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An Overview of State Surprise Medical Billing Laws in the 2020 Legislative Session

Surprise medical bills have been harming families for decades.[1] They result when patients unknowingly 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.[2] Numerous studies have shown that millions of Americans consistently lack comprehensive coverage and access to affordable care, and that many families in the United States forgo medical care due to cost.[3,4,5,6] A nationwide Bankrate survey which covered responses from the past 12 months found that nearly one in three American families have forgone medical care because of cost.[7]

In the COVID-19 era, the risk of receiving a surprise medical bill has grown as consumers have lost coverage at historic rates. This has resulted in a chilling effect on patients who would otherwise seek care.[8] During this pandemic at a time when patient burden at hospitals is skyrocketing, consumers are far more likely to receive emergency care at out-of-network facilities.[9]

While several pieces of federal legislation that attempt to solve the issue have been introduced in the last couple of years, these bills have stalled in Congress. In the meantime, several states have taken the initiative to pass key protections for their residents. In 2019, many states addressed this issue through legislation (Families USA published a policy brief in July 2019 that summarized activity on surprise medical bills for the 2019 legislative session).

This brief begins with a quick review of federal activity on the issue and a framework for evaluating legislation that protects consumers from surprise medical bills. Then, as an update to the previous publication, we provide a review of new state legislative actions and relevant updates since July 2019. Additionally, with the onset of COVID-19, we offer some insight into how the pandemic has affected surprise medical bills.

Federal Action on Surprise Medical Bills

At the federal level, Congress was unable to come to an agreement on surprise medical bills by the end of its 2019 session, and the debate over surprise medical bills continued into 2020.

Senate HELP and House Energy and Commerce Compromise[10]

In December 2019, the Senate Health, Education, Labor and Pensions (HELP) committee, along with the House Energy and Commerce committee, came to a legislative agreement on the topic of surprise medical bills. This compromise legislation prohibits balance billing for all emergency services, and it requires that consumers pay only the amount they would have paid for in-network services.

For consumers receiving care from out-of-network providers at in-network facilities, providers may balance bill only if they inform consumers about their network status and provide an estimate of charges 72 hours prior to providing services, and if they obtain consumers' consent to receive the out-of-network care.

The payment methodology includes a benchmark rate set at the market-based, median in-network negotiated rate for the same service in the geographic area. If the benchmark rate is above $750, the parties can elect to go into an independent dispute resolution.

This compromise represents the only bipartisan, bicameral solution to date. There is currently no bill text for this compromise, but a summary is available from the committees.

House Ways and Means (HR 5826) "Consumer Protections Against Surprise Medical Bills Act of 2020"[11]

The House Ways and Means committee proposed a different solution, which would also hold consumers harmless from surprise billing, but it would not have a benchmark payment rate. Instead, the proposal would allow insurers and out-of-network providers to go straight to arbitration.

White House

In 2020, the White House proposed a solution that offers patients complete protection from surprise billing, but the proposal lacks any payment mechanism.[12]

Responding to the COVID-19 Pandemic

In addition, the recent COVID-19 legislative packages failed to include comprehensive consumer protections against surprise billing. While the Department of Health and Human Services (HHS) has placed consumer protections around surprise billing when seeking COVID-19-related care from facilities or providers that receive federal dollars, Americans are still waiting on those statutory protections to become law.[13] Unfortunately, although Congress has passed legislation that would protect consumers from cost-sharing for COVID-19 testing, costs associated with treatment for the virus still expose consumers to the threat of balance billing.

Given the failure of Congress and the administration to pass comprehensive legislation, the clearest path to ensure patients have real protection from surprise medical bills is for states to take action to protect their residents from surprise billing. This is even more important during the COVID-19 crisis. Families USA published an analysis in May 2020 on how states can act to best protect families from surprise bills during the pandemic.[14] In the last two years, a handful of states have stepped into this breach and enacted surprise billing protections, or they have issued guidance on the matter during the COVID-19 pandemic.

Framework for Evaluating State Laws on Surprise Medical Bills

Our approach to reviewing the legislation for state surprise medical bills is straightforward. For legislation to be considered comprehensive, it must:

1. Hold consumers harmless in surprise bill situations, and
2. Offer a payment mechanism by which insurers and out-of-network providers may resolve the cost in a way that would ideally not inflate health care costs.

This brief describes how 2020 state legislation and laws address these factors.

To begin, we discuss Families USA's principles for surprise bill protections, which readers can use as

guidelines to help evaluate how well legislation introduced in 2020 both protects consumers and holds down overall costs.

Principles for Protecting Consumers from Surprise Medicaid Bills

- For care received 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 to which they are referred by in-network providers, including laboratories and diagnostic imaging centers.
- Consumers should not pay more toward their care than their in-network cost-sharing (including copayments, coinsurance, and deductibles) in a surprise billing 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 in advance that care will be out of network and obtained the patient's consent, along with providing projected charges.
- In situations of epidemics or pandemics (for example, COVID-19), consumers should not be balance billed for any costs associated with testing or treatment related to the pandemic.

Principles for Holding Down Costs

- To ensure surprise billing protections do not increase premiums, laws should establish a reasonable payment mechanism for out-of-network providers.
- Payment mechanisms should not inflate costs. Provider's billed charges should not be the basis for — or a factor in — calculating the payment rate. Ideal payment mechanisms should set a standard benchmark payment rate, but if based on an arbitration system, they should prohibit billed charges from consideration.

State-by-State Review of Surprise Medical Billing Laws and Legislation

According to the Commonwealth Fund,[15] 27 states have passed comprehensive consumer protections against surprise medical bills (up from 9 in 2018). In the context of COVID-19, the importance of eliminating surprise medical bills has intensified, leading many additional states to consider taking up legislation. This section summarizes state activity related to surprise medical bills in 2020.

Colorado

During the 2019 legislative session, Colorado adopted HB 19-1174 to protect consumers from balance billing and hold down overall health care costs.[16] This was published in the 2019 state legislation summary.[17] Following passage of HB 19-1174, Colorado issued emergency regulations in December 2019 establishing an arbitration program, payment methodology for ambulance services, and carrier disclosures for out-of-network services.

Consumer Protections in Colorado's Laws

- Bans balance billing in emergency situations (including from out-of-network facilities) and in nonemergency situations at in-network facilities. Balance billing is also prohibited for 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.

» Requires advance notice of out-of-network care and cost implications to be provided to consumers by insurers, providers and facilities.

Payment Mechanism in Colorado's Laws

» Establishes 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 operate 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.

» Triggers 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 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.

Emergency Regulations

The 2019 Colorado law required the Department of Regulatory Agencies, Division of Insurance to promulgate rules on ambulance services and consumer-facing disclosures to explain their rights under the new surprise billing regulations. To meet statutory deadlines, the department released draft emergency regulations during late August/early September of 2019, and they went into effect on December 20, 2019.

- Insurance carriers are required to reimburse out-of-network emergency ambulance services at 275% of the Medicare reimbursement rate in the same geographic area.
  - Consumers will be responsible for any applicable in-network cost-sharing, including deductibles, coinsurance, or copayments.
  - An ambulance service provider must show proof of being a publicly funded fire agency in order to be exempt from these requirements.
- When a consumer receives a surprise bill, the insurance carrier is required to provide a disclosure explaining the consumer's rights under the new surprise billing regulations. Additionally, the insurance carrier must provide the consumer with an explanation of their benefits.

Georgia

Both chambers of the Georgia legislature introduced the Surprise Billing Consumer Protection Act on February 4, 2020. On June 17, the Georgia Senate passed HB 888, sending the bill to Governor Kemp's desk for signature. Governor Kemp signed the bill into law on July 16, 2020 and it is set to take effect on January 1, 2021.[18]

Consumer Protections in Georgia's Law

- Patients are not accountable for surprise billing charges incurred when seeking emergency or nonemergency care. Insurers are required to pay for the medical services regardless of whether the health provider or facility are in-network or out-of-network.
- Patients are not required to pay more than their deductible, coinsurance, copayment, or other cost-sharing determined by their policy.
- If patients consent to receiving out-of-network care prior to their visit, they will pay typical out-of-network charges. In order to be able to balance bill patients, the billing party is required to receive and document both oral and written consumer consent, as well as provide the consumer with an estimate of potential charges.

Payment Mechanism in Georgia's Law

- Establishes benchmark payments.
  - When a patient incurs costs associated with seeking emergency or nonemergency services, the insurer will pay the provider the greater of three possible charges:
    1. The contracted amount paid by eligible insurers to providers furnishing the same or similar services,
    2. The most recent amount agreed to by the insurer and the out-of-network provider for the provision of the same services when they were in network, or
    3. A higher amount deemed appropriate by the insurer given the complexity and circumstances of the services provided.

- Sets up independent dispute resolution.
  - If the provider believes that payment is not sufficient given the complexity and circumstances of the care provided, the provider or facility may request arbitration within 30 days of receipt of payment.
  - Providers, facilities and insurers will have 30 days to reach a good faith agreement. If this does not occur, the dispute escalates to an arbitrator.
  - The arbitrator will consider the complexity and circumstances of each case, including the level of training, education and experience of the provider or facility.
  - The arbitrator will decide within 30 days, and the loser will pay the cost of arbitration.

Maine

On March 18, 2020, Governor Janet Mills signed into law "An Act to Establish Patient Protections in Billing for Health Care" and "An Act to Protect Consumers from Surprise Emergency Medical Bills."[19] Together, these bills provide consumer protection from surprise billing and a payment mechanism for resolution. The bills not only protect insured patients from surprise out-of-network billing, but also offer uninsured patients the ability to dispute bills that are larger than $750.

Consumer Protections in Maine's Laws

- Patients are not accountable for surprise billing charges incurred when seeking emergency or nonemergency care. Carriers are required to pay for the medical services regardless of whether the health provider or facility is in-network or out-of-network.
  - Consumers are required to pay only in-network cost-sharing (including copayments, coinsurance, or deductibles) for surprise bills.
- Providers are required to disclose any referrals they are making to out-of-network services so that patients are aware before they receive said services.
- Health care entities are prohibited from charging patients for transferring their care or medical records unless the costs are directly associated with establishing the patient as a patient of the new health care entity.
- Uninsured patients receiving emergency health care services that total $750 or more can dispute the bill and proceed to an independent dispute resolution process.

Payment Mechanism in Maine's Laws

- Establishes benchmark payments.
  - The carrier shall reimburse the out-of-network provider or facility the greater of:
    1. The carrier's median network rate paid for that health care service by a similar provider in the enrollee's geographic area; or
    2. The median network rate paid to similar providers in the enrollee's geographic area, as determined by the all-payer claims database maintained by the Maine Health Data Organization.
  - A carrier will reimburse an out-of-network provider for ambulance services that are covered under emergency services at the out-of-network provider's rate, unless the carrier and out-of-network provider agree otherwise.

- Triggering independent dispute resolution.
  - If an out-of-network provider disagrees with a carrier's payment amount for emergency services, the carrier and out-of-network provider have 30 days to reach a good faith agreement on payment.
  - If the carrier and provider do not reach an agreement within 30 days, the provider may submit a dispute regarding the payment.
  - The arbitrator will make a decision regarding charges within 30 days of receiving the dispute for review.
  - The arbitrator shall consider the circumstances of the case, including (1) the provider's training and expertise; (2) the previously contracted rate between the parties within the past year, if applicable; and (3) the median in-network rate for the particular health service performed by the provider in the same or similar specialty.
  - In the case that the two parties are either unreasonably extreme or are close to settlement after the 30-day window, the arbitrator may grant 10 additional days to reach a good faith agreement.
  - The loser of the arbitration process must pay for the costs of arbitration. If a good faith negotiation results in settlement, the carrier and provider evenly divide the cost for disputed resolution.
  - If the difference between the out-of-network provider's charge and the median network rate is less than $750, the carrier will reimburse the provider directly as long as the provider's charges do not exceed the 80th percentile of charges for the particular health service performed in the same geographic area.

Oklahoma

In 2020, two bills passed the Oklahoma House that would end surprise medical billing and provide a payment mechanism for dispute: HB 3388 and HB 3483.[20] HB 3483 outlines the consumer protections, and HB 3388 outlines the payment mechanism for out-of-network surprise billing. Both bills died, as they did not receive a vote in the Oklahoma Senate before it adjourned on May 22, 2020.

Consumer Protections in Oklahoma's Laws

- Consumers would be held harmless from surprise billing charges in certain scenarios including: (1) when the patient is at an in-network facility and does not have the ability to choose a participating provider to perform the needed services, and (2) the patient requires medically necessary care that is unavailable within a health plan's network.
- Consumers seeking emergency care from out-of-network providers or out-of-network facilities would pay the same as they do for in-network emergency benefits.
- Providers and facilities would be required to provide patients with written disclosure prior to scheduled services that they may be out of the patient's network. This disclosure must include an estimation of the range of possible charges.
- Every health facility licensed in the state would be required to provide patients with a list of all the health insurance carriers that contract with the facility.

Payment Mechanism in Oklahoma's Laws

- Establishing benchmark payments.
  - Health plans would pay the provider for the services provided the greater of:

1. The Medicare rate;
2. The in-network rate;
3. The usual, customary and reasonable rate (UCR); or
4. An agreed upon rate.

› In the case of an out-of-network surprise bill incurred at an in-network facility, the insurer would pay the out-of-network provider the UCR or an agreed upon rate.

» Sets up independent dispute resolution.

› Providers could dispute this payment via an arbitration process if the provider deems the UCR unreasonable and the health benefit claim is for out-of-network care.

› After filing the arbitration claim, the parties would have 30 days to reach a good faith settlement.

- If this does not occur, the arbitrator would make a determination that takes into consideration a number of factors:
  * Disparities in billing by the out-of-network provider or facility,
  * Fees paid to the out-of-network provider or facility,
  * The level of training and expertise of the provider,
  * The out-of-network provider's usual billed charge for comparable services,
  * The circumstances and complexity of a consumer's case,
  * Enrollee characteristics,
  * Medical journals and peer-reviewed articles,
  * Percentiles of out-of-network billed charges for the same service in the same geographic locations,
  * The UCR,
  * The history of network contracting between the parties, and
  * The offers made by parties in dispute.

» No later than 51 days after filing for independent dispute resolution, the arbitrator would provide the written decision.

Virginia

In early March 2020, Virginia passed balance billing legislation. Governor Ralph Northam signed SB 172 and HB 1251 (identical bills) into law. These laws will go into effect on January 1, 2021.[21]

Consumer Protections in Virginia's Laws

» When an enrollee receives emergency services from an out-of-network health care provider or receives out-of-network surgical or ancillary services at an in-network facility, the enrollee is not required to pay the out-of-network provider any amount other than the applicable cost-sharing requirement.

» In addition, such cost-sharing requirement cannot exceed the cost-sharing requirement for an enrollee's in-network services.

Payment Mechanism in Virginia's Laws

» The health insurance carrier will pay the out-of-network provider the commercially reasonable amount based on payments for the same or similar services provided in the same geographic area.

- If the provider decides to dispute the payment amount, the carrier and the provider have 30 days to make a good faith effort to reach a resolution. If they are unable to do so, arbitration is the next step.
- The arbitrator will consider three factors to determine the appropriate rate:
  - The evidence and methodology submitted by the parties asserting their final offers,
  - Patient characteristics and the circumstances and complexity of the case, and
  - Any other information that a party believes is relevant to the case.
- Fees associated with arbitration will be divided equally among the parties of arbitration.
- The arbitrator has 30 days to provide their final offer to the initiating party.

Summary Chart of State Surprise Billing Legislation in 2020

State	Legislative Activity	Brief Description	Status
Colorado	**HB 19-1174** Out-of-Network Health Care Services	Comprehensive legislation that protects patients from surprise bills	Legislation enacted
	19-E-05, 19-E-06, and 19-E-07 Emergency regulations	Emergency regulations protect consumers from surprise ambulance billing and provide payment mechanism for surprise billing	Regulations enacted
Georgia	**HB 888** Surprise Billing Consumer Protection Act	Comprehensive legislation that protects patients from surprise bills and includes a payment mechanism	Legislation passed and will be enacted on January 1, 2021

State	Legislative Activity	Brief Description	Status
Maine	**LD 2111** An Act to Establish Patient Protections in Billing for Health Care	Comprehensive pieces of legislation that both protect patients from surprise bills and provide a payment mechanism	Both pieces of legislation have been enacted
	LD 2105 An Act to Protect Consumers from Surprise Emergency Medical Bills	Includes a provision to protect patients from surprise billing by ambulance services	
Oklahoma	**HB 3388** Oklahoma Out-Of-Network Surprise Billing and Transparency Act	Comprehensive pieces of legislation that both protect patients from surprise bills and provide a payment mechanism	Both pieces of legislation passed the House but died in the Senate
	HB 3483 Oklahoma Surprise Billing Protection Act		
Virgina	**HB 1251 & SB 172** (companion bills)	Comprehensive legislation that protects patients from surprise bills and provides a payment mechanism	Legislation passed and will be enacted on January 1, 2021

Conclusion

With a federal legislative solution to surprise medical billing stalled, it is up to states to protect consumers from this devastating loophole in health care payments. States are implementing several mechanisms to ensure the wellbeing and financial security of their residents. This updated guide highlights some of the most promising approaches that states are pursuing. It is our hope that these models will serve as a resource for more states to pass their own comprehensive protections until the federal government acts.

As always, Families USA is available as a resource for state lawmakers or advocates who are developing policies and approaches to address surprise medical billing.

Endnotes

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