



American Heart Association Principles on Balance Billing

Introduction

For many Americans, an unexpected or surprise medical bill is an expense they cannot afford. In a survey conducted by the Kaiser Family Foundation, surprise medical bills surpassed concerns about daily living expenses such as rent or mortgage payments, utility bills, transportation costs or food.¹ Most consumers with health insurance expect their coverage will provide protection from unexpected, exorbitant medical bills, however more than half (57%) of insured Americans have been caught off guard by a medical bill for care they thought would be paid by their insurance plan.² Often, these surprise bills arise from medical care that was unknowingly provided to the patient by an out-of-network physician or at an out-of-network facility. This is an example of “balance billing”, a practice frequently utilized by payers to recoup costs. Balance billing occurs when a provider or medical group, hospital, facility, laboratory or other supplier directly bills a patient for the balance of the amount above what their insurance plan agreed to pay for their medical care.

Evolving industry practices in the coverage and care delivery arenas have led to a sharp uptick in the application and prevalence of balance billing. Insurance premiums and high levels of cost-sharing³ already place a financial strain on many individuals and families. The receipt of a surprise balance bill after a patient has already sought and received care can result in financial ruin for many Americans.

While there are several medical scenarios that may incite a balance bill, balance billing patients who unknowingly receive out-of-network care through no fault of their own is unfair and objectionable. The American Heart Association (AHA) believes that the lack of meaningful action by stakeholders to address surprise balance billing and protect patients necessitates action from lawmakers and regulators.

Background

For most Americans with health insurance coverage, their plan covers services from an established network of physicians, hospitals, facilities, and other health care providers or suppliers. When a patient receives a service from an in-network provider, the plan will pay some or all the costs of care, depending on the enrollee’s specified level of cost-sharing for a covered benefit or service. However, if a patient receives care outside of that established network, even if it’s a benefit or service that would be covered if provided in-network, these protections do not necessarily apply as the provider is not bound by the terms of a network contract. As a result, a patient may be charged an amount significantly higher than they would have if the service was provided in-network.

¹ Rau, J. “Surprise Medical Bills Are What Americans Fear Most in Paying for Health Care.” Kaiser Health News. Available at: <https://khn.org/news/surprise-medical-bills-are-what-americans-fear-most-in-paying-for-health-care/>

²<http://www.norc.org/PDFs/Health%20Care%20Surveys/Surprise%20Bills%20Survey%20August%202018%20Topline.pdf>

³ (i.e., the share of costs covered by insurance that a consumer pays out of their own pocket, including deductibles, coinsurance, and copayments or similar charges)

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According to an analysis by America's Health Insurance Plans (AHIP), out-of-network doctors can submit bills up to nearly 100 times higher than the fees paid by Medicare for the same service.⁴ These balance bills have significant financial ramifications for consumers and patients. Patients enrolled in Health Maintenance Organizations (HMOs) and Exclusive Provider Organizations (EPOs) would likely be responsible for the cost of these services in their entirety, as these plans typically place restrictions on out-of-network care except in an emergency. While Preferred Provider Organizations (PPOs) and Point-of-Service (POS) plans customarily provide out-of-network coverage, they typically pay a smaller portion of the billed charges. The non-negotiated rates for PPOs and POS are usually higher than those allowed or recognized by the payor. Therefore, patients in plans with out-of-network coverage provisions are often held liable for the balance above and beyond what their plan pays, in addition to being subject to greater levels of cost-sharing on covered benefits or services.

There is a financial incentive for consumers to use in-network services as they are more affordable. As such, many patients do their due diligence to select in-network providers and facilities to avoid incurring higher out-of-pocket costs. However, unlike pre-planned or scheduled visits to providers, situations involving hospital-based care, or facility-based care can be tricky, or sometimes near impossible, to navigate. Surprise balance bills can arise from emergency or urgent situations when the patient has no ability to select the treatment or care facility, physicians or care team, ancillary providers, or ambulance service or medical transport company. For example, air ambulances provide emergency transport for critically ill patients, primarily in life threatening situations. However despite patients' lack of control over the selection of the air ambulance provider, patients are still at financial risk for exorbitant balance bills, with almost 70% of transports being out-of-network.⁵ Additionally, the New York Department of Financial Services studied more than 2,000 complaints involving surprise medical bills and found the average out-of-network emergency bill was \$7,006, of which insurers paid about half - an average of \$3,228. Thus, consumers were left, on average, "to pay \$3,778 for an emergency in which they had no choice."⁶

Even in non-emergency situations, the savviest consumer may find themselves hit with a surprise medical bill, as the prevalence of independent, out-of-network providers operating within in-network facilities or hospitals virtually eliminates consumers' power to make an informed choice. A patient may unknowingly be treated by doctors and other providers who *work* within an in-network hospital but are not contracted with the patient's insurance network; for example, when an out-of-network anesthesiologist assists during surgery, or an in-network provider refers a patient to an out-of-network provider for laboratory tests or x-rays. In fact, the same New York study referenced above found that 90% of surprise medical bills were not for emergency services, but for other in-hospital care. The specialty areas of physicians most often submitting such bills were anesthesiology, lab services, surgery, and radiology.⁷ Further, a study of data reported by health insurers in 2013 to the Texas Department of Insurance suggest that emergency room physicians often do not participate in the same health plan networks as the hospitals

⁴ America's Health Insurance Plans. "Survey of Charges Billed by Out-of-Network Providers: A Hidden Threat to Affordability." Available at:

<http://blog.riskmanagers.us/wp-content/uploads/2013/02/SurveyofBilledChargesOONProviders1.pdf>

⁵ United States Government Accountability Office. "Air Ambulances: Available Data Show Privately-Insured Patients Are at Financial Risk." March 2019. Available at:

https://www.gao.gov/assets/700/697684.pdf?utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_a_xiosvitals&stream=top

⁶ Politz, K. "Surprise Medical Bills." Kaiser Family Foundation. March 2016. Available at: <https://www.kff.org/private-insurance/issue-brief/surprise-medical-bills/>

⁷ Ibid.

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in which they work. Of the in-network hospitals for the three Texas insurers with the largest market share, between 21% and 45% had no in-network emergency room physicians.⁸

Despite its pervasiveness, many consumers are not aware of the prospect of a surprise balance bill until they receive one. More than 60% of respondents in a national Consumer Reports survey mistakenly assumed that if they went to an in-network hospital, all the doctors at the hospital would also be in-network. Among insured adults surveyed with unaffordable out-of-network bills, nearly 7 in 10 did not know the health care provider was not in their plan's network at the time they received care.⁹ This illustrates a serious need for efforts that increase transparency of coverage and out-of-pocket costs, and provide meaningful and comprehensive protection for consumers against surprise medical bills.

Existing Consumer Protections

State Action on Balance Billing

Several states have passed laws and issued regulations that aim to protect patients from balance bills. However, only 21 states currently have protections in effect, and none are comprehensive enough to protect every insured consumer within each state. State statutes and regulations vary significantly from one state to another.

Overall, state protections only apply to a fraction of the plans or coverage arrangements under which more than 290 million Americans access health insurance. Notably, state protections laid out in statute and regulation don't apply to a large majority of employer-based plans, which cover over 150 million Americans.¹⁰ 61% of workers that utilize employer-based health insurance coverage to insure themselves and their families are enrolled in self-funded plans.¹¹ These types of plans are directly regulated by the U.S. Department of Labor (DOL) and governed by the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), which does not expressly prohibit or restrict balance billing. Further, these plans, which are typically offered by large employers, are not subject to most state statutes and regulations pertaining to health insurance due to ERISA's "preemption clause." Thus, even in states where consumer protections exist, ERISA supersedes state law and generally bars the application of balance billing prohibitions or restrictions to self-funded plans and the majority of individuals and families with employer-sponsored insurance.

Federal Action on Balance Billing

The Affordable Care Act (ACA) and its implementing regulations offer many health plan enrollees, participants or beneficiaries some degree of protection, albeit limited, from exorbitant bills in emergency scenarios. Under federal statutes and regulations, many individual market and group health plans, as well as the health insurance issuers

⁸ Pogue, S and Randall, M. "Surprise Medical Bills Take Advantage of Texans: Little-known Practice Creates a Second Emergency for ER Patients." Center for Public Policy Priorities. Available at:

http://forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf

⁹ <https://www.kff.org/private-insurance/issue-brief/surprise-medical-bills/>

¹⁰ Kaiser Family Foundation. "Health Insurance Coverage of the Total Population." Available at:

<https://www.kff.org/other/state-indicator/total-population/?dataView=1¤tTimeframe=0&selectedDistributions=employer--medicaid&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

¹¹ Kaiser Family Foundation. "2017 Employer Health Benefits Survey." Available at: <https://www.kff.org/report-section/ehbs-2017-section-10-plan-funding/>

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that provide coverage in connection with those plans, are required to treat out-of-network emergency services as if they were delivered at an in-network hospital for the purposes of determining a patient's coinsurance or copayment amounts. While the federal provisions do not prevent out-of-network providers from balance billing patients for the amount their plan does not cover, they do attempt to limit the financial exposure for patients who are treated by an out-of-network provider for emergency services. This is done through a federal payment methodology that ensures a plan or issuer does not pay an unreasonably low amount to an out-of-network provider who, in turn, will simply balance bill the patient.

In Medicare, beneficiaries are fairly insulated from balance billing and surprise medical bills, as physicians who participate in Medicare may not balance bill for any amount beyond the standard Medicare cost-sharing. Even non-participating providers- which only account for about 4% of practitioners registered with Medicare- are limited in the amount they can balance bill beneficiaries to 115% of the Medicare Physician Fee Schedule.

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Quality, affordable health care is a key advocacy priority for the AHA and represents a significant concern for the patients we represent. As an organization, we have long supported efforts that empower consumers to make informed health care decisions but recognize that strategies aimed at addressing surprise balance bills must equip patients with the adequate tools and information in order to do so. Because the practice of surprise balance billing insured patients is particularly perverse and objectionable- threatening the financial security and livelihood of Americans across the country and limiting their ability to get the care they need when and where they need it - the AHA believes policymakers, in conjunction with public and private stakeholders, must take a multi-faceted approach to comprehensively address balance billing. To that end, we have developed a set of principles to frame our advocacy in support of patient-centered and consumer-focused protections from surprise balance bills.

- **Patients should be protected from surprise balance bills:** Patients and consumers should be held harmless from balance bills in situations that arise from emergencies (including emergency ground or air transportation and transfers) and instances where an insured patient visits an in-network facility for a covered service, but unknowingly receives care from an out-of-network provider. In circumstances where a patient receives out-of-network care through no fault of their own, the patient's maximum financial liability should be no more than what their in-network cost-sharing amount would be. Patients should have comprehensive protection from balance bills regardless of the type of health insurance plan they are enrolled in or the funding mechanism under which that plan was established.
- **Consumer focused transparency:** Patients should be provided with timely, actionable, and easily understood information to help them avoid using out-of-network services for non-emergent care. Any legislation aimed at addressing balance or surprise billing practices must include *actionable* and *meaningful* transparency requirements that patients can use and understand. Policies should encourage the easy availability and use of provider information such as networks status, and out-of-network prices, and current provider databases communicated in consumer-friendly language. Directories should be kept up to date so that consumers can make informed choices about where to receive care and patients should not be held liable for bills that result from inaccurate directories. Additionally, people who live in areas with limited provider networks should not be held liable for balance bills if they cannot access medically necessary care from an in-network provider.

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- **Adequate Consumer Rights:** In non-emergent situations, patients should receive prior notification that they will be seen by a noncontracted health professional or are receiving care in an out-of-network setting. This notification should allow the patient a meaningful opportunity to seek care within their plan's network and provide concrete information on the estimated out-of-network cost of the benefits or services that the patient intends to utilize. When there is no reasonable opportunity for the patient to seek care from an in-network health care professional or at an in-network facility, prior notification should not preclude the dispute of a balance bill. Consumer notifications and disclosures alone are unable to adequately protect consumers, and therefore should not be used absent other protections.
- **Dispute Resolution:** Policymakers should craft an equitable dispute resolution processes that holds patients harmless. Patients should not be invoiced directly for disputed amounts. In establishing a payment rate and/or creating an arbitration process, patients should never be required to seek relief via a consumer-initiated request for a bill to be settled.
- **Existing State Statutes:** Any federal solution to address balance billing should consider possible interactions with state law. As many states have already undertaken efforts to protect consumers against balance billing, policymakers should ensure that federal remedies do not undermine existing state laws that provide comprehensive consumer protections, but instead ensure a minimum standard for patient protections from which states can build on.