



OnPoint: Issue Brief

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Surprise Medical Bills: Identifying A Comprehensive Policy Solution to Protect Consumers in the Commonwealth

Massachusetts has long been a leader in comprehensive health care coverage for its residents, boasting the highest rate of insured individuals in the nation at nearly 98%. Health plans in Massachusetts establish networks of physicians, hospitals and other types of providers in order to ensure that members have access to high-quality providers who can best meet their medical needs. To achieve cost savings, health plans enter into contracts with these providers, hoping to drive significant volume to them in exchange for lower contracted rates.

Even though employers and individuals pay for comprehensive health insurance coverage with a broad array of network providers, insured residents in the Commonwealth and across the country are regularly being subjected to “surprise” medical bills from health care providers that are not part of the health plan’s network. This creates significant member confusion and leads to higher health care costs. The proliferation of so-called surprise billing is a top consumer protection issue, and the practice is drawing widespread attention from legislators and regulators, both here in Massachusetts and nationally.

What Is Surprise Billing?

“Surprise billing” occurs when an insured individual receives an unexpected bill for medical care from a provider who is not in their health plan’s network, but the individual had no notice that they were receiving treatment from an out-of-network (OON) provider. Surprise billing typically occurs under one or both of the following circumstances:

- An insured individual is cared for in an emergency by a provider who is not in their health plan’s network, either by an ambulance service provider or in a hospital emergency room, or
- An insured individual receives treatment at an in-network facility from a provider, most often a radiologist, anesthesiologist, or pathologist, who is not contracted with the insured individual’s health plan, but who provides services within the contracted facility.

In each of these scenarios, the insured individual has no opportunity to be informed of the provider’s network status or to choose to receive care from an in-network provider.

Prevalence of Surprise Billing

Approximately 1 in 5 emergency room visits results in the potential for a surprise OON bill, most commonly when patients seek care at an in-network hospital but are then treated at the emergency department by an OON physician.¹

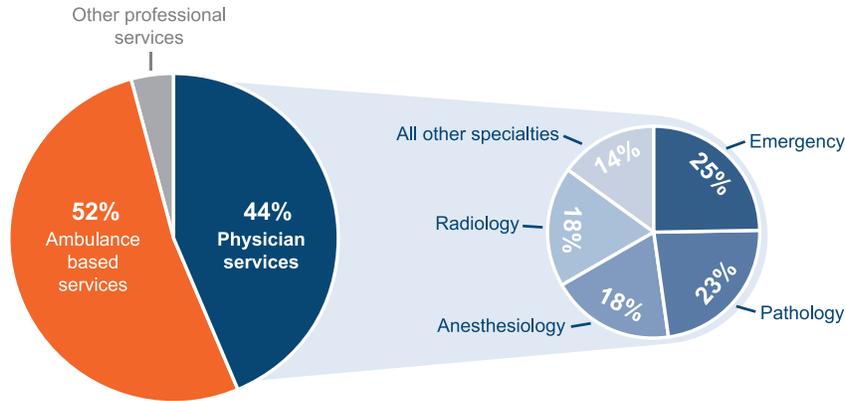
Emergency room physicians, radiologists, anesthesiologists, and pathologists

Emergency room physicians, radiologists, anesthesiologists, and pathologists, commonly referred to as ERAP providers, make up a vast majority of OON billing. An overwhelming 85% of all OON physician claims in Massachusetts originate from ERAP providers, according to OON billing research conducted by the Health Policy Commission (HPC) using a sample of claims from the All Payer Claims Database.²

Ambulance service providers

More than 50% of all ambulance rides nationwide are billed as OON.³ In Massachusetts, claims for ambulance-based services represent the largest share (52%) of OON claims for health care received, according to the HPC’s analysis.⁴

FIGURE 1: By service/provider type, ambulance and ERAP providers account for 90% of out-of-network claims



Source: Massachusetts Health Policy Commission, Research Presentation on Out-of-Network billing (Nov. 1, 2017).

How Does Surprise Billing Increase Health Care Costs?

Surprise billing increases the cost of care to health plans, to employers, and to consumers, both directly and indirectly.

Market-Wide Costs Associated with Surprise Billing

There is clear evidence that physician charges are higher for specialties in which patients have fewer opportunities to choose a physician or be informed of the physician’s network status.⁵ The OON rate can be two to three times more than the in-network rate, but there are instances in which certain providers charge five or six times what Medicare charges, and other instances in which the rate charged is even higher. Anesthesiologists charge an average of 580% of the Medicare reimbursement rates for the same service, while radiologists charge 450% of the Medicare rate, and pathologists and emergency medicine physicians regularly charge 400% of the Medicare rate.⁶

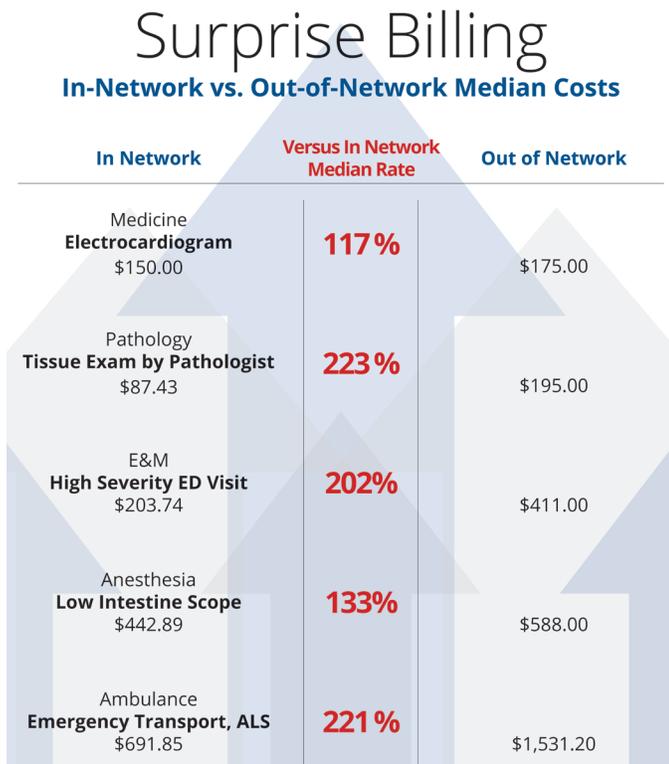


Figure 2. Data Source: Massachusetts Health Policy Commission.

The average spending on OON claims far exceeds the average spending on in-network claims for these services.⁷ Generally, health plans will pay some combination of usual and customary charges and the in-network rate to OON providers. If the provider isn’t satisfied, the plan will attempt to negotiate a special rate for that particular service. In the absence of a negotiated rate for services, health plan payment to providers is usually based on the price that a provider sets. In almost two-thirds of OON claims in Massachusetts included in the HPC analysis, the health plan paid the full charge amount.⁸

In 2014, OON payment rates for ambulance services included in the HPC analysis exceeded in-network rates by 22% to 227%.⁹ Data from the state’s All Payer Claims Database shows that an emergency ambulance ride with advanced life support provided by an in-network ambulance provider costs \$967 on average, while OON ambulance providers charge more than \$1,600 for the same trip.¹⁰ For nonemergency ambulance transportation services, the average OON payment exceeded \$1,100, compared with an in-network average payment rate of approximately \$340.¹¹

OON payment rates for emergency room visits exceeded in-network rates by 68% to 81%, on average.¹² This drastic disparity in prices has an impact on premiums. In addition to the potential cost to members, OON bills can be costly for the health care system as a whole, with possibly 0.5% of premium attributed to OON charges alone. The combined 2014 spending on OON services by just two health plans on behalf of their members in the state totaled \$27 million.¹³

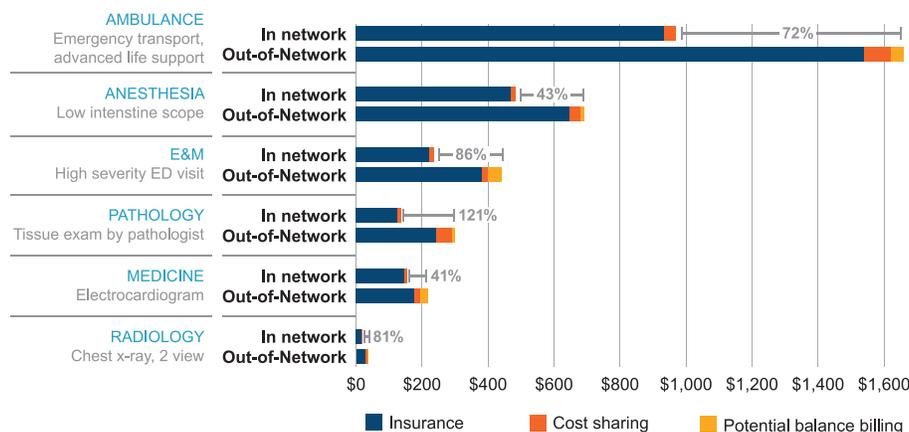
OON issues also impact bargaining dynamics between payers and providers, resulting in higher premiums. Providers may choose to not participate in health plan networks in order to obtain higher rates: “Without a meaningful cap on out-of-network charges, providers have a financial incentive to remain out-of-network and can exploit their monopoly power to drive up reimbursement and premiums.”¹⁴ Absent market pressures to contain the cost of emergency care, there is no incentive for OON providers to negotiate reasonable reimbursement with health plans, particularly if the service has already occurred. Moreover, “contracted rates as a percentage of Medicare rates are considerably higher for emergency and ancillary physicians compared to other specialties because of the lucrative out-of-network billing option available to these physicians.”¹⁵ In-network reimbursement rates for ERAP providers in the Massachusetts commercial market are higher than reasonable, “as payers may be encouraged to agree to higher negotiated rates to keep those high-priced providers in-network, as those higher rates would still be less than out-of-network charges that could occur.”¹⁶

Consumer Costs Associated with Surprise Billing – Balance Bills

Surprise billing as a result of individuals receiving treatment from OON providers also places unexpected financial responsibility on consumers. Health plan members are often billed by the OON provider for the difference between the provider’s charges and the health plan’s payment when the member’s health plan is unwilling to pay the full charge amount and a balance remains. This is referred to as balance billing.

The Health Policy Commission, in its 2017 study, estimated that nearly one quarter of OON claims may have resulted in a balance bill to a member, and that the average potential balance bill per member was \$355.¹⁷ The bills resulting from OON care can be substantial, sometimes in the hundreds or thousands of dollars, resulting in significant financial burden. Additionally, when an individual obtains care from an OON provider, they may be required to pay a greater cost sharing amount than negotiated for the same service provided by an in-network provider. For example, a health plan member’s coinsurance responsibility might be based on the provider’s full charge amount for the health care service.

FIGURE 3: Across a range of services, the average spending on out-of-network claims far exceeds the average spending on in-network claims



Source: Massachusetts Health Policy Commission, Research Presentation on Out-of-Network billing (Nov. 1, 2017).

Recommendations to Address Surprise Billing and Protect Consumers

Multiple state entities have highlighted cost concerns associated with OON billing over the past few years and have developed policy recommendations to lower health care costs in the Commonwealth. In May 2016, the Special Commission on Provider Price Variation (PPV Commission) convened health care industry stakeholders to review surprise billing, among other key issues, and concluded that “[o]ut-of-network billing must be addressed so that patients are protected and payers are able to develop innovative plans.”¹⁸

As part of its work, the PPV Commission outlined three policy elements which, in combination, constitute a comprehensive strategy to prevent surprise billing to insured individuals:

1. Consumer awareness of surprise billing scenarios,
2. Patient protections to prevent balance billing, and
3. Reasonable provider reimbursements for out-of-network services.

The Health Policy Commission has also published similar recommendations to address surprise billing, including requiring advance notice from providers to patients prior to the delivery of nonemergency services, a prohibition on balance billing of consumers, and the establishment of reasonable prices for OON services that will “facilitate value-driven payer and provider rate negotiations, and ensure that OON protections for consumers do not increase overall spending.”¹⁹

Statutory Elements Necessary to Address Surprise Billing

As recommended by the PPV Commission and the HPC, any statutory solution must include each of the following elements to prevent occurrences where members are subjected to unanticipated higher costs when accessing care and to reduce unreasonable charges that drive up the cost of health care in the Commonwealth. Specifically, the Massachusetts Legislature should consider mandating:

1. Increased Consumer Transparency

Legislation in Massachusetts should require providers to give timely notice to members accessing nonemergency care, including disclosure of the network status of all providers who will be involved in a member’s care. Providers should also be required to detail the actual or estimated costs of nonemergency services in order to inform patients in advance of treatment. Current state law and regulations already require health plans to provide detailed information to members through Evidences of Coverage that contain information on the scope of services and benefits available, including cost and network information. Chapter 176O details important consumer protections and specifies the information health plans must regularly provide to members, including toll-free phone numbers and online cost estimation for transparency purposes. Providers should be required to inform patients when a patient is going to be cared for by a nonparticipating provider and will be liable for additional health care costs.

2. Prohibition of Balance Billing in Surprise Billing Scenarios

The Legislature should enact into law prohibitions on balance billing of individuals by providers. Insured individuals should have a reasonable expectation that they are financially protected when they responsibly seek care at an in-network facility. This patient protection should apply when a health plan member receives emergency services, as well as when a member receives care from an OON provider in a network hospital or facility. Today, 21 states have consumer protection laws in place that hold members harmless in emergency OON billing situations or prohibit balance billing of members in certain circumstances.²²

3. Establishment of Reasonable Payment Rates for Out-of-Network Services

The Legislature should adopt recommendations put forward by the PPV Commission and the HPC relative to rates of payment to OON providers. Existing state law requires health plans to pay “a reasonable amount” for OON emergency services. The establishment of noncontracted commercial rates for emergency and nonemergency OON services will encourage providers to charge more reasonable rates and participate in health plan networks, resulting in lower costs for members. Given the prevalence of OON claims in Massachusetts in both circumstances, this requirement should apply equally to OON emergency services, including ambulance services, and to OON ancillary services delivered at a health plan’s in-network facilities.

Establishing an Appropriate Rate of Reimbursement

Perhaps the most controversial aspect of state and federal efforts to address surprise billing has been determining the appropriate level of reimbursement to OON providers. However, it is imperative that any legislative solution consider the impact that statutorily established default rates will have on health insurance premiums, as well as the risk of reducing health plan network participation by health care providers.

Default rates that are too high will increase health care costs and premiums and will encourage providers to leave health plan networks. Key principles established by the PPV Commission and reiterated by the HPC can serve as guidelines for setting a reasonable price for OON services:

- The overall impact should result in cost savings to consumers and employers and have minimal additional administrative expense to both providers and payers.
- There should be a reasonable, transparent, and simple approach to applying a rate, not a cumbersome metric that is not transparent or not easily administered.
- Any rate should ensure that current in-network participation levels by providers are improved upon. The rate must not inadvertently be set at such a high level as to entice providers to leave a network, or at such a low level as to make a health plan indifferent as to whether the provider is in- or out-of-network.²³

Massachusetts' Approach to Default Rates

Ideally, the establishment of default OON reimbursement rates at a level between what Medicare pays and a health plan's median in-network rate for the service will successfully meet the goals of lowering health care costs for consumers and employers while encouraging OON providers to participate in reasonable negotiations with health plans. Many provider organizations in Massachusetts have advocated for default reimbursement rates to be based on the charges routinely billed by OON providers. Such legislation would mandate reimbursement at the "usual and customary" rate, often defined 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. This approach is problematic as "[c]harges face little constraint from market forces and tend to be extremely high relative to objectively reasonable prices."²⁴ Rather than producing health care cost savings, default rates based on billed amounts will increase the rates that health plans pay for OON care delivered by emergency and ancillary providers, driving up costs and insurance premiums.

In accordance with the PPV Commission's recommendations, rates of payment for emergency OON services should be set at a level significantly below charges but not below the amount that would be paid under Medicare for the emergency service in order to incent robust network development, as well as lower the cost of care.²⁵ Since Medicare rates usually serve as the basis for contract negotiations and the determination of reasonable payments between health plans and providers, it would be beneficial for the state to utilize Medicare reimbursement rates in the development of default rates for OON services. While billed charges have no correlation to the cost of providing care, the Medicare fee schedule is publicly available, transparent, accountable to geographic market variation, and representative of a reasonable approximation of actual costs to provide particular health care services.²⁶

Several states have laws in place that utilize contracted rates as the basis for reasonable provider reimbursement. For example, California requires health plans to reimburse providers of nonemergency OON services at the greater of the average in-network rate or 125% of the Medicare rate for the same service in the relevant geographic region. Moreover, bipartisan legislation filed last month by Senators Lamar Alexander and Patty Murray in the Senate and Congressmen Frank Pallone and Gregory Walden in the House attempt to alleviate the problems associated with surprise billing through a proposed minimum reimbursement rate for OON services at the health plan-specific median contracted rate for the relevant service in that geographic area. The House legislation has been referred to by health care experts as "the strongest proposal to date on the dual fronts of protecting consumers and reducing health care costs."²⁷ The establishment of a default reimbursement methodology based on the in-network contracted rates between health plans and providers will ensure a more accurate reflection of the cost of services, given that similar providers have accepted these rates as payment in full. Contractual negotiations under true market conditions account for the provider's specialty and geographic variation. Further, this straightforward approach does not add inappropriate costs to the Commonwealth's health care system.

Conversely, some states have implemented an arbitration process for the negotiation of OON payments. However, rather than lowering health care costs for Massachusetts residents, arbitration would significantly increase administrative costs for health plans and providers, which will be assumed by insured members through premiums.²⁸ Additionally, for purposes of transparency and predictability, a dispute resolution process cannot be established without the identification of clear criteria upon which arbitration decisions on reasonable reimbursements will be made. Therefore, OON default rates are preferable to arbitration.

Conclusion

The Massachusetts Legislature put forth strong policy proposals last session as part of omnibus health care bills that attempted to address the unreasonable charges billed by providers who are unwilling to contract with health plans and continue to seek additional reimbursement from insured state residents. Enactment of legislation that requires transparency, prohibits surprise billing, and sets a reasonable rate of payment without administrative complexity is the best way to protect consumers and lower overall health care spending. The work of the PPV Commission and the HPC, and the key elements that they suggest for legislation, should serve as a framework for lawmakers and policymakers seeking to address this important consumer protection issue.

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