Health Policy Commission 2015 Cost Trends Report

POLICY BRIEF ON OUT-OF-NETWORK BILLING

As recently outlined in the Health Policy Commission's (HPC) 2015 Cost Trends Report, the HPC has identified out-of-network billing as an area of policy interest.[1] In connection with the HPC's 2015 Cost Trends Report series, this Policy Brief provides more detailed information on out-of-network billing and related concerns and highlights policy approaches taken by several other states to address these issues. While Massachusetts has already adopted certain protections to address the complicated matters of out-of-network billing, there is no current industry standard to address out-of-network billing concerns, and patients may have to be aware of their rights and affirmatively contest their medical bills to resolve unwarranted bills. This can result in difficulties for patients and may also have implications for the functioning of the health care market as a whole. The Policy Brief reiterates recommendations previously issued by the HPC for Massachusetts to build upon existing protections to more comprehensively address out-of-network billing issues.

I. BACKGROUND ON OUT-OF-NETWORK BILLING

In-Network And Out-Of-Network Providers. Most health insurance plans involve a **provider network**, which is a group of hospitals, physicians, and other providers with whom the insurer contracts (often called **in-network, preferred, or participating providers**). Provider networks generally vary between different insurers and insurance plans, as do the terms and **cost-sharing** amounts for in-network and out-of-network care. When a patient seeks care from a provider who is in the network for the patient's insurance plan, the patient typically pays a lower cost-sharing amount than what the patient would pay for care from a provider who is not in his or her insurance plan's network (an **out-of-network provider**).

Provider networks are an important way for insurers to control costs while providing benefit and value to patients. When a provider joins an insurer's network, it agrees to receive negotiated prices for services (or an **allowed amount**), which are often substantially lower than a provider's full list price or **charges** for a service. After a patient receives care from an in-network provider, the patient pays a cost-sharing amount pursuant to the terms of the health insurance plan, and the insurer pays the provider the negotiated price for services rendered.

However, when a patient seeks care from an out-of-network provider, there may not be a lower, negotiated price between the insurer and the out-of-network provider. As a result, a patient may be required to pay significantly greater cost-sharing than he or she would ordinarily pay for in-network care, and he or she could be required to pay cost-sharing that is based on the full list price or charges for the service. The patient's responsibility varies considerably based on the specific terms of the health insurance plan;

KEY TERMS:

A **provider network** is a group of providers with which an insurer contracts to provide services at negotiated prices. Providers that are part of a network for a particular insurance product may be called "in-network," "preferred," or "participating" providers.

Charges are the provider's full or total price for services. Charges are typically higher than negotiated in-network rates.

Cost-sharing is the amount a patient has to pay for an item or service under the terms of a particular health plan (e.g., deductible, copayment, coinsurance).

health maintenance organizations (HMOs) (i.e., closed network plans) usually do not cover out-of-network care except for some emergency services coverage or services otherwise pre-approved by the plan, while preferred provider organization (PPO) plans (in Massachusetts, these are called insured preferred provider plans[i]) and point-of-service (POS) plans typically cover out-of-network care but require greater cost-sharing for services delivered by out-of-network providers.[ii] These differences in cost-sharing are designed to encourage patients to obtain care from in-network providers, and the differential in cost-sharing is a key component of many insurance plans designs, including tiered networks.[iii]

Billing for Out-of-Network Care. As described above, when a patient seeks care from an out-of-network provider, there generally will not be a contract between the insurer and provider obligating the provider to accept a lower, negotiated price. The out-of-network provider would submit a bill to charge the full price (charges) for services rendered to the patient. Typically, the insurer would determine the amount to pay against the provider's charges based on a determination of the usual or reasonable fee for that service in that area. Absent any law or contract with the insurer, the provider is free to then **balance bill** the patient (meaning that the provider would bill the patient for the difference between the insurer's payment and the provider's charges).

Following is a hypothetical illustration of balance billing for out-of-network care in which an insurance plan has terms specifying that it will pay 50% of a certain allowed amount[iv] for the out-of-network service. In this scenario, the patient is responsible for paying a certain amount to the provider per the cost-sharing terms of their plan ($150) as well as an additional amount per the balance bill ($200), leading to greater financial exposure and potential confusion for the patient:

	Out-of-Network Provider Charge	Plan Allowed Amount	Balance Owed by Patient
Bill Total	$500	$300	$200
Plan Pays	-	$150 (50%)	-
Patient's Responsibility Under their Plan	-	$150	$150
Total Patient Pays:			$350

Table 1. Hypothetical Balance Billing Scenario. (Adapted from Consumers Union, Getting Started on Surprise Medical Bills: An Advocate's Guide, *infra* note 4, at 2). Hypothetical additional hospital charges not reflected.

When Out-of-Network Billing Concerns Arise. Patients may receive care from out-of-network providers in a number of different circumstances. First, a patient may have the option to seek care from an in-network provider but instead elect to receive care from a provider that is outside of the plan's network. If the patient understands the terms of his or her insurance plan and nonetheless elects to receive out-of-network care, it may be entirely appropriate for that patient to be required to pay more for that care, as permitted under Massachusetts law. In a second circumstance, a patient may seek treatment out-of-network if the insurance plan agrees that a particular type of provider is not available in their insurance plan's network; in this circumstance, Massachusetts law permits patients to seek treatment out-of-network and provides that the patient will pay no more than in-network cost levels.[2]

However, in some cases a patient may receive out-of-network care when the patient either did not or could not intentionally choose the provider. There are two key situations that could give rise to out-of-network billing concerns:

- **Emergency Care**: A patient receives emergency care from an out-of-network provider.[v] Due to emergency circumstances, the patient may not be able to choose care from an in-network provider.
- **Out-of-Network Care at an In-Network Facility**: A patient seeks care at an in-network facility or from an in-network provider, but during the course of treatment the patient is unexpectedly treated by an out-of-

i M.G.L. c. 176I; 211 Mass. Code Regs. 51.00.

ii In Massachusetts, "the coinsurance percentage for Health Care Services rendered by a non-preferred provider is no more than 20 percentage points greater than the highest coinsurance percentage for the same covered Health Care Services rendered by a Preferred Provider, excluding reasonable deductibles and copayments." 211 Mass. Code Regs. 51.05(2)(c)2.

iii Tiered and limited network insurance products in Massachusetts are designed to lower spending by rewarding purchasers (employers and consumers) for choosing high value (i.e., lower cost, high quality) providers. Limited networks offer consumers less network breadth, and therefore less choice, in exchange for lower premiums. Under tiered network plans, insurers assign (or "tier") providers to different benefit tiers based on the insurer's assessment of cost and/or quality, and the consumer's associated cost-sharing fluctuates by tier. Consumers face lower cost-sharing amounts if they choose a provider that is in a higher performing tier. *See* 211 Mass. Code Regs. 152.00 (including network adequacy requirements).

iv According to 211 Mass. Code Regs. 51.05(2)(c)1, "[the allowed amount p]ayments made to non-preferred providers shall be a percentage of the provider's fee, up to a Usual and Customary Charge, and not a percentage of the amount paid to Preferred Providers."

v The Emergency Medical Treatment & Labor Act (EMTALA) statutorily requires physicians to provide emergency care without regard to a patient's ability to pay.

KEY TERMS:

Balance Billing occurs when a patient is billed for the difference between the insurer's payment and the provider's charges.

Surprise Billing occurs when a patient receives an unexpected bill from an out-of-network provider after seeking and receiving care at an in-network facility.

network provider (e.g., an out-of-network emergency room physician, radiologist, anesthesiologist, pathologist, or assistant surgeon).[3] The patient frequently does not realize that he or she received care from an out-of-network provider until he or she unexpectedly receives a "**surprise bill**." In some circumstances, the patient may not have an opportunity to seek care from an in-network provider because the patient did not know that an out-of-network provider would be involved in the care. In other circumstances, it may be impossible for the patient to receive in-network care at an in-network facility (e.g., when there is an inadequate network within the in-network facility itself – for example, if all of the anesthesiologists are out-of-network).

These particular out-of-network billing scenarios have garnered considerable attention around the United States, spurred by concerns that out-of-network bills may create substantial and unexpected financial burdens for patients, particularly where they did not know that they were seeing an out-of-network provider, did not have the opportunity to choose an in-network provider, or did not understand the financial implications of receiving out-of-network care.[4]

II. OUT-OF-NETWORK BILLING IN MASSACHUSETTS

Current Massachusetts Law Addressing Out-of-Network Billing Concerns. Certain laws in Massachusetts aim to protect consumers in the circumstances described above but may not provide full protection.

- **Emergency Care.** Under state and federal law, HMO and insured preferred provider network plans in Massachusetts must pay a reasonable amount for out-of-network emergency services.[5] In addition, state preferred provider plan laws[6] state that for a patient who receives emergency care and cannot reasonably reach a preferred provider, the insurer must make payment for care related to the emergency at the same level and in the same manner as if the patient had been treated by a preferred provider.[vi] Moreover, federal rules require that any cost-sharing requirement imposed for out-of-network emergency services cannot exceed the cost-sharing amount imposed if the services were provided in-network.[7] Balance billing of the patient, however, is not explicitly prohibited in many situations; thus, in some circumstances, a provider may seek payment of the balance of its charges for emergency care that is over the insurer's "reasonable" payment. Insurers in Massachusetts may sometimes *elect* to pay the full charges to protect patients from balance billing even when they are not required to do so.
- **Out-of-Network Care at an In-Network Facility.** Under state law, insurers in Massachusetts are required to cover services from out-of-network providers practicing inside in-network facilities with no greater cost-sharing to the patient, where the patient did not have a "reasonable opportunity to choose to have the service performed by a network provider."[8] However, it is not clear to what degree Massachusetts patients are aware of this protection, including how many patients go through the process for getting a surprise bill resolved, which may vary by insurer and which generally require the patient to contest the bill.

KEY FACT:

Currently, there is no standardized insurer approach to addressing out-of-network billing concerns in Massachusetts, and patients may have to be aware of their rights and affirmatively contest their medical bills to resolve surprise bills.

Extent of Out-of-Network Billing Concerns in Massachusetts. Comprehensive data on the frequency and extent to which out-of-network billing concerns occur in Massachusetts is difficult to obtain or quantify. One reason for this is that some patients simply pay out-of-network bills upon receipt, and therefore no data indicates that there was an out-of-network billing concern. While data specific to Massachusetts is unavailable, there are some out-of-network billing data available on a national level[9] as well as in certain other states[10], and the HPC understands that both balance billing for emergency care and surprise billing may occur in Massachusetts.

Out-of-Network Billing Concerns Which May Need to Be Further Addressed. As discussed above, Massachusetts has already adopted certain out-of-network billing protections. Nonetheless, certain concerns remain that may continue to pose significant difficulties for patients and may also have implications for the functioning of the health care market as a whole.

1. **Lack of Patient Notice**. One key problem contributing to out-of-network billing concerns for patients is a lack of accessible, reliable, and timely information to ensure

vi The "same level" refers to the benefit level and the "same manner" refers to the way in which payment is made (e.g., to the patient or to the provider).

that they have a fair opportunity to choose in-network care where possible and understand the cost implications of out-of-network care. Even in non-emergency scenarios, it is not always easy for patients to determine which providers will be part of their care (or reasonably anticipated to be part of their care), whether all of those providers (particularly specialists) are in-network for their particular insurance product[11], how much any out-of-network care is expected to cost them[12], or how much their insurer may reasonably be expected to cover for any out-of-network care.

2 **Financial Burden for Patients.** Another key issue for patients is that the bills resulting from out-of-network care can be substantial (sometimes in the hundreds or thousands of dollars), potentially resulting in significant financial burden.[13]

3 **Administrative Burden for Patients.** The resolution of out-of-network billing issues can be complicated and administratively burdensome for patients. Currently, there is no standardized insurer approach to out-of-network billing issues in Massachusetts. For example, many insurers generally hold members harmless for out-of-network emergency care[14] (i.e., they pay the provider's full charges or some negotiated amount, which prevents balance billing of the patient), but this approach is not universal. Furthermore, the level of effort required by patients to resolve surprise billing issues varies by insurer. For example, some surprise billing issues are resolved through the insurer's internal grievance process, which requires increased patient effort. There is also a perceived burden on patients to be aware of their rights and protections under the law with respect to surprise billing, as patients often have to affirmatively alert insurers to such situations in order to get resolution.

4 **Health Care Market Implications.** The absence of balance billing prohibitions and limits on out-of-network charges for emergency care may also affect provider-insurer negotiations and potentially impact overall spending. If an insurer elects to pay full out-of-network emergency charges to protect the patient (as may occur in Massachusetts), there may be cost and market implications that ultimately impact consumers in the form of higher premiums, as the full charges the insurer might pay are likely to substantially exceed any negotiated payment amounts. For example, hospitals with high emergency volume (and the physicians who work there) are likely to receive patients through emergency or surprise billing situations, even without joining the patients' insurance networks. Concern about the risk of paying high charges for their members who go to an out-of-network emergency provider may encourage insurers to agree to high rates for those providers (i.e., higher rates than would be the case if the insurer did not have to worry about potentially paying high out-of-network charges) to keep them in-network, as these higher rates may still be less than out-of-network charges[15], which can contribute to unwarranted provider price variation and result in overall increases in health care spending.[vii]

III. POLICIES TO ADDRESS OUT-OF-NETWORK BILLING CONCERNS

Several states have taken actions to address out-of-network billing concerns in at least some out-of-network circumstances.[16] State approaches to out-of-network billing protections vary, including with respect to the scope of protection, the level of protection, and the types of plans covered. Self-insured plans (plans where the employer pays the costs for health care directly, rather than paying premiums to buy health insurance) are regulated by the federal government pursuant to the Employee Retirement Income Security Act (ERISA) and therefore are not subject to such state actions. Policies to address out-of-network billing concerns are described generally in Subsection A,

vii Observations on a national level from research about out-of-network limitations in Medicare Advantage plans (health plans that are offered by private insurers that contract with Medicare to provide benefits) may offer insight in addressing such market implications. Despite the use of contract negotiations in Medicare Advantage plans to set payment rates (i.e., more like commercial plans as opposed to traditional Medicare), Medicare Advantage payment rates show relatively little variation and remain close to Medicare fee-for-service rates. Robert A. Berenson et al, Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices, Health Affairs 34:8 (Aug. 2015), *available at* http://content.healthaffairs.org/content/34/8/1289.abstract. Medicare Payment Advisory Commission researchers theorized that this may be because out-of-network hospitals are statutorily limited with respect to prices they may charge for emergency services and other out-of-network care. Murray, *supra* note 15. The bargaining leverage of Medicare Advantage plans is strengthened by the presence of out-of-network price caps because hospitals are not able to press for higher negotiated in-network rates using the threat of even higher out-of-network charges. *Id.* Some have argued that the potential expansion of limitations on hospital emergency and other out-of-network charges to the commercial realm may serve to rebalance payer-provider negotiations and enhance competition in the marketplace. *Id.* Murray suggests that setting a limitation on emergency and out-of-network services might help shift the negotiating power back to the payers, citing a potential limit that is 125-150% of Medicare fees, for example. *Id.* Berenson et al concluded that placing an upper limit on out-of-network payment rates may "discipline commercial insurance market negotiations" and serve as a regulatory alternative to setting commercial rates themselves. Berenson et al, *supra*, at 1295.

while Subsection B highlights the specific implementation of such policies in several states.[viii]

A. Description of Policy Solutions

Disclosure and Transparency. Consumer awareness is an important component of efforts to address out-of-network billing issues. Timely, reliable, and accessible information about whether or not a provider is in-network for a patient's particular insurance product, how much the insurer will reimburse for out-of-network care, and the amount of financial responsibility that will ultimately fall on the patient is critically important, but that information may not be transparent or easily understandable for patients.[17] Some states have created stronger disclosure and transparency requirements around out-of-network care, such as requiring that patients be provided with up-to-date information on provider network status (including improving provider directories), informing patients regarding the average out-of-pocket expense for each plan, and requiring disclosure of network status prior to the delivery of services.[18]

KEY TERMS:
Hold Harmless means that patients are held responsible in an out-of-network billing situation only for their applicable cost-sharing requirements.

Hold Harmless Provisions and Balance Billing Prohibitions. A more direct approach to addressing out-of-network billing issues is the removal of the patient from the payment equation that results from out-of-network care. Hold harmless provisions and balance billing prohibitions exist in a number of states and render patients responsible only for the applicable cost-sharing under their insurance plan; insurers become directly responsible for payment to the out-of-network provider (whether they pay the billed charges or a lower negotiated amount). The bearer of financial risk differs slightly between hold harmless provisions and balance billing prohibitions. Under hold harmless provisions, the insurer can be at risk for paying the out-of-network provider's charges, which could lead to insurers paying more than what they consider reasonable absent other protections; under balance billing prohibitions, the provider can be at risk for accepting an amount less than the billed amount, which could lead to providers being required to accept amounts lower than what they consider reasonable absent other protections.[19] In connection with balance billing prohibitions, some states (New York and Maryland) have also created rules regarding assignment of benefits to facilitate out-of-network provider reimbursement.[ix] In Maryland, a January 2015 report by the Maryland Health Care Commission concluded that the 2010 assignment of benefits legislation that expanded balance billing protections to PPOs met its goal of reducing the financial burden on patients who were treated by out-of-network providers while protecting payment levels for out-of-network providers.[x]

Determination of Provider Payment. While hold harmless provisions and balance billing prohibitions aim to protect the patient, the question of the amount of the payment to the out-of-network provider remains. States have sought to address the complex balance of interests between insurers and providers with respect to determining payment amounts by the following mechanisms.

1. **Established Payment**. Establishing out-of-network provider payments can be accomplished through an array of approaches that vary in terms of administrative complexity, methodology, and their respective advantages and disadvantages. One approach is payment based on insurer calculations of what is reasonable or appropriate to pay the out-of-network provider. A second approach is to set a standardized level at which out-of-network providers are paid. Examples of such benchmarks include setting out-of-network charges to a defined percentage above an average in-network rate (or above the median rate), building a state-defined fee schedule for out-of-network charges, or limiting out-of-network payment rates to a percentage of Medicare rates.[20]

viii In preparing this Policy Brief, the HPC did not complete a 50-state survey on out-of-network billing protections.

ix For example, New York's balance billing prohibition applies beyond emergency care if the out-of-network provider accepts payment for the claim directly from the insurer based on an assignment of benefits. By assigning a claim for payment, the patient transfers the right to payment to the out-of-network provider, who then becomes entitled to receive payment directly from the insurer as payment in full. Hoadley, *supra* note 3, at 6. As assignment more readily facilitates collection of payment, physicians may be advocates for the assignment of benefits. *Id.* at 6, 8.

x Impact of the Assignment of Benefits Legislation, Prepared for the Maryland Health Care Commission by Social & Scientific System, Inc. (Jan. 15, 2015), *available* at http://mhcc.maryland.gov/mhcc/pages/plr/plr/documents/LGSPT_AOB_rpt_20150115.pdf (reporting on the Assignment of Benefits and Reimbursement of Nonpreferred Providers (Chapter 537, 2010 Laws of Maryland)). The goal of the legislation was to eliminate the financial burden on patients by reducing out-of-network provider reliance on balance billing, without reducing payment to out-of-network providers. *Id.* at 14. The report concluded that the financial burden for patients was lessened during the timeframe under review, assignment of benefits was chosen by the majority of providers who elected not to participate in private payer networks, which seemingly reduced income uncertainty for them due to less reliance on balance billing for payments. *Id.* at *ii*. The report also concluded that there was no evidence that participation rates in commercial networks declined during the timeframe studied. *Id.* Following a recommendation by the Maryland Health Care Commission, the sunset date of the legislation was removed in the spring of 2015.

2 **Dispute Resolution.** Insurers and providers can also resolve disputes about levels of payment through different dispute resolution mechanisms (e.g., arbitration). Forums to address disagreements regarding adequacy of payment may create incentives for charges and payments to be set at more reasonable levels.[21]

B. Policy Solutions Implemented by Other States

California. California has implemented balance billing protections as well as requirements for determination of out-of-network provider payment. In 2009, California prohibited balance billing in emergency cases following a decision by the Supreme Court of California.[22] Though the balance billing prohibition applies to most of the market, it does not extend beyond emergency out-of-network scenarios.[23] California insurers reimburse out-of-network providers at a "reasonable and customary" amount based on "statistically credible information that is updated at least annually" and must take into account factors like the provider's training and experience, the nature of the service provided, and fees usually charged by a provider.[24] Additionally, the California Department of Managed Health Care offers a voluntary, non-binding independent dispute resolution process for out-of-network providers who are dissatisfied with payment.[25]

New Jersey. New Jersey's out-of-network billing policy consists primarily of hold harmless provisions. In New Jersey, consumers are held harmless for emergency, surprise billing, and network adequacy scenarios.[26] Insurers are required to cover out-of-network provider costs in full, as billed. However, while intended to protect consumers, New Jersey may have undermined that very goal.[27] While consumers are financially protected, New Jersey does not prescribe limitations on out-of-network provider charges in connection with the hold harmless provisions. Without limits on what out-of-network providers can charge to insurers, providers have an incentive to remain out-of-network (or change to out-of-network) and charge higher prices. As a consequence, high out-of-network charges are a contributing factor in New Jersey's above-average premium rates, premium rate growth, and hospital costs.[28] The situation in New Jersey underscores the importance of having a comprehensive approach to out-of-network billing issues. Driven by acknowledgement by a variety of stakeholders of these unintended consequences, there are concerted efforts in New Jersey to address this issue.[29]

New York. New York's out-of-network billing protections involve a combination of disclosure and transparency requirements, hold harmless provisions and balance billing prohibitions, and requirements for determination of provider payment.[30] With a strong combination of policy approaches, New York's law, passed in 2014, has been identified as the most comprehensive response to out-of-network billing issues to date. First, balance billing by out-of-network providers for emergency care is prohibited.[31] Second, surprise billing (bills for non-emergency out-of-network services, by definition) is prohibited if the patient assigns the provider's claim to the insurer.[32] Utilizing an assignment of benefits form developed by the state, New York laws seek to remove the patient from the payment equation to facilitate reimbursement to the out-of-network provider.[33]

Furthermore, extensive disclosure requirements under New York law are designed to require that insurers, hospitals, and physicians provide information that patients need to determine provider network status and costs, including network information, the provider organizations with which hospitals maintain out-of-network contracting practices, and information on how bills are calculated. For example, insurers must provide examples of out-of-pocket costs for frequently billed out-of-network services, written information (including on the insurer's website) that reasonably permits a patient to estimate anticipated out-of-pocket costs for out-of-network services, and upon request, insurers must disclose the approximate dollar amount that the insurer will pay for a specific out-of-network service (though the approximation is not binding).[34]

KEY FACT:
The laws passed in New York and Connecticut are examples of comprehensive approaches to out-of-network billing issues, though it is too soon to determine the impact of the laws.

Hospitals are required to post on their website the insurance plans in which they are a participating provider, the contact information of physicians groups the hospital has contracted with (as applicable) to provide services including anesthesiology, pathology, or radiology, and instructions how to contact the groups to determine which plans those physicians participate in, and information about physicians employed by the hospital and the plans in which they participate.[35] Additionally, an out-of-network health care provider must inform patients prior to non-emergency services that the actual or estimated amount for the service is available upon request, and if requested, the estimate

will be disclosed in writing with a notice that costs could go up if unanticipated complications occur.[36]

With respect to out-of-network provider payment, insurers must pay providers at a reasonable payment amount. The methodology for determining reasonable payment amounts must be disclosed, including how the calculation compares to the usual and customary rates.[xi] Finally, the New York law allows for arbitration of disputes between insurers and providers pursuant to an independent dispute resolution process.[37]

Connecticut. Similar to New York, Connecticut's multi-faceted approach involves transparency and disclosure requirements, hold harmless and balance billing prohibitions, and requirements for determination of provider payment. Connecticut enacted its out-of-network protections as part of a sweeping health care law in June 2015, with most of the relevant provisions set to take effect July 1, 2016.[38] With respect to emergency care, consumer cost-sharing must be equal to what it would be if emergency services were rendered by an in-network provider instead of an out-of-network provider. Insurers must reimburse out-of-network providers the greatest of the following: (1) the amount the plan would pay for emergency services if rendered by an in-network provider; (2) the usual, customary, and reasonable rate[xii]; or (3) the amount Medicare would reimburse for such services. Nothing prohibits the insurer and out-of-network provider from negotiating a greater amount. Patients are also protected from surprise bills (bills for non-emergency out-of-network services, by definition), so that liability is limited to the applicable in-network cost-sharing amount, and the insurer must reimburse the out-of-network provider or insured, as applicable, at the in-network rate as payment in full, unless the insurer and provider agree otherwise. The law also expanded the state's unfair trade practices law to include instances in which a provider requests payment from a patient other than coinsurance or other out-of-pocket expense for out-of-network emergency services and surprise billing.

xi The New York law defines "usual and customary cost" as the 80th percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by FAIR Health, Inc., the independent entity created in New York in 2009 to maintain a database of charges for medical procedures.

xii The Connecticut law defines "usual, customary and reasonable rate" as the 80th percentile of all charges for the particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported in a benchmarking database maintained by a nonprofit organization specified by the Insurance Commissioner.

NOTABLE FEDERAL EFFORTS TO ADDRESS OUT-OF-NETWORK BILLING ISSUES

There are efforts to address out-of-network billing issues on the federal level as well. The End Surprise Billing Act of 2015 was introduced in the U.S. House of Representatives in October 2015, which would ban surprise billing in emergency situations, as well as in non-emergency situations unless the out-of-network provider gives the consumer notice twenty-four hours in advance that the provider is out-of-network and the provider gives the consumer an estimate of total charges for treatment, to which the consumer consents.

Additionally, though details are limited, President Obama's fiscal year 2017 budget for the U.S. Department of Health and Human Services supports "the standardization of billing documents and eliminating surprise out-of-network charges for privately insured patients receiving care at an in-network facility" (p. 4) and includes a legislative proposal to eliminate surprise out-of-network health care charges for privately insured individuals (p. 116).

Insurers have several obligations under the new law, including the incorporation of a surprise bill description in the insurance policy (or similar) provided to enrollees, as well as posting the description on the insurer's website. Additionally, if an enrollee prospectively or concurrently requests a review, insurers must inform a covered person of the network status of the professional who will be providing the treatment, an estimate of the amount the insurer will reimburse the professional for such service or treatment, and how such amount compares to the usual, customary and reasonable charge for that service or treatment, as determined by the Centers for Medicare and Medicaid Services. If an insurer does not inform the consumer as to the network status of the out-of-network provider at the time of service as required in the law, the consumer will not be held responsible for more cost than that for in-network care at in-network providers. Insurers must also maintain a website and toll-free phone number that enables consumers to request and obtain information on network status, including information on out-of-network costs for inpatient admissions, health care procedures and services.

Providers also have obligations under Connecticut's new law. Beginning January 1, 2016, providers must determine whether a patient is insured prior to any scheduled admission, procedure, or service for nonemergency care. If the patient is uninsured or the provider is out-of-network, the provider must provide written notification to the patient about the charges for the upcoming treatment, the fact that the patient may be charged and is responsible for unforeseen service that may arise out of the proposed care, and that any out-of-network rates under the patient's health plan may apply.

Below is a summary of the select state policy approaches to out-of-network billing:

	Scope of Protection	Types of Plans Covered	Disclosure and Transparency Requirements	Hold Harmless Provisions and/or Balance Billing Bans	Provider Payment Determination	Additional Notes
California	Emergency services	HMOs, some PPOs	*None beyond standard notices*[39]	Yes	"Reasonable and customary" amount based on "statistically credible information updated at least annually"	State offers a voluntary, non-binding independent dispute resolution process for payment dispute
New Jersey	Emergency services and surprise billing scenarios	HMOs, PPOs	*None beyond standard notices*	Yes	Insurers pay the out-of-network provider charges (or litigate charges)[40]	With no ceiling on provider charges, hold harmless provisions have proved costly
New York	Emergency services and surprise billing scenarios	HMOs, PPOs	Extensive requirements for insurers, hospitals and providers	Yes (tied to assignment for surprise billing scenarios)	Insurers must establish a reasonable payment amount; must disclose methodology and how it compares to usual and customary rates, as defined in the law	State offers an independent dispute resolution process administered by a third party; review is binding and can be reviewed in court
Connecticut	Emergency services and surprise billing scenarios	HMOs, PPOs	Yes, for insurers and providers	Yes	For emergency services, insurers must reimburse the greatest of in-network rate, usual, customary and reasonable rate, or the Medicare rate; for surprise billing, insurers must reimburse provider or insured, as applicable, the in-network rate as payment in full, unless insurer and provider agree on another amount	Law expands unfair trade practice law; submitting a surprise bill to a patient for payment beyond patient's legal cost-sharing obligation, without "This is not a bill" is considered an unfair trade practice (as is reporting failure to pay a surprise bill to collections)

IV. RECOMMENDATIONS FOR OUT-OF-NETWORK BILLING CONCERNS IN MASSACHUSETTS

As outlined in the HPC's 2015 Cost Trends Report, the Commonwealth should consider implementing additional safeguards related to out-of-network billing. Such action could address patient concerns and improve market functioning. The Commonwealth should draw on models from other states to help inform policy recommendations, particularly the comprehensive New York model.

Specifically, the Legislature should require providers to inform patients whether they and any other providers likely to be involved in the patients' care are in-network or out-of-network prior to the delivery of services. Additionally, the Legislature should establish a maximum reasonable price for out-of-network services to improve market functioning and ensure that out-of-network billing protections do not (either directly or indirectly) result in increased overall spending or have other unintended consequences. There are a variety of approaches the Legislature can consider to appropriately balance the interests of insurers and providers, including but not limited to setting out-of-network charges in relation to an insurer's average or median in-network rate, limiting out-of-network payments to a percentage of Medicare rates, or building a state-defined fee schedule. In connection with the maximum reasonable price for out-of-network services, the Legislature should further require that insurers hold their members harmless in cases of out-of-network emergency services and prohibit balance billing, as well as enhance consumer awareness of existing surprise billing protections provided by Massachusetts law.

ENDNOTES

1 Health Policy Comm'n, 2015 Cost Trends Report, *available at* http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2015-cost-trends-report.pdf. Out-of-network billing was also discussed in the HPC's Special Report on Provider Price Variation. Health Policy Comm'n, 2015 Cost Trends Report, Provider Price Variation, available at http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2015-ctr-ppv.pdf.

2 M.G.L. c. 176O, § 6(a)(4)(i).

3 Common examples of out-of-network providers in this treatment scenario are contracted anesthesiologists, radiologists, pathologists, surgical assistants, or follow-up care subsequent to emergency care (e.g., an out-of-network cardiologist or physical therapist). Bob Herman, *Billing Squeeze: Hospitals in Middle as Insurers and Doctors Battle Over Out-of-Network Charges*, Modern Healthcare (Aug. 29, 2015), http://www.modernhealthcare.com/article/20150829/MAGAZINE/308299987; Karen Pollitz, *Surprise Medical Bills*, The Henry J. Kaiser Family Foundation (Jan. 6, 2016), http://kff.org/private-insurance/issue-brief/surprise-medical-bills/; Jack Hoadley et al, Balance Billing: How Are States Protecting Consumers from Unexpected Charges?, Ctr. on Health Insurance Reforms 4 (June 2015), *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf420966.

4 *See generally, e.g.*, Herman, *supra* note 3; Erin Taylor & Layla Parast, *A Tale of Two Deliveries, Or an Out-of-Network Problem*, Health Affairs Blog (Nov. 3, 2015), http://healthaffairs.org/blog/2015/11/03/a-tale-of-two-deliveries-or-an-out-of-network-problem/; Elisabeth Rosenthal, *After Surgery, Surprise $117,000 Medical Bill From Doctor He Didn't Know*, N.Y. Times (Sept. 20, 2014), http://www.nytimes.com/2014/09/21/us/drive-by-doctoring-surprise-medical-bills.html?_r=0; Pollitz, *supra* note 3; Consumers Union, Getting Started on Surprise Medical Bills: An Advocate's Guide (Nov. 2015), *available at* http://consumersunion.org/wp-content/uploads/2015/11/SurprisebillsAdvocatesGuide.pdf.

5 M.G.L. c. 176G, § 5(f) (applying to HMOs); Patient Protection and Affordable Care Act (PPACA or Affordable Care Act or ACA), 42 USC § 18001 (broadening coverage for emergency services in Massachusetts). The Affordable Care Act requires that insurers must pay out-of-network providers the greatest of (i) the plan's median in-network payment amount for emergency services, (ii) a payment based on the methods the plan generally uses to determine payments for other out-of-network services (e.g., the usual, customary, and reasonable amount), or (iii) the amount that Medicare would pay for the emergency services provided. The minimum payment standards are designed to reduce any potential balance billing of the patient, which the ACA does not prohibit.

6 M.G.L. c. 176I, §3(b); 211 Mass. Code Regs. 51.05(2)(b) .

7 29 C.F.R. § 2590.715-2719A(b).

8 M.G.L. c. 176O, § 6(a)(4)(ii). Insurers must explain this in the insured's evidence of coverage. *Id.*

9 *See, e.g.*, Consumer Reports Nat'l Research Ctr., Surprise Medical Bills Survey (May 5, 2015), *available at* http://consumersunion.org/wp-content/uploads/2015/05/CY-2015-SURPRISE-MEDICAL-BILLS-SURVEY-REPORT-PUBLIC.pdf (reporting on the results of a nationally representative online survey that sought to ascertain the frequency of insurance issues, namely unexpected medical bills, and what consumers know about their rights regarding conflicts with health insurers).

10 For example, a 2011 study by the New York Department of Financial Services of more than 2,000 complaints involving surprise medical bills found that the average out-of-network emergency bill was $7,006, for which insurers paid an average of $3,228, leaving consumers to pay an average of $3,778 for emergency services for which they had no choice about treating providers. NY State Dep't of Financial Services, How New Yorkers Are Getting Stuck with Unexpected Medical Bills from Out-of-Network Providers 19 (Mar. 7, 2012), *available at* http://www.statecoverage.org/files/NY-Unexpected_Medical_Bills-march_7_2012.pdf. The study also found that 90% of the surprise medical bills were not for emergency care but rather other in-hospital care. *Id.* at 13. In Texas, a 2014 report revealed that 8% of hospitals (23 of 276 hospitals) that contracted with all three of the state's largest insurers had no in-network emergency room physicians for any of the three insurers (i.e., ER physicians at those 23 hospitals were not in the PPO network of any of the state's three largest insurers). Ctr. for Public Policy Priorities, Surprise Medical Bills Take Advantage of Texans: Little Known Practice Creates a "Second Emergency" for ER Patients 4 (Sept. 15, 2014), *available at* http://forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf. While the data in the report do not explicitly identify the magnitude of out-of-network billing issues, they serve to illustrate the likelihood that insured patients who use the ERs in those hospitals may get unexpected bills that are substantially higher than ER co-payments they would expect under the terms of their insurance plan. *Id.* at 3.

11 In Massachusetts, insurers are expected to maintain updated provider directories. 211 Mass. Code Regs. 52.15(1).

12 Health care providers in Massachusetts are required to disclose the allowed amount or charge of an admission, service, or procedure to a patient or prospective patient upon request. M.G.L. c. 111, § 228.

13 *See supra* note 4 and accompanying text. Though not specific to Massachusetts, a recent report by the Kaiser Family Foundation found that 32% of people who had problems paying household medical bills in the prior 12 months while insured said they received care from an out-of-network provider that their insurance would not pay for (or would not pay for in full). The Henry J. Kaiser Family Foundation, The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey (Jan. 2016), *available at* https://kaiserfamilyfoundation.files.wordpress.com/2016/01/8806-the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey.pdf.

14 Health Policy Comm'n, Pre-filed Testimony pursuant to the 2015 Annual Cost Trends Hearings, *available at* http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/annual-cost-trends-hearing/2015/testimony.html (see payer testimony).

15 Robert Murray, *Hospital Charges and the Need for a Maximum Price Obligation Rule for Emergency Department & Out-of-Network Care*, HealthAffairs Blog (May 16, 2013), http://healthaffairs.org/blog/2013/05/16/hospital-charges-and-the-need-for-a-maximum-price-obligation-rule-for-emergency-department-out-of-network-care/.

16 Approximately one-quarter of states have implemented protections for consumers in at least some out-of-network circumstances. Hoadley, *supra* note 3, at 5. *See also State Restriction Against Providers Balance Billing Managed Care Enrollees*, The Henry J. Kaiser Family Foundation, http://kff.org/private-insurance/state-indicator/state-restriction-against-providers-balance-billing-managed-care-enrollees/ (last visited Feb. 22, 2016) (citing 2013 data).

17 *See, e.g.*, Kelly A. Kyanko & Susan H. Busch, The Out-of-Network Benefit: Problems and Policy Solutions, Inquiry 49 353 (Winter 2012/2013).

18 *Id.* at 355-56 (discussing options to address lack of information on network participation and cost transparency).

19 Hoadley et al, *supra* note 3, at 12.

20 *See, e.g.*, Jay C. Ripps, Value Promoting Policy Review: Payments to Out-of-Network Hospitals in California 5-9 (2007), *available at* http://www.pbgh.org/storage/documents/reports/Milliman-OON-Hospital-Report.pdf (reviewing alternative solutions for payment determinations to out-of-network hospitals in California).

21 *See, e.g.*, Hoadley et al, *supra* note 3, at 9 (citing New York's independent dispute resolution process).

22 *See, e.g.*, R. Michael Scarano, Jr. & Judith A. Waltz, *California Supreme Court Prohibits Balance Billing by Non-Contracting Emergency Room Physicians*, Foley & Lardner LLP (Jan. 13, 2009), https://www.foley.com/california-supreme-court-prohibits-balance-billing-by-non-contracting-emergency-room-physicians-01-13-2009/ (summarizing the case and the decision).

23 A current legislative bill in California proposes to address this, which would expand protections beyond emergency services. A.B. 533, 2015-2016 Sess. (Ca. 2015).

24 Cal. Code Regs. tit. 28, § 1300.71 (2015).

25 *See generally Independent Dispute Resolution Process (IDRP),* CA.gov Dep't of Managed Health Care, https://www.dmhc.ca.gov/FileaComplaint/ProviderComplaintAgainstaPlan/Independent-DisputeResolutionProcess.aspx#.VtCr2X0rJaQ (last visited Feb. 25, 2016). According to some stakeholders, however, the dispute resolution process is not used frequently. Hoadley et al, *supra* note 3, at 7.

26 N.J. Admin. Code §§ 11:24-5.3, 11:22-5.8(b).

27 *See generally* Avalere Health LLC, An Analysis of Policy Options for Involuntary Out-of-Network Charges in New Jersey (Mar. 2015), *available at* http://www.horizonblue.com/sites/default/files/ah_analysis_of_policy_options_wp_v3b.pdf (providing an analysis of New Jersey's insurance regulations on involuntary out-of-network care).

28 *Id.* As identified in the report, Aetna estimated that in three years, high out-of-network costs at select for-profit hospitals drove up costs for Aetna members by $15 million. *Id.* at 6.

29 However, a bill that sought to directly address these concerns stalled in late 2015. Susan Livio, *'Greed' Helped Stall N.J. Bill to Curb Surprise Out-of-Network Medical Costs: Lawmaker* (Dec. 11, 2015), http://www.nj.com/politics/index.ssf/2015/12/greed_sidelines_nj_out-of-network_insurance_legisl.html; Andrew Kitchenman, *Doctors, Hospitals Still Oppose Revised Bill to Limit Out-of-Network Charges* (Nov. 24, 2015), http://www.njspotlight.com/stories/15/11/23/doctors-hospitals-still-oppose-revised-bill-to-limit-out-of-network-charges/.

30 N.Y. Fin. Serv. Law §§ 601 to 608 (McKinney 2015).

31 N.Y. Fin. Serv. Law §§ 601 to 608 (McKinney 2015) and N.Y. Ins. Law § 3241(c).

32 N.Y. Fin. Serv. Law §§ 603, 606.

33 *New York State Out-of-Network Surprise Medical Bill Assignment of Benefits Form, available at* http://www.dfs.ny.gov/insurance/health/OON_assignment_benefits_form.pdf.

34 N.Y. Ins. Law § 3217-a(a)(19), (a)(20), (b)(14) (McKinney 2015).

35 N.Y. Pub. Health Law § 24(6) (McKinney 2015).

36 N.Y. Pub. Health Law § 24(2) (McKinney 2015).

37 *Protection from Surprise Bills and Emergency Services*, New York State Dep't of Fin. Serv., http://www.dfs.ny.gov/consumer/hprotection.htm (last visited Feb. 27, 2016).

38 An Act Concerning Hospitals, Insurers and Health Care Consumers, Pub. Act No. 15-146 (Reg. Sess.), *available at* https://www.cga.ct.gov/2015/act/pa/pdf/2015PA-00146-R00SB-00811-PA.pdf (see Sections 3, 5, 9, 10, 11, and 12; to be codified at Conn. Gen. Stat. §§ 19a-904a, 38a-477e, 38a-477aa, 38a-591b, 20-7f, and 38a-193, respectively).

39 However, with respect to one disclosure and transparency element, a bill signed in October 2015 requires insurers to update provider directories weekly. Susan Abram, *California Bill That Requires Accurate Health Provider Directories Signed Into Law,* L.A. Daily News (Oct. 10, 2015), http://www.dailynews.com/government-and-politics/20151010/california-bill-that-requires-accurate-health-provider-directories-signed-into-law.

40 There is a voluntary mediation process in New Jersey, but according to one report, it is not clear how frequently the process is used. Avalere, *supra* note 27, at 5.