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State Surprise Billing Laws in the 2019 Session

Surprise medical bills have been harming families for decades. They occur when families receive out-of-network care due to no fault of their own. Surprise medical bills can amount to hundreds, thousands, or even tens of thousands of dollars in unexpected medical costs for families.[1]

In 2019, many states addressed this issue through legislation. This brief summarizes 2019 state legislative activity on surprise medical bills.

Evaluating State Laws on Surprise Medical Bills

Comprehensive legislation on surprise bills addresses two factors: (1) how to hold consumers harmless in surprise bill situations and (2) how to address payment between insurers and out-of-network providers in surprise bill situations, ideally so that payment does not inflate health care costs and thereby increase premiums for consumers. This brief describes how 2019 state laws on surprise bills address both of these factors.

As guidelines to help readers evaluate how well these 2019 laws both protect consumers and hold down overall costs, here are Families USA's principles for surprise bill protections.

Principles for Protecting Consumers

- In emergencies (including at out-of-network facilities) and at in-network facilities, laws should completely prohibit balance billing.
- Laws should protect consumers across all health care settings and provider types, including at laboratories and diagnostic imagining centers to which they are referred by in-network providers.
- Consumers should not pay more toward their care than their in-network cost-sharing (including copayments, coinsurance, and deductibles) in a surprise bill situation.
- Cost-sharing amounts should count toward a consumer's in-network out-of-pocket maximum and deductible.
- For provider types where a consumer may reasonably choose to go out of network (such as for office-based care), surprise billing protections should apply unless the provider has informed the patient with advanced notice (such as seven days) and consent, along with projected charges, that care will be out of network.

Principles for Holding Down Costs

- To ensure surprise bill protections don't increase premiums, laws should establish a reasonable payment mechanism for out-of-network providers in surprise bill situations.

- Payment mechanisms should not inflate costs. They should not be based on or factor in providers' billed charges. Ideal payment mechanisms set a standard benchmark payment rate, but if based on an arbitration system, they should prohibit billed charges from consideration.

Surprise Bill Action at the Federal Level

At the federal level, Congress is also working to tackle the issue of surprise medical bills. In both the House of Representatives and the Senate, legislation is under consideration that would address surprise medical bills for consumers nationwide in a wide range of care settings while creating a payment mechanism between insurers and providers. However, as Congress works through its debate on the issue, state progress can still make an important difference in consumers' lives. Additionally, legislation that Congress enacts may be considered a minimum standard, and some states may want to work above that floor to implement surprise bill standards that go beyond federal law.

2019 State Laws on Surprise Medical Bills

The following four states enacted comprehensive surprise medical bill laws in 2019.

> State progress can still make an important difference in consumers' lives.

Colorado

The fifth time's a charm in Colorado, as after four years of coming to a stalemate on surprise bill legislation, the state passed HB 19-1174 to protect consumers and hold down overall health care costs. As Caitlin Westerson, of the Colorado Consumer Health Initiative, stated in a Families USA case study, "Advancing a legislative initiative with so many changes to our current health care system did not come without its challenges."[2] The law will take effect on January 1, 2020.

Consumer Protections in Colorado's Law

- Balance billing in emergency situations (including from out-of-network facilities) and in nonemergency situations at in-network facilities is prohibited. Balance billing is also prohibited from commercially owned ambulances.
  - Consumers are required to pay only in-network cost-sharing (including copayments, coinsurance, and deductibles) in the situations described above.
  - In out-of-network emergency facilities, the amounts above count toward an enrollee's in-network out-of-pocket maximum.
- Insurers, providers, and facilities have new notice requirements to inform consumers about out-of-network care and its cost impacts.

Payment Mechanism in Colorado's Law

- Establishing benchmark payments
  - When a consumer receives *out-of-network care at an in-network facility*, the insurer must pay the out-of-network provider the greater of (1) 110% of the insurer's median in-network rate for the service in the same geographic area or (2) the 60th percentile of the in-network rate for the service in the same geographic area for the prior year based on data from the state's all-payer claims database.

- When a consumer receives *emergency care at an out-of-network facility*, the insurer must pay the facility the *greater* of (1) 105% of the insurer's median in-network rate for the service in a similar setting in the same geographic area or (2) the median in-network rate for the service in a similar setting in the same geographic area for the prior year based on data from the state's all-payer claims database. (Rates are determined separately for facilities operated by the Denver Health and Hospital Authority.)
- The insurance commissioner shall promulgate rules to identify and implement a payment rate for out-of-network commercial ambulance services.
- Nothing precludes insurers and providers or facilities from voluntarily negotiating a different rate for out-of-network care in surprise billing situations.

» Arbitration when a provider or facility believes the benchmark rate is insufficient

- If a provider or facility believes payment under the benchmark rate is insufficient, it can initiate an arbitration process within 90 days of the receipt of payment.
- The insurance commissioner will establish rules for an independent arbitration process.
- Within 30 days after the commissioner appoints an arbitrator, each party must submit its final offer and supporting documentation. The arbitrator will select one of the two amounts submitted as a final and binding decision within 45 days.
- The arbitrator shall consider the circumstances of the case, including (1) the provider's training and expertise and (2) the previously contracted rate between the parties within the past year, if applicable.
- The loser of the arbitration process must pay for the costs of arbitration.

New Mexico

New Mexico joined its neighbors to the north in passing surprise bill legislation to hold consumers harmless and protect against inflating the underlying costs of health care. The governor signed SB 337 in April 2019, and it will take effect January 1, 2020.

Consumer Protections in New Mexico's Law

» For out-of-network emergency services and services at in-network facilities from out-of-network providers when consumers do not have the ability or opportunity to choose an in-network provider, insurers may only impose cost-sharing at the same level they would charge in network (including copayments, coinsurance, and deductibles).

- This protection also extends to when an insurer's network does have providers available to provide medically necessary nonemergency care in network.

» Providers or facilities in these surprise billing situations may not balance bill consumers (and specifically may not seek to collect payment beyond in-network cost-sharing amounts).

Legislation that Congress enacts may be considered a minimum standard, and some states may want to work above that floor.

- Providers can balance bill consumers who knowingly select nonemergency out-of-network care.
- Facilities have new notice requirements to inform consumers about surprise bill protections and network status. Providers also have new notice requirements in certain circumstances.

Payment Mechanism in New Mexico's Law

- In surprise bill situations, insurers shall directly reimburse out-of-network providers based on a benchmark rate.
- The benchmark rate is the 60th percentile of the allowed commercial reimbursement rate for the particular service performed by a provider in that specialty in the same geographic area based on claims paid in 2017.
  - This amount will be determined based on data reported in a benchmarking database maintained by a nonprofit, conflict-free organization specified by the superintendent of insurance after consultation with health care sector stakeholders.
  - No reimbursement shall be paid at less than 150% of the 2017 Medicare rate for the relevant service.

Texas

Texas enacted partial surprise billing protections in prior years, but these often trapped consumers in a process to fight for their own protection. In 2019, the state built upon its initial laws to hold consumers harmless from surprise bills while establishing a process to determine reimbursement that keeps consumers out of the middle under SB 1264.

Consumer Protections in Texas's Law

- Balance billing in emergency situations (including from out-of-network facilities), in nonemergency situations at in-network facilities, and by out-of-network diagnostic imaging providers and laboratory service providers in connection with a service performed by an in-network provider is prohibited.
  - Consumers are required to pay only in-network cost-sharing (including copayments, coinsurance, and deductibles) in the situations described above.
- Insurers have new notice requirements to inform consumers about surprise bill protections.
- For nonemergency situations, if consumers choose to go out-of-network, providers may balance bill, but only if they provide an advanced written disclosure that they are out of network, along with projected amounts that enrollees would pay for out-of-network care.
- Protections apply to fully insured PPO, EPO, and HMO plans, as well as to plans offered through the Employees Retirement System of Texas (for state employees) and the Teacher Retirement System of Texas (for both active and retired teachers)

In 2019, Texas built upon its initial laws to hold consumers harmless from surprise bills.

Payment Mechanism in Texas's Law

- Within a limited time after receiving a claim from an out-of-network provider in a surprise billing situation, an insurer must pay the provider the amount initially determined payable by the insurer.
- The law establishes two different dispute resolution processes for disputes over payments in surprise bill situations: mediation for facilities and arbitration for nonfacilities.
  - Insurers and providers or facilities will attend a conference call in an attempt to settle before mediation or arbitration.
  - The state's insurance commissioner will adopt rules for the two dispute resolution programs and maintain a list of qualified mediators and arbitrators. Mediators and arbitrators will be selected by mutual agreement of the parties; if no consensus is reached, the commissioner will select a mediator or arbitrator from the list.
  - The cost of mediation or arbitration will be split evenly between the parties.

In arbitration, the arbitrator determines whether the provider's charge or the insurer's payment amount is closest to the reasonable amount. This amount is the arbitrator's binding decision.

- In mediation, the mediator evaluates whether the charge is excessive or the insurer's payment unreasonably low. The goal is to reach an agreement on the payment amount.
  - If the parties do not reach an agreement, either party may file a civil action to determine the payment amount within 45 days of the mediator's report.
- In arbitration, the arbitrator determines whether the provider's charge or the insurer's payment amount is closest to the reasonable amount. This amount is the arbitrator's binding decision.
  - Arbitrators must consider a number of factors in decision-making, including those related to: provider charges; the insurer's typical out-of-network reimbursement; the provider's training; the complexity of the case; the 80th percentile of all billed charges for the service in the same area; the 50th percentile of in-network rates for the service in the same area; any history of contracting between the parties; and any offers made during the informal pre-arbitration conference call.
  - The insurance commissioner will establish rules for submitting multiple claims in one arbitration proceeding for an individual provider. Such claims may not together exceed $5,000.
  - Although an arbitrator's decision is considered binding, a party not satisfied with the decision may file an action in court to determine payment within 45 days of the arbitrator's decision. The court must determine whether the arbitrator's decision is proper within 30 days.

Washington

Starting January 1, 2020, Washington state consumers will have new protections against surprise medical laws, thanks to HB 1065, legislation spearheaded by the state's insurance commissioner.

Consumer Protections in Washington's Law

- Balance billing in emergency situations (including from out-of-network facilities) and in nonemergency situations at in-network facilities involving surgical or ancillary care (anesthesiology, pathology, radiology, laboratory, or hospitalist services) is prohibited.
  - Consumers are required to pay only in-network cost-sharing (including copayments, coinsurance, and deductibles) in the situations described above. These amounts count toward the enrollees' in-network out-of-pocket maximum.
- Self-insured plans regulated under federal law may opt in to regulation under HB 1065.
- Insurers must hold consumers harmless from surprise bills in emergency situations that occur in states bordering Washington. Insurers no longer have this obligation if federal legislation, an interstate compact, or another state's legislation is enacted to prohibit border-state hospitals from balance billing in such situations.

Payment Mechanism in Washington's Law

- Insurers must pay out-of-network providers or facilities a "commercially reasonable amount." This is based on payments for the same services provided in a similar geographic area.
- The provider or facility can dispute this amount and seek to negotiate with the carrier.
- If negotiation is unsuccessful, the insurer and provider or facility can go to a "baseball-style" arbitration process.
  - The insurance commissioner will provide the parties a list of approved arbitrators, and the parties will select an arbitrator together. If they cannot agree, they undergo a process with the commissioner to secure an arbitrator.
  - Each party must provide its final reimbursement offer and submit information to defend its offer to the arbitrator. Within 30 days of receiving this information, the arbitrator will release a written decision on which payment rate they've selected.
  - The arbitrator may consider the following factors in decision-making: patient characteristics and the circumstances of the case; data from the Washington all-payer claims database; and other information a party to the arbitration believes is relevant.
  - The costs of arbitration will be borne equally by the parties.

Based on research published by The Commonwealth Fund,[3] with the addition of these states' laws, 13 states now have comprehensive protections against surprise medical bills (up from nine in 2018). The momentum on this issue is strong, indicating a high potential for more states to act on surprise medical bills in the 2020 legislative session.

Starting January 1, 2020, Washington state consumers will have new protections against surprise medical laws.

Endnotes

[1] New York State Department of Financial Services, "An Unwelcome Surprise: How New Yorkers Are Getting Stuck with Unexpected Medical Bills from Out-of-Network Providers," (Albany, NY: New York State, 2012), available online at http://www.statecoverage.org/files/NY-Unexpected_Medical_Bills-march_7_2012.pdf; Zack Cooper and Fiona Scott Morton, "Out-of-Network Emergency-Physician Bills — An Unwelcome Surprise," *New England Journal of Medicine* 375, no. 20 (2016): 1915–1918, available online at https://www.nejm.org/doi/full/10.1056/NEJMp1608571.

[2] Caitlin Westerson, "Colorado Will Finally Protect Patients from Surprise Medical Bills," Families USA (blog), June 24, 2019, available online at https://familiesusa.org/blog/2019/06/colorado-will-finally-protect-patients-surprise-medical-bills.

[3] Jack Hoadley, Kevin Lucia, and Maanasa Kona, "State Efforts to Protect Consumers from Balance Billing," (New York, NY: The Commonwealth Fund, January 18, 2019), available online at https://www.commonwealthfund.org/sites/default/files/2019-01/To_the_Point_BalanceBilling.pdf.

This publication was written by:

Claire McAndrew, Director of Campaigns and Partnerships, Families USA

The following Families USA staff contributed to the preparation of this material (listed alphabetically):

Kimberly Alleyne, Senior Director of Communications

Nichole Edralin, Senior Designer

Justin Mendoza, Partnerships Manager

FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

1225 New York Avenue NW, Suite 800
Washington, DC 20005
202-628-3030
info@familiesusa.org
FamiliesUSA.org
facebook / FamiliesUSA
twitter / @FamiliesUSA

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