders believe that their approach will work for them. One physician stakeholder emphasizes that a formula fails to recognize

that physicians have different abilities and charge histories. Although New York does not require that payments be based on the usual and customary rates calculated by an independent entity (Fair Health), those rates could become something of a “safe harbor” in practice, especially if the IDR process relies heavily on this standard.

The Role of Mediation and Dispute Resolution.

Mediation or dispute resolution processes have a mixed record to date in California and Florida. Regulators in Florida indicate that the potential cost to participate for providers is a barrier, particularly if they are unsuccessful. In California, regulators reported that insurers have little incentive to participate because balance billing is already prohibited for emergency services.

While the IDR process in New York became effective in April 2015,⁵⁸ some stakeholders hope that the threat of its use and the procedure for selecting the amount ultimately paid to the provider will convince both providers and insurers to charge or pay at more reasonable levels. They suggest the IDR will be a success if health plans and providers use the process infrequently. One stakeholder compared the IDR to the binding arbitration model that Major League Baseball uses today, which succeeds by encouraging “bids” that are close enough together to encourage voluntary settlements in advance of arbitration.

By contrast, stakeholders in Texas suggest that requiring consumers to initiate the dispute resolution process poses an overly high barrier to its use, even if the current \$1,000 threshold were lowered. Overall, the success of a mediation or dispute resolution process appears to depend both on who initiates the process and the cost of using the process. Low use of a dispute resolution process may signal success if it creates an incentive for health plans and providers to negotiate or accept rates that are viewed as reasonable.

Disclosure and Transparency. Most of our study states have made some provisions to improve consumer disclosures. Disclosure provisions may be used in lieu of more direct protections (PPOs in Texas) or to complement other measures (New York). But it remains an open question how much value consumers derive from disclosure rules. One consumer advocate suggests that disclosure rules can yield good information, especially if it means more accurate and easy-to-use provider directories; however, she thinks that disclosure does little to protect consumers from balance billing. At best it helps a small subset of consumers who take an active role in reviewing their disclosures. At worst and more likely, as

some respondents note, it is one more piece of paper that consumers receive when they have a health care encounter, without improving their understanding of the financial implications of receiving in- versus out-of-network care. At the same time, transparency provisions in Texas have encouraged data disclosures that have proved valuable for advocates and journalists who use the data to identify and highlight problem areas.

Plans have an interest in making sure their members know which providers are in the network, but insurers’ track record of providing this information has been mixed at best.⁵⁹ Some insurers report taking steps to improve how they provide information. One health plan highlights its efforts to use care managers to alert members which specialists are in network when they schedule care—information that is useful because it arrives at a time when the member is seeking out new providers.

Impact on the Market. The market environment is critical because it creates a context for how states approach consumer protection relative to balance billing. The design of provider networks vary, in part because the supply, distribution, and expertise of providers vary from state to state, as do the concentration and market leverage of health insurers. In New Mexico, one stakeholder suggests that the need for state protections is minimal because there are few non-contracted providers in the state. In other words, most plans have contracts with most providers. But in many states, this is not the case.

The presence of non-network physicians and other providers in network hospitals has been documented in Texas, but occurs in other states as well. In some markets, insurers may have the leverage to encourage or require participating hospitals to guarantee that all of their clinicians contract with the network. But in many markets, physicians or other providers have enough market power to block these efforts. In our stakeholder interviews, we heard about specialist physicians (e.g., anesthesiologists) and other providers (e.g., surgical assistants) who frequently avoid contracting with insurer networks. Some stakeholders express concerns that balance billing restrictions might interfere with negotiations over networks. For example, a hold harmless provision might encourage providers to stay outside the network since they would likely get paid at higher rates (i.e., their full charges or a regulated rate) if they decline to participate in a plan’s network.

Narrow Networks. In recent years, insurers have changed the designs of their provider networks, and many are offering narrower networks.⁶⁰ These changes may lead

more people to use out-of-network providers and thus may increase the likelihood of balance billing. While most respondents indicate that there were no documented trends in that direction, there have been anecdotal reports linking balance billing to narrower networks. The trend could increase the likelihood of surprise billing situations, in which non-network providers are delivering services in network hospitals or in which patients are referred to non-network specialists. It could also lead to more situations in which network providers are unavailable (either because of gaps in a network or because network providers are not taking new patients). Furthermore, the use of narrower networks could influence the willingness of health plans and providers to protect consumers in the absence of legal remedies.

Politics of Balance Billing Legislation. Passing meaningful consumer protection legislation can be challenging, particularly since legislators must balance the interests of insurers, providers, and consumers. Although all stakeholders may agree that consumers should not be caught in the middle of payment disputes between insurers and providers, they tend to disagree on how to implement that protection. Both the degree of market concentration and the political clout of providers and health plans can influence the ability of states to pass legislation to protect consumers. Some stakeholders

suggest that the political clout of Texas physicians has been a factor in the more modest approach taken there. Similarly, in the 2015 Florida legislative session, a subcommittee of the Florida House of Representatives reported out a bill that would have extended the prohibition on balance billing in emergency settings to PPOs. The bill would have also modified the payment standard to the greater of the negotiated amount, the in-network amount, or the Medicare allowable amount.⁶¹ The bill, however, was not enacted. Although supported by the insurance industry it was opposed by the Florida Medical Association. The Colorado Medical Society was also instrumental in convincing a state Senate Committee to postpone legislation that would prohibit out-of-network providers at in-network facilities from balance billing.⁶³

The comprehensive approach taken in New York, which tried to balance all stakeholder interests, will be tested as implementation proceeds. Accompanying issues, such as the desire of physicians to be paid on assignment when out of network or the desire of health plans to take their plan members out of the crossfire, can encourage agreement on legislation initiatives. Similarly, publicity over the growth of narrow networks and a push to address network adequacy in legislation may raise the related issue of balance billing.

Conclusion

Only a few states have acted through regulations or legislation to protect consumers against the unexpected charges that result when providers send balance bills to their patients. Even those states enacting protections typically limit their scope to scenarios in which consumers have limited control: in hospital emergency departments and when treated by a non-network provider while in an in-network facility. The states studied for this report took varied approaches but shared the goal of ensuring that consumers are not liable for charges that are mostly outside their control. But the approaches have different levels of effectiveness. The most effective protections appear to share two common elements. First, they do not require active intervention by the consumer. Second, they have a mechanism, acceptable to both plans and providers, for determining the amount of payment. Many consider New York's new law to be the most

comprehensive approach in this domain; it will thus be important to monitor its impact.

The necessity of state remedies may be mitigated when the market environment encourages plans and providers to resolve bills from non-network providers without involving the consumer. But publicity over surprise balance bills can place this issue squarely on the political agenda and put pressure on stakeholders to find some common ground. Once a law or regulation is in place, states often return to the issue to address gaps or solve unresolved issues. Most states in this study with laws or regulations on the books (California, Colorado, Florida, and Texas) are or were considering bills in the 2015 legislative session to expand existing protections.⁶⁴ As seen from these examples, it may be easier to enact additional incremental measures after taking some initial steps, although this does not always guarantee success as seen recently in Florida and Colorado.

The evolution of provider networks may increase pressures on states to address balance billing. Colorado includes network inadequacy as one trigger for requiring plans to hold consumers harmless when using a non-network provider in a network hospital; other states may consider such approaches in the future. Conversely, state efforts to address network adequacy can help to reduce opportunities for unexpected bills. If there are a greater number of situations in which network providers are unavailable to provide care in emergency departments

at network hospitals or in which patients must obtain needed care out of network, more consumers could feel the financial sting of surprise balance bills. The financial harm they may face is exacerbated because the amounts they pay for balance bills are not typically counted toward either deductibles or annual out-of-pocket maximums.⁶⁵ The promise of financial security in the Affordable Care Act could be called into question if we see large increases in balance billing.

Endnotes

- 1 A balance bill is in addition to amounts owed by the patient in cost sharing under the terms of the insurance contract.
- 2 We looked at this issue previously in a 2009 policy brief; this brief draws on that earlier effort. Hoadley J, Lucia K, and Schwartz S, *Unexpected Charges: What States Are Doing about Balance Billing*, California HealthCare Foundation, April 2009.
- 3 Rosenthal E, *After Surgery, Surprise \$117,000 Medical Bill From Doctor He Didn't Know*, New York Times, September 20, 2014; Pollitz K, et al., *Medical Debt among People with Health Insurance*, Kaiser Family Foundation, January 2014.
- 4 Traditional Medicare does not involve a provider network. In addition, Medicare has provisions that prohibit balance billing in most situations. In the few cases in which balance bills are permitted, they are limited to a small share of the amount paid by Medicare.
- 5 Kaiser Family Foundation and Health Research and Educational Trust, *2014 Employer Health Benefits Survey*, September 10, 2014. Available at <http://kff.org/report-section/ehbs-2014-section-five-market-shares-of-health-plans/>.
- 6 Ambulance services may also fall under this scenario.
- 7 Pogue S and Randall M, *Surprise Medical Bills Take Advantage of Texans*, Center for Public Policy Priorities, September 15, 2014.
- 8 McDavitt R., et al., *Financial Protection Afforded by Employer-Sponsored Health Insurance: Current Plan Designs and High-Deductible Health Plans*, Medical Care Research and Review 64(2):212-228, April 2007.
- 9 Also, about half of consumers with out-of-network encounters reported a lack of cost transparency (they reported they did not know how much they would have to pay for the service). Kyanko K, et al., *Out-of-Network Physicians: How Prevalent Are Involuntary Use and Cost Transparency?* Health Services Research 48(3):1154–1172, June 2013.
- 10 Corlette S, et al., *Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality Care*, Robert Wood Johnson Foundation, May 2014; Corlette S, et al., *Implementation of the Affordable Care Act: Cross-Cutting Issues: Six-State Case Study on Network Adequacy*, Robert Wood Johnson Foundation, September 2014.
- 11 The Public Health Service Act (PHS Act) section 2719A, amended by the Affordable Care Act, generally provides, among other things, that if a group health plan or individual health plan provides benefits for emergency services, an insurer must provide coverage for such emergency services without regard to whether the health care provider is in-network. Insurers generally cannot impose any copayment or coinsurance that is greater than what would be imposed if services were provided in network. The statute, however, does not require insurers to cover amounts that out-of-network providers may “balance bill.” Current regulations at 29 C.F.R. §2590.715-2719A; 45 C.F.R. § 147.138 set forth minimum payment standards to ensure that a plan does not pay an unreasonably low amount to an out-of-network emergency service provider who, in turn, could simply balance bill the patient. See also Centers for Medicare and Medicaid Services, Center for Consumer Information & Insurance Oversight, *Affordable Care Act Implementation FAQs – Set 1*. Available at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html.
- 12 29 C.F.R. §2590.715-2719A (b)(3)(i)(A) to (C) and 45 C.F.R. § 147.138 (b)(3) (i)(A) to (C).
- 13 Kaiser Family Foundation, *State Restriction Against Providers Balance Billing Managed Care Enrollees*. Available at <http://kff.org/private-insurance/state-indicator/state-restriction-against-providers-balance-billing-managed-care-enrollees/>.
- 14 In this project, we did not conduct a 50-state survey of state laws. Two available sources for state laws are American Health Lawyers Association, 3 Health L. Prac. Guide Appendix B-2: State Law Charts (2014) and Kaiser Family Foundation, *State Restriction Against Providers Balance Billing Managed Care Enrollees*. Available at <http://kff.org/private-insurance/state-indicator/state-restriction-against-providers-balance-billing-managed-care-enrollees/>. These sources are not fully consistent on interpretations of state laws.
- 15 See Kaiser Family Foundation, *State Restriction Against Providers Balance Billing Managed Care Enrollees*. Available at <http://kff.org/private-insurance/state-indicator/state-restriction-against-providers-balance-billing-managed-care-enrollees/>.
- 16 Employee Retirement Income Security Act, § 514.
- 17 Some plans participate in a Multiplan agreement that acts like a supplemental provider network. Participating providers agree to accept amounts from a network fee schedule as payment in full and do not send balance bills. Plans agree to base their payments on the network fee schedule, which may be higher than fees paid to providers in their own network.
- 18 Shapiro J, *Policy Shift by Nation's Largest Insurer Could Leave Some with Unexpected Bills*, St. Louis Post-Dispatch, March 30, 2015.
- 19 Cal. Code Regs. tit. 28, § 1300.71.39 (2014). The policy was established through a regulatory interpretation of the Knox-Keene Act by the California Department of Managed Health Care (DMHC). It was challenged in court by providers, but was affirmed unanimously by the California Supreme Court. *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, 45 Cal. 4th 497 (Cal.), Jan. 8, 2009.
- 20 Wilson K, *California Health Insurers: Brink of Change*, California Healthcare Foundation, February 2015. Available at <http://www.chcf.org/publications/2015/02/california-health-plans-insurers>.
- 21 DMHC also has the authority to enforce its regulations. See Cal. Code Regs. tit. 28 § 1341. Recently, the agency reached a settlement with a group of emergency department physicians for sending illegal balance bills to 324 patients. See California Healthline, *DMHC Issues Fines Against Several Health Care Organizations*, March 26, 2015. Available at <http://www.californiahealthline.org/articles/2015/3/26/dmhc-issues-fines-against-several-health-care-organizations>.
- 22 Cal. Code Regs. tit. 28, § 1300.71 (2015).

- 23 California DMHC, *Independent Dispute Resolution Process (IDRP)*. Available at <https://www.dmhc.ca.gov/FileaComplaint/ProviderComplaintAgainstaPlan/IndependentDisputeResolutionProcess.aspx#VW-Ces9Viko>.
- 24 One area of complaints has been hospital-based specialists.
- 25 Colo. Rev. Stat. § 10-16-704 (3)(a)(I). Colorado also requires insurers to allow members to assign benefits to out-of-network providers. Colo. Rev. Stat. § 10-16-106.7.
- 26 By federal law, high-deductible plans (HDHP) under health savings accounts (HSAs) cannot have deductibles less than \$1,300 for self-coverage and \$2,600 for family coverage. Insurers are not permitted to start paying for covered benefits unless the consumer has met the deductible for the plan year (excludes preventive services). See IRS Publication 969, *Health Savings Account and Other Tax-Favored Health Plans*, 2014.
- 27 Fla. Stat. Ann. § 641.513 (West 2014).
- 28 Fla. Stat. Ann. § 641.3154 (West 2014).
- 29 Fla. Admin. Code r. 59A-12.030 (2014).
- 30 MD. Code Ann. Health-Gen. §§ 19-710(p); 19-710.1 and 19-712.5.
- 31 MD. Code Ann. Insurance §§ 14-205.2 and 14-205.3.
- 32 MD. Code Ann. Insurance § 14-205.3. This provision does not apply to hospital-based or on-call physicians.
- 33 The bill was scheduled to sunset in 2015, but a measure removing the sunset date became law on April 14, 2015.
- 34 MD. Code Ann., Health-Gen. § 19-710.1, MD. Code Ann. Ins.-Gen. § 14-205.2 (West 2015).
- 35 MD. Code Ann., Health-Gen. § 19-710.1 (West 2015).
- 36 MD. Code Ann. Insurance § 14-205.3 (West 2015).
- 37 N.Y. Fin. Services Law §§ 601 to 608 (McKinney 2015); N.Y. Comp. Codes R. & Regs. tit. 23 § 200 (2014). Since the cycle for many insurance contracts is January to January, the effective date of the new policies for many consumers will be January 1, 2016.
- 38 N.Y. Fin. Services Law §§ 603 and 606 (McKinney 2015).
- 39 N.Y. Fin. Services Law § 607 (McKinney 2015). FAIR Health was created after the state's attorney general uncovered potential conflicts of interest in the methods that health insurers were using to determine reimbursements to patients who received care from providers outside their health plans' networks. Settlement agreements with New York insurers focused on bringing fairness and transparency to the out-of-network reimbursement system. FAIR Health maintains a database of charge data for medical procedures and website designed to help consumers estimate charges for health care services. Insurers use the data to help determine reimbursement rates for out-of-network claims.
- 40 N.Y. Fin. Services Law § 607 (McKinney 2015).
- 41 N.Y. Pub. Health Law § 24 and Insur. Law § 3217-a (McKinney 2015).
- 42 N.Y. Insur. Law § 3217-a (McKinney 2015).
- 43 N.Y. Pub. Health Law § 24 (6) and (7) (McKinney 2015).
- 44 N.Y. Pub. Health Law § 24 (1) and (2) (McKinney 2015).
- 45 N.Y. Pub. Health Law § 24 (4) (McKinney 2015).
- 46 Tex. Insur. Code § 1271.00 and 1271.155 (2015); proposed regulation 28 Tex. Admin. Code § 11.1611. The language in the proposed regulation covers "circumstances where an enrollee cannot reasonably reach a network provider, including circumstances where an enrollee is not given a choice between network and non-network providers when receiving care at a network facility."
- See Pogue S and Randall M, *Surprise Medical Bills Take Advantage of Texans*, Center for Public Policy Priorities, September 15, 2014, noting confusion about the Texas HMO law.
- 47 Pogue S and Randall M, *Surprise Medical Bills Take Advantage of Texans*, Center for Public Policy Priorities, September 15, 2014.
- 48 28 Tex. Admin. Code § 3.3725.
- 49 28 Tex. Admin. Code § 3.3705 (2015).
- 50 28 Tex. Admin. Code § 3.3705 (2015).
- 51 28 Tex. Admin. Code § 3.3705 (2015).
- 52 28 Tex. Admin. Code § 3.3705 (2015).
- 53 28 Tex. Admin. Code § 3.3708 (2015).
- 54 Tex. Ins. Code Ann. § 1467.051 (West 2015); 22 Tex. Admin. Code §§ 187.85 to 187.89.
- 55 Shapiro J, *Policy Shift by Nation's Largest Insurer Could Leave Some with Unexpected Bills*, St. Louis Post-Dispatch, March 30, 2015
- 56 In the event that a patient arrives at a hospital that is not in the insurer's network, stakeholders report that the insurer typically negotiates a rate with the hospital for its services. Historically, these situations arise less often than encounters with out-of-network physicians and other providers. But as narrower networks are employed by insurers, they may arise more often in the future.
- 57 See A.B. 533 (Bonta), 2015-2016 Gen. Assembly, Reg. Sess. (Ca. 2015).
- 58 Because the law became effective mid-year, it will only applies immediately to consumers with new health plans or health plans that renew on or after April 1, 2015. The majority of consumers will have to wait until their health plans renew, i.e., January 1, 2016.
- 59 See Tahir S, *Why Can't Insurers Publish Accurate Provider Directories?* Modern Healthcare, December 13, 2014. Available at <http://www.modernhealthcare.com/article/20141213/MAGAZINE/312139963>; Corlette S, et al., *Implementation of the Affordable Care Act: Cross-Cutting Issues: Six-State Case Study on Network Adequacy*, Robert Wood Johnson Foundation, September 2014.
- 60 Corlette S, et al., *Implementation of the Affordable Care Act: Cross-Cutting Issues: Six-State Case Study on Network Adequacy*, Robert Wood Johnson Foundation, September 2014.
- 61 H.B. 681, 2015 Leg. Sess. (Fl. 2015).
- 62 Sexton C, *House Panel OKs Balance Billing Ban, Sponsor Says Unlikely to Pass this Year*, Saint Petersburg Blog, April 9, 2015. Available at <http://www.saintpetersblog.com/archives/225230>.
- 63 Colorado Medical Society, *SB 259 Provider Out-of-Network Legislation Defeated*, April 21, 2015. Available at <http://www.cms.org/communications/sb-259-provider-out-of-network-legislation-defeated>.
- 64 A.B. 533 (Bonta), 2015-2016 Leg. Sess. (Ca. 2015); S.B. 15-259, 2015 Gen. Assembly, Reg. Sess. (Co. 2015); H.B. 681, 2015 Leg. Session (Fl. 2015); H.B. 3102, 84th Leg., Reg. Sess. (Tx. 2015); H.B. 1638, 84th Leg., Reg. Sess. (Tx. 2015); S.B. 481, 84th Leg., Reg. Sess. (Tx. 2015).
- 65 One law professor has argued that network adequacy rules under the Affordable Care Act could be used to require exchange plans to contract with emergency department physicians at all network hospitals or that state insurance commissioners could apply such a policy for plans under their jurisdictions. Bagley N, *What Should the Law Do about Out-of-Network ER Docs?* The Incidental Economist, September 29, 2014. Available at <http://theincidentaleconomist.com/wordpress/what-should-the-law-do-about-out-of-network-er-docs/>.

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