The Economic Alliance for Michigan

SURPRISE BILLING

A State-by-State Summary and Policy Analysis

September 2018

SURPRISE BALANCE BILLING: A STATE-BY-STATE SUMMARY AND POLICY ANALYSIS

Provided by The Economic Alliance for Michigan

THE PROBLEM:

Privately insured consumers expect that by paying premiums and using in-network providers, their insurer will cover the cost of medical care beyond their cost-sharing. However, problems arise when consumers seek care in emergency departments or in-network facilities and are treated by an out-of-network provider working in that institution. For emergency services, there is often not enough time to find an in-network provider or properly inform a patient of their payment responsibilities. For non-emergencies, patients may be unaware that their provider or lab that their in-network facility uses is out-of-network, and insurers and providers may not properly inform patients of the risks of receiving out-of-network care. Patients in these circumstances may receive a surprise "balance bill" for an amount beyond what their insurer is willing to pay the providers. This practice can be exceedingly costly for consumers, who received unexpected bills for hundreds, or even thousands, of dollars when they believed that they were making a responsible choice by choosing an in-network hospital or emergency department. In 2014, up to 14% of emergency department visits and 9% of hospital stays were likely to produce balance bills, indicating that this is a significant problem in the United States (Garmon & Chartock, 2017). With no explicit federal protections against balance billing, some states have stepped in to protect consumers from this expensive and confusing practice. Protections in other states can be models for how states lacking in consumer protections can begin to address the issue of surprise balance billing.

CURRENT LANDSCAPE

FEDERAL LEVEL

There is no explicit protection at the federal level against balance billing unless patients are Medicare beneficiaries. The last significant health care legislation, the Patient Protection and Affordable Care Act (ACA), did not address balance billing. The ACA limited cost-sharing for emergency services that are received out of network, and limited the amount insurers must pay to providers, but did not prohibit providers from balance billing patients in addition to what was paid by insurers.

Where the federal government has implemented protections against balance billing, it has been extremely successful in reducing costs for patients. Facing high costs for beneficiaries, Congress limited the amount that non-participating physicians can balance bill Medicare patients in 1989.

Since the implementation of this legislation, beneficiary liability has declined from $5.65 billion in 1989 to $40 million in 2011 (Hoadley, Ahn, & Lucia 2015). This prohibition against balance billing also protects many dual-eligible patients, or those covered by Medicare and Medicaid.

While states may enact some policies to protect their patients from balance billing, federal law does not allow states to regulate all insurers. The Employee Retirement Income Security Act of 1974 (ERISA) gives the federal government regulation authority over self-funded insurance plans, which constitute about 60% plans covering insured workers (EBRI). Even states that pass comprehensive protections for consumers from balance billing are unable to protect vast numbers of people because state laws cannot regulate self-funded plans. If complete protection from surprise balance billing is to be achieved, federal intervention is necessary in ensuring that all patients receive equal protection.

Bills were introduced in both the House and Senate that would have required hospitals to notify patients about the possibility and cost of out-of-network services. These bills would have also prevented hospitals from billing extra for services provided out-of-network if patients were not properly informed. The legislation would have also prevented hospitals from charging more than in-network cost-sharing for patients who received out-of-network services in emergency situations. Neither the House or Senate bills left committee.

STATE LEVEL

Different legislation at the state-level has resulted in a patchwork of regulations regarding balance billing. Some states, such as California and New York, have adopted comprehensive legislation that addresses balance billing on many fronts. Such comprehensive legislation covers emergent and non-emergent care, prohibits providers from balance billing, holds patients harmless for balance bills, creates a dispute resolution process between insurers and providers to determine reimbursement for out-of-network bills, and covers Preferred Provider Organizations (PPOs) and Health Maintenance Organizations (HMOs). Most of the states with comprehensive legislation also outline a standardized way to determine provider reimbursement for surprise out-of-network bills, though the standards that states have adopted vary widely.

Some states have also implemented laws that require transparency from insurers and providers. For instance, in Georgia and Ohio, insurers are required to maintain an updated directory of providers in their network. This allows patients to avoid seeing out-of-network providers. In Illinois and Texas, providers are required to disclose whether they are in a patient's insurance network and the potential costs of seeing them out-of-network if they are asked by the patient. Transparency around which providers are in-network and the cost of seeking health care can make avoiding surprise balance bills easier for patients.

There has been varied success in passing balance billing legislation. States like New Jersey and Washington are poised to pass new legislation to protect patients in 2018, while North Carolina

and Colorado had bills die in committee in 2017. Most states have not passed any balance billing legislation to date, leaving many Americans at risk of facing steep surprise bills.

Several states have passed laws that, in tandem with federal laws, prohibit balance billing for Medicare patients.

COMMON CONSUMER PROTECTIONS OFFERED:

- Increased levels of transparency required in health insurance plan explanation of benefits, and clearer information about which doctors and hospitals are covered
- A process for insurers and providers to establish a fair payment rate in balance billing situations
- Insurance companies, rather than consumers, cover the difference between the amount a consumer is charged and what the insurance company has agreed to pay
- Patients are held harmless for balance bills, or balance billing is banned altogether

STATE POLICIES

Below is a summation of the protections currently offered to patients across the United States. While 20 states offer some varying layers of protection, currently only six states are considered to have comprehensive laws protecting patients from balance billing. The remaining 24 states and the District of Columbia have no laws protecting consumers. **Michigan is one of the states that does not protect patients.**

COMPREHENSIVE LEGISLATION- 6 STATES

CALIFORNIA

This state is another example of a judicial case and legislation being utilized to provide comprehensive protection. AB 72 went into effect in July of 2017. Protections include:

- A California Supreme Court case outlawing balance billing in emergency cases for HMOs. Providers can only receive a “reasonable and customary,” amount for services.
- AB-72 requires patients to only pay in-network cost sharing for non-emergency services if they received out-of-network services at an in-network provider without proper notification and consent about the billing of the services.
- If patients are not properly notified, providers receive the higher amount between 125% of Medicare reimbursement, or the average contracted rate for services provided.
- Disputes between the provider and the health plan are referred to an independent dispute resolution process.
- AB-72 only applies to health plans regulated by the California Department of Managed Health Care or the California Department of Insurance. Self-insured plans, MediCal, and Medicare are excluded.

Sources: AB 72, Department of Managed Health Care, American Bar Association, SheppardMullin Healthcare Law Blog

CONNECTICUT

This state chose to pass one comprehensive law which was signed June 2015 and went into effect July of 2016. Protections include:

- For emergency services provided by an out-of-network provider, the patient can only be charged their in-network cost sharing rate.
- For emergency services, providers are able to charge the usual, customary, and reasonable rate to the insurer for services, defined as the 80th percentile for such a service in the geographic range.
- For non-emergency services, the patient will only be responsible for their typical cost sharing that they would be charged if they had seen an in-network provider.
- Requires insurers and hospitals to provide more information to patients about coverage and costs.

Sources: Public Health Act 15-146, Robinson+Cole Health Law Pulse,

FLORIDA

Protections in Florida arise from a Florida Supreme Court case and a recent law titled HB 221. This legislation was signed by Republican Governor Rick Scott, this law went into effect January 2017. Protections include:

- For HMOs, balance billing is prohibited for emergency services.
    - 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.
- For HMOs, out-of-network providers are prohibited from balance billing HMO patients for covered non-emergency services that are authorized by the HMO. 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.
- For PPOs, balance billing for emergency cases has been outlawed by a State Supreme Court decision
- For PPOs, patients who received out-of-network services are only responsible for in-network cost sharing. Providers and health plans may resolve disputes over the remaining balance in a voluntary state-arranged resolution process, with rates based on geographic standards.
- Hospitals that utilize out-of-network physicians in their treatment of hospital patients must post statements on their websites indicating that its physicians may separately bill patients, that its physicians might not participate in the same insurers and HMOs as the hospital, and that patients should contact the physicians who will be treating them to make sure that they participate in their insurance network.

Source: HB221, Modern Healthcare

ILLINOIS

Protections include:

- When patients are seen by an out of network "facility-based" provider because there is not an in-network provider available, patients are only responsible for their in-network cost sharing rate.
- A process for insurers and facility-based providers to process payment for out-of-network services, while only billing the patient for in-network cost-sharing. Patients must acquiesce to this process in writing.
- Designates arbitrators for an optional resolution process for resolving disputes between providers and payers.
- Protects patients from higher out-of-pocket costs if they are referred to a non-preferred provider by their preferred provider or administrator.
- Requires patient notification in hospitals about the possibility and potential cost of receiving out-of-network services from affiliated providers.

Sources: 215 Ill. Comp. Stat. 5/356z3a, 50 Ill. Admin Code 2051.310, (210 ILCS 88/) Fair Patient Billing Act

MARYLAND

Protections include:

- Maryland prohibits providers from balance billing HMO consumers for covered services including but not limited to emergency services.
- 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.
- The PPO law grants the protection against balance billing to patients who assign benefits to their physicians.

NEW YORK

This state has one of the most comprehensive plans to protect its citizens from surprise medical billing, titled the Emergency Medical Services and Surprise Bills Law. Effective March of 2015.
Protections include:

- Out-of-network providers are *prohibited* from balance billing the patient.
- For emergency services, patients insured by state-regulated health plans are *held harmless* for costs beyond the in-network cost sharing amounts that would otherwise apply.
- For non-emergency care, patients who receive surprise out-of-network bills can submit a form authorizing the provider to bill the insurer directly, and then are *held harmless* to pay no more than the otherwise applicable in-network cost sharing.

- Patients who are uninsured or covered by self-insured group health plans may also apply to the state-run arbitration process to limit balance billing by providers under certain circumstances.
- Providers who dispute the reasonableness of health plan reimbursement may *appeal* to a state-run arbitration process to determine a binding payment amount.
- Hospitals must disclose which health plans they accept, list the standard charges for services, and inform patients that physicians working at an in-network facility might not actually participate in the insurance network and can bill the patients directly.
- The law also requires that in-network physicians obtain written consent from the patient before referring to out-of-network providers or sending a specimen to an out-of-network lab.

Source: New York State Department of Financial Services

NON-COMPREHENSIVE LEGISLATION OR BILLS- 15 STATES

ARIZONA

SB 1441: This bill has been signed by the Governor and will go into effect in 2019. Protections include:

- Defines surprise out-of-network bill as an emergency service by an out-of-network provider, or a non-emergency service that was provided by an out-of-network provider without written consent providing information about the network status of the provider and potential cost of services being presented to and signed by the enrollee
  If the patient is left with a balance bill of at least $1,000 after cost-sharing, they may request dispute resolution process consisting of:
  i) A teleconference between the enrollee, the provider or provider representative, and the health insurer;
  ii) Should the teleconference fail, the health insurer or provider may trigger an arbitration process through the Insurance Department;
  iii) The arbitration process will ultimately resolve the issue between the provider and the health insurer, thus absolving the patient of responsibility for the balance bill.

Source: SB1441

COLORADO

Protections include:

- The Division of Insurance in Colorado has interpreted their network adequacy requirements under Colorado law to mandate that patients are held harmless when they receive out-of-network services at an in-network facility. Cost-sharing must match in-network cost-sharing for these services.
- The legislature upheld this interpretation by passing an act that expired in 2010.

SB17-206: Considered in 2017, died in the Senate Business, Labor, & Technology Committee. Protections include:

- Would have established a method for insurers and providers to determine a payment for out-of-network bills at in-network facilities, as well as a dispute process should a provider seek review of the payment
- Would have required providers to notify patients about the possibility and consequences of receiving out-of-network services

Source: SB06-213, SB17-206

GEORGIA

SB302. Protections include:

- Requires insurers to maintain updated directory of in-network providers for accuracy
- Protects consumers who received out-of-network services based on inaccurate information from an insurer's directory

The Georgia legislature also considered two separate bills HB 71 and SB 8 respectively, that would have expanded disclosure requirements concerning pricing and coverage for hospitals and insurers, created a resolution process for disputed bills, and banned balance billing for emergency services.

Source: SB 302, SB 8, HB 71, Georgia Health News

DELAWARE

Protections include:

- Prohibits MCOs from balance billing patients for services provided in emergency situations
- Prohibits MCOs from balance billing patients when they are referred to an out-of-network provider for primary, specialty, or ancillary care that is not offered by providers within the MCOs network in a reasonable amount of time, or when in-network providers are not geographically accessible
- Prohibits MCOs from balance billing patients for facility-based or ancillary care when in-network providers are not geographically accessible
- Prohibits balance billing for lab services if providers do not provide disclosure to patients about out-of-network labs
- Requires signed general disclosure to patients about the possibility of seeing an out-of-network provider

Source: Delaware Administrative Code: Title 18: 1300, 1400,

INDIANA

Protections include:

- Requires providers making referrals in non-emergency situations to notify patients that they may receive out-of-network services at the referred provider, that the referred provider is not bound by the payment agreement of the patient's insurer, and to contact their insurance providers before receiving services.

Source: HB 1273

IOWA

Protections include:

- Holds patients harmless for balance bills that derive from emergency department services.

Source: Commonwealth Fund

MASSACHUSETTS

Protections include:

- HMO and insured preferred provider network plans in Massachusetts must pay a reasonable amount for out-of-network emergency services. However, patients may still be balanced billed for the difference between the reasonable amount insurers pay and the price charged by the provider.
- For preferred provider plans, if patients receive emergency care and cannot reasonably reach a preferred provider, the insurer is required to pay the non-preferred provider at the same level and in the same manner as if they were a preferred provider. However, patients may still be balanced billed for the difference between the reasonable amount insurers pay, and the price charged by the provider.
- If patents get treatment at an in-network facility and did not have a "reasonable opportunity to choose to have the service performed by a network provider," then insurers may not charge greater cost-sharing.

HB 4333: Under consideration in the Massachusetts legislature

- Would require providers to notify patients if they are ordering a test, procedure, or lab work that is out of the patient's insurance network

SB 528: Under consideration in the Massachusetts legislature

- Would require insurers to maintain a database of in-network providers that is easily available to consumers. The legislation requires the database to be audited for accuracy regularly.

Source: Massachusetts Health Policy Commission, HB4333, SB 528

MINNESOTA

Protections include:

- Includes comprehensive definition of “unauthorized provider services,” defining them as:
    - Services from a nonparticipating provider at a participating hospital or ambulatory surgical center when the services are rendered:
      (a) due to the unavailability of a participating provider;
      (b) by a nonparticipating provider without the enrollee's knowledge; or
      (c) due to the need for unforeseen services arising at the time the services are being rendered
    - Services from a participating provider that sends a specimen taken from the enrollee in the participating provider's practice setting to a nonparticipating laboratory, pathologist, or other medical testing facility.
    - Emergency services are not included in the definition of unauthorized provider services.
    - If the enrollee gives advance written consent to the provider acknowledging that the use of a provider, or the services to be rendered, may result in costs not covered by the health plan, then they cannot be considered unauthorized services.
- Enrollees are only responsible for cost-sharing as if they had been seen by a participating provider if they received unauthorized services. Cost-sharing must be applied to the annual out-of-pocket limit.
- The health plan and the unauthorized provider are responsible for negotiating a reimbursement for services.
- Failure to negotiate between the health plan and provider, either party may elect to seek binding arbitration services by selecting and arbitrator from a list provider by the commissioner of health.

Source: Minnesota Statute 62Q.55

MISSISSIPPI

Protections include:

- If the patient assigns benefits to a provider, the provider is prohibited from balance billing beyond normal cost-sharing for both emergency and non-emergency care.

Source: Clarion Ledger, Mississippi Code title 83 Chapter 83

NEW HAMPSHIRE

Protections include:

- Health carrier shall require that the hospital include in its contract with any person performing services within the hospital, but not employed by the hospital, the following provisions:
- An agreement that if the out-of-network person performs on a patient for whom the hospital is in-network, the out-of-network person shall accept as payment in full an

amount no greater than the amount generally billed and received by a provider for that service for patients covered by health insurance in the state.
- hold the covered person harmless, upon payment by the health carrier of the amount requested.

HB 1809. Protections include:
- Prohibits balance billing for anesthesiology, radiology, emergency medicine, or pathology services for patients enrolled in managed care plans who seek services at in-network facilities.

Source: HB 1809

NEW MEXICO

New Mexico Patient Protection Act and New Mexico Preferred Provider Arrangements Law. Protections include:
- Holds HMO and PPO patients harmless for emergency out-of-network care.
- If a preferred provider cannot be reasonably reached for emergency care, then the law requires that the out-of-network provider be reimbursed as if the patient was in-network.

Source: Office of Superintendent of Insurance

NORTH CAROLINA

HB 447. Protections include:
- Balance billing is prohibited for HMO enrollees who seek care at an in-network facility. This law does not cover PPOs.

SB 629. This bill was introduced in 2017 but was not passed out of the Senate.
Protections include:
- Requires disclosure of the possibility of receiving out-of-network services at an in-network facility, and the resulting financial liability
- Sets a benchmark rate for the lowest a provider can be paid for out-of-network services

Source: HB 447, SB 629

OHIO

Ohio Administrative Code 3901-8. Protections include:
- Requirement that insurers provide a directory of providers who are in-network and update the directory quarterly.
    - Should a provider leave the network, the insurer must update the directory within 15 business days.

    - Should a provider leave the network, all enrollees that used the provider's services within the last year must be notified of the network status change within 15 business days.
- Requirement that insurer directory discusses the possibility of out-of-network services, such as those provided by anesthesiologists and radiologists, and disclose the financial obligations patients may have if they receive out of network services.

Source: Ohio Administrative Code 3901-8

OREGON

HB 2339. This bill was passed in June of 2017 and went into effect March 2018. Protections include:

- Prohibition of balance billing for emergency services or inpatient or outpatient services from an out-of-network provider at an in-network facility unless patients chose to receive out-of-network services.
- Patients are still responsible for copayments, deductibles, or coinsurance that they would pay if they saw an in-network provider.
- Patients who choose out-of-network providers must be informed by that provider of the increased financial obligation of seeing an out-of-network provider.
- Directed the Department of Consumer and Business Services to create an advisory group of stakeholders to provide recommendations for appropriate reimbursement of out-of-network services at in-network facilities.

Source: HB 2339

PENNSYLVANIA

Protections include:

- Holds patients harmless for balance bills incurred from out-of-network emergency services

Source: Commonwealth Fund, insideARM

RHODE ISLAND

Protections include:

- Holds patients harmless for balance bills resulting from emergency or non-emergency services if they are enrolled in an HMO

Source: Commonwealth Fund

TEXAS

SB507. Protections include:

- Allow a mediation process for consumers with a PPO plan to address balance bills of over $500 after cost sharing

- This medication process is only available to resolve disputes over emergency services or out-of-network provider services in in-network hospitals.
- Requires facility-based or emergency care provider to disclose network status and explain patients' responsibility for payment if requested by the patient
- Requires bills to patients from providers or explanation of benefits from insurers to notify patients in plain language about the availability of the mediation process to reduce out-of-pocket costs
- Effective January 1, 2018

Source: SB 507

UTAH

SB 216. This law was signed in March of 2016, and only affects specific cases of balance billing: Protections include:

- Prohibits balance billing of beneficiaries in circumstances where workers' compensation insurance or self-insured employer benefits are obligated to pay medical benefits.

Source: SB 216

VERMONT

- Holds patients harmless for balance bills resulting from emergency and non-emergency care. This protection applies to both PPO and HMO enrollees.

Source: Commonwealth Fund

WEST VIRGINIA

Protections include:

- Holds patients harmless for balance bills resulting from emergency care if they are enrolled in an HMO plan.

Source: Commonwealth Fund

PENDING LEGISLATION

NEW JERSEY

SB 1285. This bill, introduced in 2017, was not voted out of the Senate. Protections include:

- Required providers to disclose whether or not they participate in the patient's health plan before making an appointment for non-emergency services
    - Providers were also required to provide provider name and contact information for other providers, such as anesthesiologists or radiologists, that may participate in care.

- Providers must maintain a website that discloses which health plans they participate in, and if any of the services provided are not covered up these health plans.
- For emergency or urgent services, out-of-network providers cannot balance bill a patient beyond in-network cost sharing.
- If providers and insurers cannot agree on a reimbursement rate for emergency or urgent services, one of the parties or the patient can trigger a binding arbitration process. The arbitrator will pick one of the two reimbursement options offered by the insurer and provider.

Source: SB 1285

WASHINGTON

ESHB 2114. This bill is not yet passed and is currently being reviewed by the Washington State Senate, having passed the House in February of 2018. Protections include:

- Prohibits balance billing from out-of-network providers for emergency services or non-emergency surgical or ambulatory services at an in-network facility. Also bans balance billing for non-emergency services when an in-network provider was unavailable.
- Patients are only responsible for the cost-sharing they would have been responsible for had they seen an in-network provider.
- Requires an informal settlement process between insurers and providers. Should settlement fail, the law has created an arbitration process through the Office of the Insurance Commissioner to resolve disputes.
- Disclosure requirements for providers and insurers concerning which services or providers are in-network, cost of services, and patients' financial obligations.

Source: ESHB 2114

UNPASSED LEGISLATION

OKLAHOMA

HB 2216. This bill was not passed. It passed the Oklahoma House of Representatives in March of 2017 but was not voted out of the Senate Retirement and Insurance Committee. Protections include:

- Requirement that a non-contracted provider give a health plan enrollee notice, a good-faith estimate of charges, and a disclosure that the provider will either accept the assignment of benefits for the plan's allowed amount or balance-bill the enrollee.
    - For emergency patients, notice must be given once the patient is stable
    - For non-emergency patients, notice must be provided 14 days prior to services being rendered.
- Patients will be able to request a different provider who is covered by insurance.

Source: HB 2216

PENNSYLVANIA

SB 678 and HB 1553. The Senate bill, proposed in 2017 did not leave the Banking and Insurance Committee. The House Bill was passed out of the Health Committee in 2017 but did not received any further votes.

Protections include:

- Removed financial liability from patients, except for in-network cost sharing, if they received out-of-network services at an in-network facility without written consent or were referred to an out-of-network provider by an in-network provider without written consent. Only applied to non-emergency services.
- Allowed insurers and health care providers to settle involuntary out-of-network bills through binding arbitration, removing the patient from the process.
- For out-of-network emergency services, insurers are only allowed to bill patients as much as they would have been charged for in-network services.
- Required insurers to create a publicly available form for patients to submit balance bill claims.

Source: SB 1158, SB 678, HB 1553

RHODE ISLAND

HB 5012. Introduced in the 2017 session, was not voted out of the House Corporations Committee.

Protections include:

- Holds patients harmless for any charges beyond in-network cost sharing for emergency services at out-of-network providers, or for out-of-network services at in-network providers without patient consent.
- Instructed the Health Insurance Commissioner to create a resolution process for providers and insurers to determine appropriate reimbursement for out-of-network services.

Source: HB 5012

UTAH

HB 395. Introduced in the 2017 session, was not ultimately passed by the House.

Protections include:

- Required HMOs to notify patients in writing about the possibility of being treated for a covered service at an in-network facility by an out-of-network provider, and the possibility of balance billing for these services.
- Required HMOs to have an electronically available provider directory and update it monthly.
- Would have utilized a national benchmark for typical charges to limit what hospitals and doctors can charge patients for balance bills.

Source: HB 395

POLICY ANALYSIS

IN FAVOR OF BALANCE BILLING LEGISLATION

Balance billing protections offer savings to patients. In a study comparing out-of-pocket spending for physician care, it was found that Medicare beneficiaries saved $140 annually on physician care as restrictions on balance billing Medicare patients were rolled out at the state and federal level. The amount of care received by beneficiaries was unaffected, indicating that patients did not lose out on care because of the balance billing laws (McKnight, 2007). A review of national surprise out-of-network billing for emergency services showed that unless their insurer paid the bill, patients could be billed an average of $622.55, and the largest emergency bill in their data set totaled $19,603.30 (Cooper & Morton, 2016). News outlets across the country have covered stories of patients impacted by severe balance bills, such as a woman from New Hampshire's emergency department who was billed for $9,000 for no intensive treatment, and a man from New York who was billed $117,000 for an out-of-network assistant surgeon he had never met. In a study using nationwide claims data, researchers found that about one in five inpatient ED admissions, one in seven outpatient ED visits, and almost one in ten elective inpatient admissions were likely to result in balance billing (Garmon & Chartock, 2016).

Laws that mandate transparency help patients avoid accidentally seeing out-of-network providers and incurring balance bills in the first place. With laws that hold patients harmless for balance bills when not properly notified, patients are saved from exorbitant surprise billing costs. Establishing a resolution process for payers and providers to negotiate the balance bill removes stress from the patient, who may not have the time or knowledge to properly advocate for themselves.

Comprehensive balance billing laws that create transparency and a resolution process can also help payers and providers. Without a resolution process outlined in legislation, payers and providers have to negotiate reimbursement for out-of-network services without standardization. Depending on the market, this can mean that payers may reimburse too much for services, or providers are undercompensated for care.

OPPOSED TO BALANCE BILLING LEGISLATION

Providers may be opposed to balance billing legislation, as prohibiting balance billing eliminates a path for revenue. Without balance billing prohibitions, providers are currently free to bill patients for thousands of dollars in addition to insurance reimbursement, and that option would no longer be available if all states banned surprise balance billing. Providers who do not adequately notify patients of their out-of-network status will face revenue loss or have to enter a resolution process with the patient's insurer in order to be reimbursed. The resolution processes may not result in the desired compensation rate for providers. Additionally,

notification requirements about out-of-network status may result in additional administrative burden but will be necessary for providers in order to avoid the revenue lost from not complying. There will also be an administrative burden for providers who choose to utilize reconciliation processes, or those who negotiate reimbursement individually with insurers. Insurers will also have to assume more responsibility for paying balance bills, and also take on the administrative burden of negotiating reimbursement in states where patients are held harmless.

SOURCES:

Cooper, Z. and Morton, F.S., 2016. Out-of-network emergency-physician bills—an unwelcome surprise. *N Engl J Med*, *375*(20), pp.1915-1918.
http://www.zackcooper.com/sites/default/files/paper-files/NEJM_surprise_billing.pdf

Garmon, C. and Chartock, B., 2016. One in five inpatient emergency department cases may lead to surprise bills. *Health Affairs*, *36*(1), pp.177-181.
https://www-healthaffairs-org.proxy.lib.umich.edu/doi/full/10.1377/hlthaff.2016.0970

Hoadley, J., Ahn, S., & Lucia, K. (2015). Balance Billing: How Are States Protecting Consumers from Unexpected Charges?. *Center on Health Insurance Reforms, Georgetown University*.
http://www.statecoverage.org/files/Georgetown_Balance_Billing.pdf

Lucia, K., Hoadley, J., & Williams, A. (2017). Balance Billing by Health Care Providers: Assessing Consumer Protections Across States. *Issue brief (Commonwealth Fund)*, *16*, 1-10.
https://pdfs.semanticscholar.org/6f4a/4bfcc63fc9473657faf978abdb52c51bc156.pdf

McKnight, R., 2007. Medicare balance billing restrictions: Impacts on physicians and beneficiaries. *Journal of health economics*, *26*(2), pp.326-341.
https://www-sciencedirect-com.proxy.lib.umich.edu/science/article/pii/S016762960600097X