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# MEDICAL BALANCE BILLING: INADEQUATE REGULATIONS, INCREASING CONSUMER OUTRAGE, AND COMPETING ECONOMIC INTERESTS – HOW DO WE FIX IT?

By Christine O’Neill

## I: Introduction

Healthcare spending in the United States topped \$2.9 trillion dollars in 2013, with per capita healthcare spending at approximately \$9,255.<sup>1</sup> Industry experts have many explanations for such high costs, including excessive administrative outlays. Americans also pay higher prices for care and receive more healthcare than citizens in many other developed countries.<sup>2</sup> Because of the high cost burden and amount of care received, unpaid medical bills add up extremely quickly.<sup>3</sup> High medical bills do not discriminate, they affect both the insured and uninsured, and are the leading cause of bankruptcy in the United States, surpassing both credit card debt and unpaid mortgages.<sup>4</sup>

Aside from bankruptcy, CNBC estimated that 20 percent of the population between ages nineteen and sixty-four struggled to pay their medical bills in 2013.<sup>5</sup> According to the Centers for Disease Control and Prevention (“CDC”), that estimate is conservative.<sup>6</sup> The CDC found that more than one in four families faced the financial burden of funding

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<sup>1</sup> Centers for Medicare & Medicaid Services, *National Health Expenditure Data*, (last modified Dec. 9, 2014, 6:26AM), <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>.

<sup>2</sup> David Cutler, *Why does health care cost so much in America? Ask Harvard’s David Cutler*, PBS NEWSHOUR (Nov. 19, 2013), <http://www.pbs.org/newshour/rundown/why-does-health-care-cost-so-much-in-america-ask-harvards-david-cutler/>.

<sup>3</sup> Dan Mangan, *Medical Bills Are the Biggest Cause of US Bankruptcies: Study*, CNBC (Jun. 25, 2013), <http://www.cnbc.com/id/100840148#>.

<sup>4</sup> *Id.*

<sup>5</sup> *Id.*

<sup>6</sup> Centers for Disease Control, and Prevention *Financial Burden of Medical Care: A Family Perspective*, (last modified Jan. 28, 2014), <http://www.cdc.gov/nchs/data/databriefs/db142.htm>.

medical care.<sup>7</sup> Further, one in six families had trouble paying medical bills in the past year and one in ten were unable to pay *at all*.<sup>8</sup>

The prevalence of medical debt can be partially attributed to the difficulty and confusion that befalls consumers when initially selecting health insurance coverage.<sup>9</sup> Consumers tend to believe that once they secure medical insurance they will be protected against unmanageable financial outlays from either everyday medical issues or life-changing accidents and illnesses.<sup>10</sup> Unfortunately, that is not always the case.<sup>11</sup> In fact, a sizeable number of consumers do not understand how insurance plans operate, exactly what they cover, and which providers are within their covered network.<sup>12</sup> When Massachusetts opened its online insurance exchange in 2007, as many as 40 percent of users found the cost information unclear or difficult to understand.<sup>13</sup> This problem has yet to be completely solved. US Consumers struggle with insurance and billing literacy with critics calling the new changes to the healthcare system under the Affordable Care Act (ACA), “...obscure, scary, and downright befuddling.”<sup>14</sup>

Although the controversial law may be unclear, it has considerably expanded insurance coverage and is projected to save hospitals \$5.7 billion dollars in previously

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<sup>7</sup> *Id.*

<sup>8</sup> *Id.*

<sup>9</sup> Sarah Kliff, *Buying Health Coverage is Insanely Confusing, Can Obamacare Fix That?*, THE WASHINGTON POST (Jan. 30, 2013), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/01/30/buying-health-coverage-is-insanely-confusing-can-obamacare-fix-that/>.

<sup>10</sup> Tricia Spencer, *Balanced Billing is the Ugly Beast of Medical Insurance*, Huffington Post Business Blog (Aug. 4, 2014, 5:59AM), [http://www.huffingtonpost.com/tricia-spencer/balanced-billing-is-the-obamacare\\_b\\_5419026.html](http://www.huffingtonpost.com/tricia-spencer/balanced-billing-is-the-obamacare_b_5419026.html).

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*

<sup>13</sup> *Id.*

<sup>14</sup> Olga Khazan, *Why People Find Obamacare so Confusing*, THE ATLANTIC (Jan. 2, 2014), <http://www.theatlantic.com/health/archive/2014/01/why-people-find-obamacare-so-confusing/282747/>.

uncompensated hospital care (referred to as write-offs or charity care).<sup>15</sup> Under the long-standing federal Emergency Medical Treatment and Labor Act (EMTALA), patients have already been guaranteed access to emergency medical care regardless of ability to pay.<sup>16</sup> The United States government has successfully increased overall access to care and guaranteed patient care in emergencies, but what happens after patients actually receive that lifesaving care and the bills start rolling in?

The answer to this question differs by state and gives rise to a nationwide dilemma known as balance billing – often referred to as the “black scourge” of the insurance industry – that patients now face.<sup>17</sup> Balance billing occurs when a hospital or individual physician attempts to collect from the patient the difference between what the hospital or physician originally billed and what the patient’s health plan actually paid for the care.<sup>18</sup> Another explanation is that a physician or hospital will accept some level of reimbursement from an insurer and then bill the patient above that amount to bring in extra revenue.<sup>19</sup>

Some critics argued that the ACA would contribute to increases in these surprise balance bills, because some plans sold through the ACA’s health insurance marketplaces only cover in-network care, or fail to disclose payment policies when physicians, nurses,

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<sup>15</sup> Robert Pear, *Affordable Care Act Reduces Costs for Hospitals, Report Says*, THE NEW YORK TIMES, (Sep. 24, 2014), [http://www.nytimes.com/2014/09/25/us/health-act-cuts-spending-at-hospitals-report-finds.html?emc=edit\\_tnt\\_20140924&nlid=58462464&tntemail0=y&r=1](http://www.nytimes.com/2014/09/25/us/health-act-cuts-spending-at-hospitals-report-finds.html?emc=edit_tnt_20140924&nlid=58462464&tntemail0=y&r=1); See also Ziva Branstetter, Clifton Adcock, & Curtis Killman, *Hospitals Spend Small Fractions of Revenue on Charity Care*, OKLAHOMA WATCH, (Nov. 1, 2013), <http://oklahomawatch.org/2013/11/01/hospitals-spend-small-fractions-of-revenue-on-charity-care/> (using Oklahoma hospitals as an example of how hospitals only spend a fraction of what they claim on charity care).

<sup>16</sup> 42 USCS § 1395dd.

<sup>17</sup> Spencer, *supra* note 10.

<sup>18</sup> Michelle Andrews, *Beware of Higher Charges if You Go to an Out-of-Network Emergency Room*, KAISER HEALTH NEWS (Aug. 29, 2014), <http://www.kaiserhealthnews.org/stories/2014/august/29/beware-of-higher-charges-if-you-go-to-an-out-of-network-emergency-room.aspx?referrer=search>.

<sup>19</sup> *Id.*

and other medical professionals fall outside a patient's insurance network.<sup>20</sup> However, recent statistics have indicated that the ACA has had a significant impact on affordability overall.<sup>21</sup> The Commonwealth Fund's Biennial Health Insurance survey showed that "[i]n 2014, insured adults ... reported fewer problems getting care because of concerns about costs for the first time since 2005," suggesting long-awaited gains in affordability of healthcare.<sup>22</sup>

The authors of the Commonwealth Fund's survey attribute the increased affordability of care to the ban on coverage discrimination for those with preexisting conditions, essential health benefit package guarantees, and the improving economy.<sup>23</sup> Although these are promising indicators, questions remain about whether this trend of affordability of healthcare will continue. Additionally, it is unclear whether the aforementioned factors will somehow help eliminate balance billing. Some of the states are not convinced and have taken action individually because there are no concrete projections of affordability in years to come.<sup>24</sup>

Despite isolated state action, the United States requires a widespread solution to help patients cope with often crushing medical debt. It is simply unacceptable that 35 percent of Americans are still struggling to pay medical bills in 2014.<sup>25</sup> This note will

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<sup>20</sup> Abby Goodnough, Reed Abelson, & Anemona Hartocollis, *Has Insurance Under the Law Been Affordable?*, THE NEW YORK TIMES, (Oct. 26, 2014), <http://www.nytimes.com/interactive/2014/10/27/us/is-the-affordable-care-act-working.html?module=Search&mabReward=relbias%3Ar%2C%7B%22%22%3A%22RI%3A15%22%7D&r=0#/>.

<sup>21</sup> Sara R. Collins, Petra W. Rasmussen, Michelle M. Doty, & Sophie Beutel, *The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014*, The Commonwealth Fund, (Jan. 2015), [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/jan/1800\\_collins\\_biennial\\_survey\\_brief.pdf?la=en](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/jan/1800_collins_biennial_survey_brief.pdf?la=en).

<sup>22</sup> *Id.* at 4.

<sup>23</sup> *Id.* at 4.

<sup>24</sup> Mangan, *supra* note 3.

<sup>25</sup> Collins, *supra* note 21, at 5.

explore existing and proposed solutions to the balance billing dilemma and proceeds as follows. Part II explains the history of balance billing, explores the ongoing ‘real’ cost debate within the healthcare industry, and recent case law. Part III examines potential policy levers, which are currently being used to regulate balance billing or which have been discussed as possible solutions. Part IV concludes.

## **II: Background**

### **A. Compensation: How Much Money Do Physicians Actually Receive?**

At first glance, the concept of balance billing may seem cruel and unfair to some – how can providers justify billing patients for such seemingly high amounts?<sup>26</sup> Some argue that physician compensation is the culprit here, either because physicians receive too much money or because they receive too little from Medicare and Medicaid and balance bill other patients to make ends meet.<sup>27</sup> Many physicians tend to argue the latter as evidenced by Medscape’s annual surveys in both 2011 and 2012, 49 percent of physicians surveyed stated they were not fairly compensated for their services.<sup>28</sup>

Physician compensation is such a complicated area that the Centers for Medicare and Medicaid Services (“CMS”) does not even compile statistics on the topic.<sup>29</sup> CMS compiles statistics for Medicare, Medicaid, and Physician and Clinical Services separately, yet does not indicate overall physician compensation, which would be some combination

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<sup>26</sup> See Health Access Blog, *Victory at the Supreme Court!*, (Jan. 8, 2009), <http://www.health-access.org/blog/labels/balancebilling.htm> (referring to balance billing as an unfair practice).

<sup>27</sup> Louis Goodman & Tim Norbeck, *Who’s To Blame For Our Rising Healthcare Costs?*, FORBES, (Oct. 3, 2013, 7:30PM), <http://www.forbes.com/sites/physiciansfoundation/2013/10/03/whos-to-blame-for-our-rising-healthcare-costs/>.

<sup>28</sup> Medscape Physician Compensation Report: 2012 Results, Medscape, (2012), <http://www.medscape.com/features/slideshow/compensation/2012/public> (Medscape is a resource for physicians for CME’s, clinical trial information, drug updates, journal articles, etc.).

<sup>29</sup> Centers for Medicare & Medicaid Services, *NHE Fact Sheet*, (last Modified Dec. 3, 2014 3:15 PM), <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html>.

of all three categories.<sup>30</sup> According to private data analysts, total physician compensation estimates range from about 7 percent to 10 percent of total healthcare spending in the United States.<sup>31</sup> Despite receiving a low level of compensation relative to overall healthcare spending, individual physicians are still responsible for running offices with very expensive administrative costs as a result of managing billings, filing insurance claims, and managing patient treatment plans and prescriptions.<sup>32</sup> Ultimately, even though critics claim physician compensation levels are a major contributor to national healthcare costs, they are not likely the primary or even secondary driver behind the overall increase in healthcare costs in recent years.<sup>33</sup>

Physician compensation may not be a major cause of escalating costs overall, but balance billing still contributes to individual patient cost responsibilities. So why do physicians engage in it? A number of physicians cite the nature of the market as one of the main justifications for engaging in balance billing.<sup>34</sup> Unlike other industries like retail clothing stores or automobile dealerships, physicians are unable to compete in the same manner on price and quality because of third party private insurers and Medicare,

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<sup>30</sup> *Id.*

<sup>31</sup> See Physician Compensation Eight Percent of Healthcare Costs, Jackson Healthcare, (May 26, 2011), <http://www.jacksonhealthcare.com/media-room/news/md-salaries-as-percent-of-costs/#sthash.d2yI3NiR.dpuf>; Louis Goodman & Tim Norbeck, *Who's To Blame For Our Rising Healthcare Costs?*, FORBES, (Oct. 3, 2013, 7:30PM), <http://www.forbes.com/sites/physiciansfoundation/2013/10/03/whos-to-blame-for-our-rising-healthcare-costs/>.

<sup>32</sup> Louis Goodman & Tim Norbeck, *Who's To Blame For Our Rising Healthcare Costs?*, FORBES, (Oct. 3, 2013, 7:30PM), <http://www.forbes.com/sites/physiciansfoundation/2013/10/03/whos-to-blame-for-our-rising-healthcare-costs/>.

<sup>33</sup> *Id.* See also The Return on Investment for Law, Business, and Medical School, *The Stopped Clock*, (May 27, 2013), <http://thestoppedclock.blogspot.com/2013/05/the-return-on-investment-for-law.html> (discussing the ongoing debate on the ROI for medical degrees based on time spent in training and lifetime salary).

<sup>34</sup> Lucy Hornsetin, *Understanding balance billing, a primer for patients*, (Jul. 21, 2010), <http://www.kevinmd.com/blog/2010/07/understanding-balance-billing-primer-patients.html>.

Medicaid, and other government payers..<sup>35</sup> Rather than negotiating with individual patients for payment, physicians sign a contract to ‘participate’ in an insurers network or with the Medicare and Medicaid programs and receive less than their regular fee to see enrolled patients.<sup>36</sup> Physicians critical of the existing reimbursement system often ask how other professionals would react if they only received 50 or 75 percent of their original bill or if consumers were able to pay thirty dollars for groceries and walk out with eighty dollars worth of product.<sup>37</sup>

Instead of joining insurance company networks and balance billing on their own, a minority of physicians have converted their practices to all cash to avoid the administrative hassle and overhead costs.<sup>38</sup> Some of these all-cash physicians cater to wealthier patients, while others charge an affordable monthly fee to maintain their patient base.<sup>39</sup> Justifications vary by individual physician, but some interviewed for a *New York Times* article, cited lower overhead and an ability to provide more personalized care to patients as significant reasons for converting to a cash-only practice.<sup>40</sup> Other justifications include making more money and avoiding what physicians consider convoluted billing requirements.<sup>41</sup> If the move to all cash medical care substantially increases, patients could potentially be priced out of receiving adequate care and Medicare and Medicaid enrollees would be unable to use their coverage.<sup>42</sup>

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<sup>35</sup> *Id.*

<sup>36</sup> *Id.*

<sup>37</sup> *Id.*

<sup>38</sup> *Id.*

<sup>39</sup> Paul Sullivan, *Dealing with Doctors Who Take Only Cash*, THE NEW YORK TIMES, (Nov. 23, 2012), <http://www.nytimes.com/2012/11/24/your-money/dealing-with-doctors-who-accept-only-cash.html?pagewanted=all>.

<sup>40</sup> *Id.*

<sup>41</sup> *Id.*

<sup>42</sup> *Id.*

From a physician's perspective, starting a cash practice presents a dilemma of whether to accept some insurance or none at all and can create greater demands on the physician's time.<sup>43</sup> Only a small percentage, about 4 to 6 percent of American physicians have transitioned to an all-cash model, but it is more common in metropolitan areas and in fields that require highly specialized treatment.<sup>44</sup> Ultimately, the federal government and individual states need to balance the economic needs of physicians with those of patients when addressing insurance regulations and balance billing. It will be important for the government to keep in mind the risk of more physicians choosing to make the jump to an all cash practice.

### **B. Real Costs of Care vs. The Number on the Medical Bill**

Both hospitals and physicians are quick to claim that their costs warrant their general and balance bills – but that can be difficult to establish. Resources like the Healthcare Bluebook allow patients to determine fair market prices in their region for any treatment including a procedure to implant a cardiac stent and the price of prescription asthma medication.<sup>45</sup>

It is unclear how market prices actually influence the rates that hospitals charge patients. According to one economist, there are major price differences, and hospital pricing is, “basically arbitrary and not connected to underlying costs or market prices [hospitals] can set them at any level they want. There are no market constraints.”<sup>46</sup> The

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<sup>43</sup> *Id.*

<sup>44</sup> Steve Hargreaves, *Cash-only doctors abandon the insurance system*, CNN Money, (Jun. 11, 2013), <http://money.cnn.com/2013/06/11/news/economy/cash-only-doctors/>.

<sup>45</sup> HEALTHCARE BLUEBOOK, [https://healthcarebluebook.com/page\\_Default.aspx](https://healthcarebluebook.com/page_Default.aspx), (last visited Nov. 14, 2014).

<sup>46</sup> Elizabeth Rosenthal, *As Hospital Prices Soar, a Stitch Tops \$500*, THE NEW YORK TIMES, (Dec. 2, 2013), <http://www.nytimes.com/2013/12/03/health/as-hospital-costs-soar-single-stitch-tops-500.html?src=un&feedurl=http%3A%2F%2Fjson8.nytimes.com%2Fpages%2Fhealth%2Findex.jsonp>.

Healthcare Bluebook lists \$3,676 as an appropriate national price for a knee arthroscopy.<sup>47</sup> However in northern New Jersey, that price rises to \$4,144 and in Manhattan, prices are even higher at \$4,209.<sup>48</sup> Las Vegas, Nevada and Providence, Rhode Island fall considerably closer to the national average at \$3,888 and \$3,776 respectively.<sup>49</sup> This price disparity occurs for many items from Tylenol with codeine administered in a hospital to intravenous fluids to surgical procedures.<sup>50</sup> Ultimately, these cost disparities are usually attributed to regional cost differences, the incorporation of hospital or physician administrative costs into prices, and the need to purchase new technology.<sup>51</sup> However, cost disparities make it difficult to figure out the true cost of an item or medical service itself.

Hospitals often claim that price disparities occur because the hospitals require highly trained professionals available year-round and constant upgrades to the latest equipment and building standards to meet regulations and patient expectations.<sup>52</sup> The truth exists somewhere between hospitals and physicians overpricing care to increase profits and being forced to raise rates above market in order to stay afloat and on par technologically. Hospitals have overhead, expenses, and charity care amounts that may not be entirely covered by their regular revenue streams. But does that warrant charging over thirty-six

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<sup>47</sup> HEALTHCARE BLUEBOOK, [https://healthcarebluebook.com/page\\_ProcedureDetails.aspx?id=39&dataset=MD&g=Knee+Arthroscopy](https://healthcarebluebook.com/page_ProcedureDetails.aspx?id=39&dataset=MD&g=Knee+Arthroscopy), (last visited Jan. 22, 2014). For an example of vast pricing disparities look at pricing for a knee arthroscopy, where a camera is used to see inside the knee.

<sup>48</sup> HEALTHCARE BLUEBOOK, [https://healthcarebluebook.com/page\\_ProcedureDetails.aspx?id=39&dataset=MD&g=Knee+Arthroscopy](https://healthcarebluebook.com/page_ProcedureDetails.aspx?id=39&dataset=MD&g=Knee+Arthroscopy), (last visited Jan. 22, 2014) (using 07640 and 10026 as specific zip code searches).

<sup>49</sup> *Id* (using zip codes 89101 and 02908 zip code searches).

<sup>50</sup> Rosenthal *supra*, note 46.

<sup>51</sup> Steven Novella, *Disparities in Regional Healthcare Costs*, (Mar. 21, 2012), <http://www.sciencebasedmedicine.org/disparities-in-regional-health-care-costs/>.

<sup>52</sup> Rosenthal *supra*, note 46.

dollars for a pill that costs fifty cents outside the hospital?<sup>53</sup> It might be easier for patients to accept their medical bills as a fair price for services received if they actually knew how hospitals or individual physicians reached those amounts. As it stands now, patients are unable to ascertain the true cost of the treatment they are going to or have already received and the lack of transparency in price calculations makes patients distrustful of the healthcare system.

### **C. Why Regulate Balance Billing?**

The main justification for balance billing prohibitions is protecting patients from excessive billing and medical debt, and preventing non-notification of network status. In excessive billing cases, a provider bills a patient for an additional amount it is not entitled to claim after being reimbursed by an insurer (if it has a network contract) or by Medicare or Medicaid.<sup>54</sup> Economists and patient advocates estimate that patients pay up to \$1 billion or more annually for bills they are not actually required to pay for fear of having bill collectors knocking on their doors.<sup>55</sup> Another issue is non-notification – patients cannot opt to choose a different physician or hospital if they are uninformed about the network status of a physician who has entered their room or simply looked at their file.

Additionally, emergency circumstances may prevent patients from selecting their care location. One recent case in Wisconsin involved the transportation of a heart attack victim to the *nearest* hospital for emergency treatment as state law mandates.<sup>56</sup> Unfortunately, the nearest hospital was out of the patient's network, so she was left with

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<sup>53</sup> *Id.*

<sup>54</sup> Chad Terhune, *Medical Bills You Shouldn't Pay*, BLOOMBURG BUSINESSWEEK MAGAZINE, (Aug. 27, 2008), <http://www.businessweek.com/stories/2008-08-27/medical-bills-you-shouldnt-pay>.

<sup>55</sup> *Id.*

<sup>56</sup> CBS News, *Out-of-network hospital care lands woman \$300K bill*, CBS INTERACTIVE INC., (Nov. 13, 2014, 7:13AM), <http://www.cbsnews.com/news/wisconsin-woman-sent-to-out-of-network-hospital-faces-hundreds-of-thousands-in-bills/>.

more than \$300,000 in balance bills, even though a hospital only three blocks away would have provided her care in-network with final costs of about \$1,500.<sup>57</sup> There are countless cases like this where a patient secured health insurance to protect themselves in routine and emergency cases only to find simply having a policy was not enough. One health care advocate expressed disdain for the current system and said the Wisconsin ambulance patient did everything right except have a heart attack.<sup>58</sup> Clearly, current state practices intend to get patients the care they need, but the way they achieve that goal has left patients at an extreme disadvantage when the bills start pouring in.

As physicians have attempted to increase their overall reimbursements, some have engaged in what industry analysts have coined “drive-by doctoring.”<sup>59</sup> Drive-by doctoring occurs when out-of-network physicians or other medical professionals assist the primary physician assigned to a case and then charge their full fees for their participation in the procedure.<sup>60</sup> These additional assistants are often brought in after a patient is sedated and has no opportunity to inquire about their network status or why they were necessary to successfully perform the procedure.<sup>61</sup>

Insurance companies experience similar disadvantages for reimbursement purposes. An insurer cannot argue the additional practitioner was not medically necessary or that an in-network substitute could have been used when the company did not have a representative present to ask questions on the insurer’s behalf.<sup>62</sup> Whatever fees the insurer

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<sup>57</sup> *Id.*

<sup>58</sup> *Id.*

<sup>59</sup> Nicolas Bagley, *Is drive-by doctoring legal?*, THE INCIDENTAL ECONOMIST BLOG, (Sep. 24, 1:36PM), <http://theincidentaleconomist.com/wordpress/is-drive-by-doctoring-legal/>.

<sup>60</sup> *Id.*

<sup>61</sup> *Id.*

<sup>62</sup> *Id.*

declines to pay are then passed on to patients in the form of balance bills.<sup>63</sup> This practice may sound outlandish, but it is very real and completely legal in a majority of states.<sup>64</sup> Increased regulation of balance billing would also help discourage providers from bringing in additional practitioners unless their services were absolutely necessary because their reimbursement potential would be limited to in-network rates. In order to keep costs at a reasonable level and best protect patients, balance billing for assistant providers should be limited.

#### **D. Medicare and Medicaid Balance Billing Prohibitions**

Because of federal regulation, balance billing is a problem that only affects enrollees in private insurance plans. Medicare does not allow any type of balance billing for its Part A [hospital insurance] and Part B [medical insurance] enrollees including coinsurance, deductibles, or copayments.<sup>65</sup> For Part C [Medicare Advantage] enrollees, out of pocket costs differ by plan because each plan is offered by a private company and individuals select their own plan from a list offered by Medicare.<sup>66</sup> In short, balance billing can be permissible based on the terms of the plan.<sup>67</sup> The courts have upheld this prohibition

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<sup>63</sup> *Id.*

<sup>64</sup> See Tara Siegel Bernard, *Out of Network, Not by Choice, and Facing Huge Health Bills*, THE NEW YORK TIMES, (Oct. 18, 2013), <http://www.nytimes.com/2013/10/19/your-money/out-of-network-not-by-choice-and-facing-huge-health-bills.html?pagewanted=all&r=0>. (Examining the story of a premature newborn with over 60 bills and over \$10,000 in out-of-pocket costs); See also Elizabeth Rosenthal, *After Surgery, Surprise \$117,000 Medical Bill from Doctor He Didn't Know*, THE NY TIMES, (Sep. 20, 2014), [http://mobile.nytimes.com/2014/09/21/us/drive-by-doctoring-surprise-medical-bills.html?\\_r=2](http://mobile.nytimes.com/2014/09/21/us/drive-by-doctoring-surprise-medical-bills.html?_r=2). (Telling the story of a patient who received neck surgery and also a \$117,000 bill from an assistant out-of-network surgeon he had never met and a woman who was billed over \$250,000 by two plastic surgeons who sewed her back up after surgery); *State Restriction Against Providers Billing Managed Care Enrollees*, KAISER FAMILY FOUNDATION, <http://kff.org/private-insurance/state-indicator/state-restriction-against-providers-balance-billing-managed-care-enrollees/> (last visited Nov. 12, 2014).

<sup>65</sup> 42 USCS § 1396a.

<sup>66</sup> Centers for Medicare & Medicaid Services, *Official U.S. Government Site for Medicare*, (last accessed Mar. 9, 2015) <http://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/how-medicare-advantage-plans-work.html>.

<sup>67</sup> *Id.*

and indicated that hospitals cannot manipulate distraught patients or next of kin and prevent them from entering into contracts of adhesion promising to pay costs above what Medicare covers.<sup>68</sup> Similar to Medicare, courts have also upheld Medicaid prohibitions on balance billing above authorized copayments in recent years.<sup>69</sup>

The ACA did not include a blanket prohibition against balance billing by out-of-network providers. However, it did include some restrictions for non-grandfathered health plans - including Health Maintenance Organizations [“HMOs”] and Preferred Provider Organizations [“PPOs”].<sup>70</sup> The relevant restrictions state that both HMOs and PPOs are required to cover the cost of emergency services regardless of whether a provider participates in the plan’s network.<sup>71</sup> Additionally, the organizations are required to provide out-of-network providers with the same compensation they would typically have applied to an in-network provider.<sup>72</sup> The ACA guarantees payment for the out-of-network providers responsible for providing emergency care but does not prohibit the additional billing of patients in non-emergency cases.<sup>73</sup> The ACA thus allows patients to seek emergency treatment out-of-network and only be responsible for typical co-payment and co-insurance amounts that would have applied at an in-network provider.<sup>74</sup>

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<sup>68</sup> See *Valley Hosp. v. Kroll*, 368 N.J. Super. 601, 847 A.2d 636 (Super. Ct. Ch. Div. 2003) (granting summary judgment where a wife asserted she was not responsible for balance billing of her husband’s care under Medicare statute 42 U.S.C.S. § 1395cc(a)(1)(A)).

<sup>69</sup> See *Smallwood v. Cent. Peninsula Gen. Hosp.*, 151 P.3d 319 (Alaska 2006) (Court held that the hospital must ensure its invoices do not exceed authorized Medicaid copay amounts); see also *West v. Shelby County Healthcare Corp.*, 2013 Tenn. App. LEXIS 88 (Tenn. Ct. App. Feb. 11, 2013) (reversing a trial court determination that allowed a hospital to hold liens after accepting Medicaid reimbursement).

<sup>70</sup> PATIENT PROTECTION AND AFFORDABLE CARE ACT; ELDER JUSTICE ACT, 111 P.L. 148, Part 1 of 3,124 Stat. 119; *State Restriction Against Providers Billing Managed Care Enrollees*, KAISER FAMILY FOUNDATION (Sep. 25, 2014), <http://kff.org/private-insurance/state-indicator/state-restriction-against-providers-balance-billing-managed-care-enrollees/>.

<sup>71</sup> *Id.*

<sup>72</sup> *Id.*

<sup>73</sup> *Id.*

<sup>74</sup> PATIENT PROTECTION AND AFFORDABLE CARE ACT; ELDER JUSTICE ACT, 111 P.L. 148, Part 1 of 3,124 Stat. 119.

The ACA prohibitions on balance billing only apply to plans created after March 23, 2010 and are not applicable in non-emergency cases but do not clearly establish specific criteria to determine whether a case is an emergency or when an emergency case ends.<sup>75</sup> As a result, many questions remain regarding the scope and criteria for emergency care and subsequent billing practices. Major news outlets including *The New York Times*, Yahoo! News, and NPR have repeatedly written a slew of articles examining patient concerns associated with emergency care and resulting balance bills.<sup>76</sup> The preceding articles and increasing media coverage indicate the need for additional legislative reform to ensure the affordability of healthcare and elimination of the crushing medical debt that has been piling up as a result of balance bills.

#### **E. Recent Case Law Addressing the Balance Billing Problem**

Although balance billing may seem like a problem to be solved through legislative action or contract negotiation, several cases dissect the practice. This section will discuss some of the most recent and important court cases addressing balance billing and provide an overview of some issues the courts have found to be significant when addressing balance billing claims. Perhaps the most shocking case in recent years occurred in 2013 the state of California brought a case against Dr. Jeannette Martello, a plastic surgeon.<sup>77</sup> The state alleged that Martello had been impermissibly balance billing emergency patients and

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<sup>75</sup> *Id.*

<sup>76</sup> See Carrie Feibel, *Surprise Medical Bills: ER Is In Network, But Doctor Isn't*, NPR, (Nov. 11, 2014), [http://www.npr.org/blogs/health/2014/11/11/363059517/surprise-medical-bills-er-is-in-network-but-doctor-isnt?utm\\_source=facebook.com&utm\\_medium=social&utm\\_campaign=npr&utm\\_term=nprnews&utm\\_content=2036](http://www.npr.org/blogs/health/2014/11/11/363059517/surprise-medical-bills-er-is-in-network-but-doctor-isnt?utm_source=facebook.com&utm_medium=social&utm_campaign=npr&utm_term=nprnews&utm_content=2036) (where a father was hit with a baseball at a little league game and was balanced billed for his ER treatment); See also Elise Sole, *Mother Owes Nearly \$1 Million for Daughter's Birth*, Yahoo! News, (Nov. 19, 2014), <https://www.yahoo.com/parenting/mother-owes-nearly-1-million-for-daughters-birth-103061950107.html> (where a woman bought supplemental insurance while pregnant and was denied coverage for an emergency delivery. The delivery resulted in a bill of almost a million dollars).

<sup>77</sup> *Martello v. Superior Court*, 2014 Cal. App. Unpub. LEXIS 2614, Cal. App. 2d Dist. (Apr. 11, 2014).

having their families sign documents guaranteeing payment in full if their insurance coverage was inadequate.<sup>78</sup> Dr. Martello filed civil lawsuits against patients and their families to recover the remainder of the bills, and tried to force the sale of a family home for a \$9,000 recovery.<sup>79</sup>

Ultimately, the court fined Dr. Martello \$562,500 for balance billing in violation of the Knox-Keene Health Care Service Plan Act of 1975, issued an injunction enjoining her from such billing practices, and sentenced her to five days in jail for violating the injunction.<sup>80</sup> Dr. Martello appealed the jail sentence and succeeded.<sup>81</sup> Additionally, the state medical board placed her medical license on probation for five years as a result of their own investigation into the charges.<sup>82</sup> The case was the first of its kind in California and sent a clear message to physicians and hospitals that predatory billing practices would not be tolerated in the state.

Lawsuits involving balance billing are not limited to enforcement actions by the states. In 2014, the Louisiana Supreme Court ruled that a Blue Cross and Blue Shield of Louisiana (“BCBSL”) insurance policyholder was entitled to sue BCBSL when she was balance billed after visiting an in-network provider.<sup>83</sup> The provider refused to accept her insurance despite having a pre-negotiated contract with BCBSL (they were within the BCBSL network; an “in-network” provider). As a result, she sued the provider and added

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<sup>78</sup> Chad Terhune & Erin Brown, *Doctor Gets Jail Time, \$562,500 Penalty in Improper-Billing Case*, THE L.A. TIMES, (Dec. 6, 2013), <http://articles.latimes.com/2013/dec/06/business/la-fi-mo-doctor-balance-billing-case-20131205>.

<sup>79</sup> *Dr. Jeannette Martello gets five years medical probation for aggressive balance billing*, THE PATHOLOGY BLAWG, (Aug. 20, 2013), <http://pathologyblawg.com/medical-news/balance-billing/jeannette-martello-five-years-medical-probation-aggressive-balance-billing/>.

<sup>80</sup> *Martello*, Cal. App. 2d Dist.; *Supra* note 79. *See also* Cal Health & Saf Code § 1340 (for text of the Knox-Keene Health Care Service Plan Act).

<sup>81</sup> THE PATHOLOGY BLAWG, *supra* note 79.

<sup>82</sup> *Id.*

<sup>83</sup> *Emigh v. W. Calcasieu Cameron Hosp.*, 145 So. 3d 369 (La. 2014).

BCBSL as a defendant for failure to ensure performance of its provider under the contract.<sup>84</sup> Although the final determination of liability has yet to be made in this case, the Supreme Court of Louisiana has effectively held insurers accountable for the billing practices of their contracted providers.

Now, if an insurer in Louisiana contracts with a physician or hospital and that provider declines to accept that insurance at the time of service, patients can now sue the insurer itself for failing to enforce its provider contracts. This is a legal victory for patients in Louisiana because it guarantees them the ability to visit any contracted provider without fear of refusal, and if they are refused, they can recover damages from their insurer. The Louisiana Supreme Court instructed insurers to hold their providers accountable for their negotiated obligations, including ensuring that providers accept the insurance as agreed, abide by the pre-negotiated reimbursement rates, and do not pursue patients for additional payments. This is the first occasion where a Louisiana court allowed a patient to recover from the insurer itself and not just from the provider who violated the contract.

The State of New Jersey has also addressed reimbursement practices and balance billing in its courts. The Watchel Action was a case originally filed in New Jersey state court, removed to federal court in 2001, and [defendant HealthNet] settled for \$261 million in 2008 after seven years of litigation and over one hundred motions.<sup>85</sup> The final case consolidated three related claims into a class action [Watchel] and addressed how providers determined reimbursements for patients who chose to receive care from out-of-network providers.<sup>86</sup> According to the settlement, the insurers were not updating their payments to

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<sup>84</sup> *Id.* at 372-373.

<sup>85</sup> Erin Marie Daly, *Health Net To Pay Up To \$261M to Settle Suits*, LAW 360, (Aug. 8, 2008, 12:00AM), <http://www.law360.com/articles/65653/health-net-to-pay-up-to-261m-to-settle-suits>.

<sup>86</sup> *Id.*

out-of-network providers within sixty days of new “usual, customary, and reasonable” charge calculations as required by New Jersey insurance regulation.<sup>87</sup> As a result, the providers impermissibly balance billed patients considerably higher amounts because they neglected to deduct prior reimbursement from the insurer.<sup>88</sup>

HealthNet, [the defendant in the *Watchel Action*] was also subpoenaed in New York state in 2008 along with sixteen other insurers as part of a probe into how health insurance companies calculate how much to reimburse patients when they use out-of-network doctors.<sup>89</sup> Then-Attorney General, Andrew Cuomo subpoenaed several major insurers including HealthNet, WellPoint, UnitedHealth Group, etcetera largely to determine the influence profit margins were having on patient care.<sup>90</sup> Essentially, Cuomo argued that insurance companies were secretly ranking physicians, and sending patients to lower ranked physicians to ensure they could pay lower reimbursement rates.<sup>91</sup> The investigation resulted in New York insurers agreeing to disclose how doctors are ranked, using established national standards to measure quality and providing a way for consumers to register complaints about the system.<sup>92</sup> Ultimately, the 2008 probe was a stepping-stone toward more patient protections in New York state, including the balance billing legislation passed in 2014.

Other recent cases have taken an approach similar to *Watchel* and addressed how insurers calculate what they are willing to pay out-of-network providers and in turn how

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<sup>87</sup> *Id.*

<sup>88</sup> *Id.*

<sup>89</sup> *Id.*

<sup>90</sup> *N.Y. Attorney General to Sue Health Insurer, Probe the Industry*, BLOOMBERG NEWS, (Feb. 13, 2008), <http://www.bloomberg.com/news/articles/2008-02-13/ny-attorney-general-to-sue-health-insurer-probe-the-industry>.

<sup>91</sup> *Id.*

<sup>92</sup> *Id.*

much of the balance patients will be responsible for paying.<sup>93</sup> The issue is not specific to one or even a few states, and several courts have taken a stand to ensure patients are being balance billed only after providers have received proper reimbursement from their insurers. Unless legislative action is taken on a federal or state-by-state basis to remedy concerns of fairness in balance billing, plaintiffs will certainly bring more of these cases

### **III: Potential Policy Levers to Combat Balance Billing**

Depending on an individual's professional background or their politics, every individual may cite different solutions to the balance billing dilemma. The following section discusses the major policy levers being used to address the issue in different states and their respective results when available.

#### **A. Universal Healthcare – A Single Payer System**

Single-payer national health insurance, often referred to as universal healthcare or socialized medicine, is a system where, “a single public or quasi-public agency delivers health care financing with healthcare delivery remaining largely in private hands.”<sup>94</sup> Under a single payer system, patients would receive medical care without paying individual premiums because program costs would be drawn from taxes and efficiency savings.<sup>95</sup>

Political unpopularity will likely prevent a single payer system from being instituted in the United States for the foreseeable future. Originally, the ACA included a Medicare expansion to include citizens under age 65, which was later stripped from the bill

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<sup>93</sup> See *Franco v. Conn. Gen. Life Ins. Co.*, 818 F. Supp. 2d 792 (D.N.J. 2011) (granting in part several motions to dismiss claims asserting CIGNA used a flawed database to determine reimbursement rates for out-of-network services).

<sup>94</sup> *What is Single Payer?*, PHYSICIANS FOR A NATIONAL HEALTH PROGRAM, (last visited Oct. 31, 2014), <http://www.pnhp.org/facts/what-is-single-payer>.

<sup>95</sup> *Id.*

in order to garner enough support to pass the reforms.<sup>96</sup> Advocates for a single-payer system cite benefits including reduced costs for underwriting, billing, sales, administrative activities, and marketing.<sup>97</sup> Additional benefits of a single payer system are coverage for all citizens for medically necessary care effectively reducing financial barriers and increasing patient choices between providers.<sup>98</sup>

On the other hand, critics of single-payer claim patients experience extremely long wait times for care, rationing of care, scarcity of vital medical equipment and services, unsustainable costs, and overall poor-quality care.<sup>99</sup> A single-payer system would not likely be a viable solution to the balance billing dilemma because there is no political consensus for its adoption and patients fear access to care issues like those seen in the 2014 Veteran's Administration scandal.<sup>100</sup>

## **B. Transparency**

Policymakers and consumers alike cite the importance of transparency in the medical field, stating that it implies openness, communication, and accountability in all areas of medicine including treatment, comparison of practitioners, and billing.<sup>101</sup> Transparency statutes in the healthcare arena certainly aim to promote those goals and many states including New Hampshire, California, and New York have addressed high costs and billing concerns at least partially by enacting transparency statutes. Although well intentioned, many of these transparency statutes have not achieved their intended

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<sup>96</sup> W. James Antle III, *America: Beware of Single-Payer Health Care*, THE NATIONAL INTEREST, (Jun. 9, 2014), <http://nationalinterest.org/feature/america-beware-single-payer-health-care-10625>.

<sup>97</sup> *Single Payer National Health Insurance*, PHYSICIANS FOR A NATIONAL HEALTH PROGRAM, (last visited Oct. 31, 2014), <http://www.pnhp.org/facts/single-payer-resources>.

<sup>98</sup> *Id.*

<sup>99</sup> Sally C. Pipes, *The false promise of single-payer healthcare*, NEW YORK POST, (Apr. 16, 2014), <http://nypost.com/2014/04/16/the-false-promise-of-single-payer-healthcare/>.

<sup>100</sup> Antle, *supra* note 96.

<sup>101</sup> WIKIPEDIA, [http://en.wikipedia.org/wiki/Transparency\\_\(behavior\)](http://en.wikipedia.org/wiki/Transparency_(behavior)) (last visited Nov. 14, 2014).

results. Most have not resulted in the expected increase in the number of consumers “shopping around” for the best price for their medical care.

### **1. Bundled Cost Estimates**

Currently, New Hampshire is the only state that requires providers by statute to report their cost estimates annually for particular procedures which the state subsequently posts online for consumers.<sup>102</sup> The New Hampshire statute requires all health carriers and licensed third party administrators to provide the methodology to determine and change premium rates, the factors that can affect premium prices, provisions for renewability of coverage, and the benefits and premiums available under all health insurance coverage.<sup>103</sup> The law was fully enacted in 2007 and initially intended to provide consumers with cost information so they could shop among various providers for about thirty common procedures including emergency room visits, X- Rays, CT scans, and hernia repair surgery.<sup>104</sup> The New Hampshire Insurance Department maintains a website called New Hampshire HealthCost [authorized by the aforementioned statute] that “provides comparative information about the estimated amount that a hospital, surgery center, physician, or other health care professional receives for its surgery.”<sup>105</sup> The website is updated annually with cost estimates based on the median amount paid for a procedure.<sup>106</sup>

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<sup>102</sup> MOVING MARKETS: LESSONS FROM NEW HAMPSHIRE’S HEALTH CARE PRICE TRANSPARENCY EXPERIMENT (California Healthcare Foundation & Robert Wood Johnson Foundation, publ’n., 2014), available at <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MovingMarketsNewHampshire.pdf>.

<sup>103</sup> N.H. Rev. Stat. Ann. §420-G:11.

<sup>104</sup> *Id.*

<sup>105</sup> National Conference of State Legislators: *Transparency and Disclosure of Health Costs and Provider Payments*, <http://www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx> (last visited Mar. 19, 2015).

<sup>106</sup> *Id.*

The estimates are of the total cost, meaning they do not distinguish between how much money is paid to each individual physician, nurse, or other person involved in the care.<sup>107</sup>

A report by the CA Healthcare and Robert Wood Johnson Foundations showed that New Hampshire's transparency initiative helped put pressure on high-price providers and helped change market dynamics in the state.<sup>108</sup> Hospitals introduced lower priced alternatives, negotiated lower contract rates, and engaged in new transparency initiatives on their own.<sup>109</sup> Lower price alternatives included the introduction of outpatient surgery centers by hospitals as well as internal transparency initiatives to increase competition.<sup>110</sup>

Although the main benefit was improved market dynamics, consumers cited other positive changes, including an ability to compare prices with new price shopping tools, which is especially beneficial for individuals with high-deductible plans and tiered copayments.<sup>111</sup> Overall, consumers did not price shop as much as advocates expected, but New Hampshire succeeded in modifying the design of its healthcare market.<sup>112</sup> The only clear drawback of the New Hampshire transparency program was its lack of quality comparisons or consumer reviews about the level of care received at each listed facility.<sup>113</sup> New Hampshire is a clear example of a program implemented to aid consumers that had unintended results.

## 2. Hospital Price Lists

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<sup>107</sup> NH Health Cost, *Methodology for Health Costs for Consumers*, <http://www.nhhealthcost.org/methodology-health-costs-consumers> (last visited Nov. 14, 2014).

<sup>108</sup> Moving Markets, *supra* note 102.

<sup>109</sup> *Id.*

<sup>110</sup> *Id.*

<sup>111</sup> *Id.*

<sup>112</sup> *Id.*

<sup>113</sup> *Id.*

Several states including New Hampshire, California, Maryland, and most recently New York now require posted lists of hospitals prices. In California, hospitals are required to list their prices in online “charge-masters” so patients can see what the hospital charges for items, such as IV fluid bags and echocardiograms.<sup>114</sup> Similarly, New York will require hospitals to post a list of their standard charges for items and services on their websites beginning in March 2015.<sup>115</sup>

Although not all states require hospitals to disclose their individual price lists, CMS has released information for the top one hundred procedures billed by hospitals nationwide.<sup>116</sup> According to Jonathan Blum, the former director of the Center for Medicare, CMS released the information in an attempt to encourage hospitals to address what is often a gross disparity in pricing.<sup>117</sup>

Industry expert opinions on hospital charge-master prices run the gamut. Some describe the charge-masters as helpful to cost-conscious patients who are looking for the best deal and others call the lists, “complete nonsense that really doesn't matter – unless you are an uninsured person and you're getting these huge bills driving you toward bankruptcy.”<sup>118</sup> The main difficulty is that if an individual state does not mandate price list disclosure, a patient may only be able to find an estimated cost before deciding to commit to a provider. Ultimately, patients are disadvantaged in states that do not mandate price listing and are vulnerable to balance billing after receiving treatment.

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<sup>114</sup> Rosenthal, *supra* note 46.

<sup>115</sup> 2013 N.Y. S.N. 6914.

<sup>116</sup> Centers for Medicare & Medicaid Services, *Medicare Provider Utilization and Payment Data*, (last modified Apr. 9, 2014, 12:00AM), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/index.html>.

<sup>117</sup> Jeffrey Young & Chris Kirkham, *Hospital Prices No Longer Secret As New Data Reveals Bewildering System, Staggering Cost Differences*, HUFFINGTON POST, (May 8, 2013, 12:00AM), [http://www.huffingtonpost.com/2013/05/08/hospital-prices-cost-differences\\_n\\_3232678.html](http://www.huffingtonpost.com/2013/05/08/hospital-prices-cost-differences_n_3232678.html).

<sup>118</sup> *Id.*

### 3. Limits of Transparency

According to an emergency room patient in Texas, “in reality . . . all the transparency in the world doesn’t change the fact that – knowing everything [which providers are in or out of network] – I could not be sure I would get a different outcome.”<sup>119</sup> Despite being able to research hospitals within a chosen insurance network, there is no guarantee that the actual treating doctor will be within network. Hospital-based physicians such as emergency room physicians, radiologists, and anesthesiologists often are not employed by the hospital. They contract independently and often work in large practice groups.<sup>120</sup> As a result, they are able to decide independently which insurance companies to contract with for reimbursement.<sup>121</sup>

Additionally, as with the Wisconsin heart attack victim discussed earlier, some state laws will dictate which hospital a patient is brought to for emergency medical care, which eliminates any possibility of choosing an in-network provider in an attempt to limit excess costs. Transparency statutes do not necessarily supersede other regulations that dictate how patients should receive care, especially in an emergency, and do not always allow patients to make a fully informed decision about their care. Ultimately, transparency goals are admirable but in practice transparency does not offer a complete solution to solving the balance billing dilemma.

#### C. Network Adequacy

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<sup>119</sup> Carrie Feibel, *Surprise Medical Bills: ER Is In Network, But Doctor Isn't*, NPR, (Nov. 11, 2014), [http://www.npr.org/blogs/health/2014/11/11/363059517/surprise-medical-bills-er-is-in-network-but-doctor-isnt?utm\\_source=facebook.com&utm\\_medium=social&utm\\_campaign=npr&utm\\_term=npnews&utm\\_content=2036](http://www.npr.org/blogs/health/2014/11/11/363059517/surprise-medical-bills-er-is-in-network-but-doctor-isnt?utm_source=facebook.com&utm_medium=social&utm_campaign=npr&utm_term=npnews&utm_content=2036).

<sup>120</sup> *Id.*

<sup>121</sup> *Id.*

Network adequacy is an evaluation of a health plan or insurer’s ability to deliver the benefits it promises under its plan by providing reasonable access to a sufficient number of in-network primary care and specialty physicians.<sup>122</sup> While network adequacy and balance billing are two separate issues, they are directly related because inadequate networks often result in an increase in balance billing.<sup>123</sup> According to industry experts, the narrower a network is, the higher the frequency of out-of-network care and resulting balance billing.<sup>124</sup>

The ACA requires that qualified health plans (generally sold through the health insurance marketplaces) must, “ensure a sufficient choice of providers [in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act], and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers.”<sup>125</sup> The final Health and Human Services (“HHS”) regulations also require access to “essential community providers, a network that has sufficient providers in number and type, and access to mental health and substance abuse services without unreasonable delay”.<sup>126</sup> The regulations also require insurers to allow access to a provider directory through online publication and hard copies upon request to ensure that patients can access the

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<sup>122</sup> Sally McCarty & Max Farris, *ACA Implications for State Network Adequacy Standards*, Robert Wood Johnson Foundation, (Aug. 2013), [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2013/rwjf407486](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf407486).

<sup>123</sup> Texas Department of Insurance, Report of the Health Network Adequacy Advisory Committee, January 2009, pg. 8.

<sup>124</sup> Steven Pearlstein, *Tendon surgery sheds light on the lack of clarity in some out-of-network pricing*, THE WASHINGTON POST, (Oct. 10, 2014), [http://www.washingtonpost.com/business/tendon-surgery-sheds-light-on-the-lack-of-clarity-in-some-out-of-network-pricing/2014/10/10/a2646334-50ad-11e4-8c24-487e92bc997b\\_story.html](http://www.washingtonpost.com/business/tendon-surgery-sheds-light-on-the-lack-of-clarity-in-some-out-of-network-pricing/2014/10/10/a2646334-50ad-11e4-8c24-487e92bc997b_story.html).

<sup>125</sup> PATIENT PROTECTION AND AFFORDABLE CARE ACT; ELDER JUSTICE ACT, 111 P.L. 148, Part 1 of 3, 124 Stat. 119; 42 USCS § 300gg.

<sup>126</sup> 45 CFR § 156.230.

information they need to secure covered medical care.<sup>127</sup> However, the language in section 2702(c) of the Public Health Service Act, does little to clarify the scope of the ACA requirement for sufficient providers. It states that the Secretary of HHS is responsible for examining, “the extent to which patients have direct access to, and choice of, health care providers, including specialty providers, within a network plan, as well as the opportunity to utilize providers outside of the network plan, under the various types of coverage offered.”<sup>128</sup> Examining the amount of choices is a far cry from providing insurance networks with a specific number or geographical range for a provider list to be considered adequate under the ACA. Because the ACA provision and its subsequent regulations are so vague, states are left to fashion their own definitions of what an adequate network really is.

Additionally, depending on the state, network adequacy regulations may only apply to HMOs or to both HMOs and PPOs – they do not necessarily apply to all plan types.<sup>129</sup> Some states have differentiated between the two types of plans because PPOs tend to partially reimburse out-of-network expenses, at least to some extent, whereas HMOs traditionally do not and only provide reimbursement within their narrow network.<sup>130</sup> Regardless of the type of insurance or health plan, if their network does not include sufficient providers that enrollees can reasonably access, the plan is effectively meaningless to them.<sup>131</sup>

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<sup>127</sup> *Id.*

<sup>128</sup> 42 USCS § 300gg

<sup>129</sup> McCarty, *supra* note 122, at 4.

<sup>130</sup> *Id.*

<sup>131</sup> *Id.*

The impact of the ACA regulation has yet to be fully examined, but some states have had clear success with restrictions enforcing harsher adequacy standards than the ACA.<sup>132</sup> For example, California prohibits networks from asking enrollees to travel more than thirty miles to see a primary care physician or more than fifteen miles to go to a hospital and requires networks to provide network information at the time of enrollment or upon request.<sup>133</sup> Texas also enforces mileage restrictions but has slightly different standards for rural versus non-rural areas.<sup>134</sup> Similarly, Minnesota requires timely access to care and restricts primary care providers to within thirty miles or thirty minutes and sixty respectively for specialty care.<sup>135</sup> By placing mileage restrictions on the distance patients have to travel to see an in-network provider, states can further their efforts to ensure reasonable access to care without undue burden or delay to patients.<sup>136</sup>

Prior to the enactment of the ACA provisions for network adequacy, the National Association of Insurance Commissioners (“NAIC”), comprised of the chief insurance regulators from the 50 states, offered its own Model Law #74 for network adequacy.<sup>137</sup> The NAIC Model Law was considerably stricter than ACA provisions and even addressed issues such as contracting with health carriers, enforcement of network adequacy policies, and filing requirements and administration to be implemented by the states.<sup>138</sup> Additionally, the NAIC wanted to go so far as to *guarantee* access to care 24/7,

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<sup>132</sup> *Id.*

<sup>133</sup> *Id.* at 7; California Code of Regulations §2240.1(c)(2).

<sup>134</sup> *Id.* at 8; 28 TAC § 11.1607.

<sup>135</sup> *Id.*; Minn. Stat. § 62D.124.

<sup>136</sup> *Id.*

<sup>137</sup> National Association of Insurance Commissioners, *NAIC Managed Care Plan Network Adequacy Model Act (#74)*, comparison of ACA and Model Act #74 available at: [http://www.naic.org/documents/committees\\_b\\_related\\_wp\\_network\\_adequacy.pdf](http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf) (last visited Mar. 19, 2014).

<sup>138</sup> *Id.* at 24-25.

enact specific selection criteria for primary and specialty care providers, and even spelled out explicit provisions for relationships between providers and insurers including a prohibition on inducements to provide less care than is medically necessary.<sup>139</sup> In scope and specificity, the NAIC Model Law #74 far exceeded the ultimate standards imposed by the ACA. It is unclear why Congress took such a seemingly lax approach to network adequacy in the ACA, when chief insurance regulators from all the states were able to come together with a comprehensive network adequacy plan.

Although the federal approach has been relatively lax, states have enacted network adequacy requirements determining how many physicians are required per enrollees, placing limits on mileage or travel time to receive adequate care, and in the process protecting patients from paying for a service that they could not actually receive. Network adequacy is certainly important for a well-functioning healthcare system, but even having an adequate network may not be enough for an emergency case or when a patient requires hyper-specialized treatment. Ultimately, the ACA has provided a framework to ensure adequate provider networks, but states still play a major role. By implementing additional rules and guidance, states can do even more than the ACA to ensure patients within their borders have easy access to the care they need.<sup>140</sup>

#### **D. Price Controls**

The use of price control mechanisms to prevent patients from receiving additional bills is another frequently cited solution to balance billing. In general, a price control approach to healthcare would set maximum prices for medical supplies or services. This

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<sup>139</sup> *Id.* at 21-22.

<sup>140</sup> Center for Consumer Information and Insurance Oversight Health Insurance Exchange System-Wide Meeting, (May 21-23, 2012), available at <http://cciio.cms.gov/resources/files/hie-plan-management-in-the-ffe.pdf>.

approach exists in the Medicare system – the government fixes the prices it is willing to reimburse doctors and hospitals for certain services, effectively allowing it to control prices.<sup>141</sup>

Some additional price control approaches involve paying providers a flat rate for expensive procedures like knee or hip replacements or bundling payments so that providers have to share a predetermined sum for an entire procedure.<sup>142</sup> Bundled payment options are frequently used by Medicare and also available through private insurers.<sup>143</sup> Sometimes insurers even use the bundled payment arrangement to provide extra benefits for patients.<sup>144</sup> One insurer in California, Cigna, has contracted with at least one hospital under a bundled payment arrangement and now provides a surgical warranty for joint replacement surgery.<sup>145</sup>

Although price controls and fee arrangements are often suggested as a means to avoid higher costs and balance bills, not all patients have that option and not all insurers are willing to engage in the practice.<sup>146</sup> As a result, flat fee and bundling arrangements are not the most likely remedy for balance billing and would likely be combined with another element in practice.

## **E. Mediation or Arbitration**

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<sup>141</sup> Martin S. Gaynor, *Are Price Controls the Answer?*, THE HEALTH CARE BLOG, (Feb. 27, 2013) <http://thehealthcareblog.com/blog/2013/02/27/are-price-controls-the-answer/>.

<sup>142</sup> Jon Healey, *The ugly surprise of out-of-network doctors and 'balance-billing,'* THE L.A. TIMES, (Sep. 22, 2014, 1:06PM) <http://www.latimes.com/opinion/opinion-la/la-ol-out-of-network-doctor-bills-surprise-new-york-times-20140922-story.html>.

<sup>143</sup> Lisa Zamosky, *Considering surgery? Some healthcare providers offer warranties,* THE L.A. TIMES, (Sep. 14, 2014), <http://www.latimes.com/business/la-fi-healthcare-watch-20140914-story.html>.

<sup>144</sup> *Id.*

<sup>145</sup> *Id.*

<sup>146</sup> *Id.*

Rather than prohibiting or strictly regulating balance billing practices, some states have passed legislation requiring a form of mediation or arbitration process to help consumers avoid exorbitant bills.

### 1. Texas

In 2009, Texas Governor Rick Perry signed a law creating a new right for consumers in balance billing disputes with out of network providers.<sup>147</sup> First, beyond the mediation law, Texas does not regulate balance billing by out-of-network providers outright, even in emergency cases.<sup>148</sup> As a result, if someone is involved in an accident and taken to the nearest hospital that happens to be outside their network, the patient will have no control over the costs even if they have insurance.

According to the Texas Department of Insurance, patients must be enrolled in a preferred provider organization (PPO) plan or a member of a special Texas retiree insurance plan and bills must exceed \$1,000 in order to qualify for the mediation process under the statute.<sup>149</sup> Because of this PPO or retiree requirement, not all citizens of Texas are eligible for mediation – they must fall into one of those specific categories.<sup>150</sup>

Additionally, under Texas law, patients only have a right to seek mediation if the hospital-based physician did not make a “complete and accurate disclosure” before providing the service, as required by Texas law.<sup>151</sup> If that is the case, the insurer and

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<sup>147</sup> Texas Dept. of Insurance, *Mediation for Out-of-Network Hospital-based Health Care Provider Claims*, <http://www.tdi.texas.gov/consumer/cpmmediation.html> (last visited Feb. 17, 2015). 28 TAC §21.5010 – 21.5013.

<sup>148</sup> *State Restriction Against Providers Billing Managed Care Enrollees*, KAISER FAMILY FOUNDATION, <http://kff.org/private-insurance/state-indicator/state-restriction-against-providers-balance-billing-managed-care-enrollees/> (last visited Nov. 12, 2014).

<sup>149</sup> 28 TAC § 21.5010 – 21.5013; TDI *supra*, note 147.

<sup>150</sup> *Id.*

<sup>151</sup> *Id.*

provider will be required to participate in the mediation process.<sup>152</sup> In other words, if a physician discloses to a patient that he is out-of-network and later balance bills the patient, the patient will not be entitled to state mediation under the statute.<sup>153</sup> However, if the physician neglects to disclose his out-of-network status, he and the relevant insurer will be required to participate in the mediation process if the patient makes a request with the Texas Department of Insurance.<sup>154</sup> The Texas regulation gives patients the option to participate in the mediation or allow their insurer and the provider to negotiate independently.<sup>155</sup>

Patients are not required to seek mediation through the aforementioned process, but the regulation grants them the right to do so if they qualify.<sup>156</sup> Providers and insurers are required to participate in the mediation via an initial telephone conference within 30 days of the patient request and an official conference is required within 180 days of the request.<sup>157</sup> During the mediation, the physician cannot attempt to collect any payment (other than copayments, deductibles, or coinsurance) until the mediation process is resolved or the request is withdrawn.<sup>158</sup> If the mediation is unsuccessful, the patient may be able to seek a resolution in court. The regulation makes it clear that attempting mediation does not eliminate the right to take the issue to court.<sup>159</sup> Although the law seems to be a step in the right direction, its highly specific criteria leaves much to be desired as it does not protect all patients, is complex in its application, and does not necessarily provide a full resolution.

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<sup>152</sup> *Id.*

<sup>153</sup> *Id.*

<sup>154</sup> *Id.*

<sup>155</sup> *Id.*

<sup>156</sup> *Id.*

<sup>157</sup> *Id.*

<sup>158</sup> *Id.*

<sup>159</sup> *Id.*

## 2. New York

Unlike in Texas, New York's approach to managing balance billing operates in a way to completely remove the patient from the process altogether.<sup>160</sup> The state even chose to create a binding arbitration process as a matter of last resort.<sup>161</sup> The New York statute will effectively protect all patients against rampantly high balance bills in emergency and other cases where they are unable to select a provider in advance beginning in March 2015. Prior to seeking independent dispute resolution under the statute, the insurer must pay reimbursement equivalent to what an in-network provider would receive.<sup>162</sup> If the out-of-network provider still seeks additional payment, the parties are supposed to engage in negotiations of their own and if no resolution can be reached, either the insurer or the provider can submit the claim for last resort, binding arbitration.<sup>163</sup>

On its face, the New York statute succeeds in both leaving the patient out of the fee dispute and in protecting *all* patients regardless of who their insurer is or the amount of the bill. The New York approach is a marked improvement from the Texas law from the patient perspective because it applies to all patients and not just those that fulfill extremely specific criteria. Additionally, the New York statute takes the patients out of the process altogether and does not require them to evaluate criteria or to file a request with the state department of insurance, unlike the Texas law.<sup>164</sup> The argument over fees is shifted to be

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<sup>160</sup> Caroline Chen, *Surprise Medical Bills Lead to Protection Laws: Health*, BLOOMBERG NEWS, (Apr. 4, 2014, 12:01AM) <http://www.bloomberg.com/news/2014-04-04/surprise-medical-bills-lead-to-protection-laws-health.html>.

<sup>161</sup> NY CLS FINANCIAL SERVICES LAW § 607.

<sup>162</sup> *Id.*

<sup>163</sup> *Id.*

<sup>164</sup> Compare NY CLS FINANCIAL SERVICES LAW § 607 and Texas Dept. of Insurance, *Mediation for Out-of-Network Hospital-based Health Care Provider Claims*, <http://www.tdi.texas.gov/consumer/cpmmediation.html> (last visited Feb. 17, 2015) (where NY mandates providers engage in reimbursement negotiations and only then may the provider or insurer seek binding

between the provider and insurer so a patient who required emergency care or was unable to select a doctor because of the nature of care required will not be held liable for additional costs above their typical copayment, coinsurance, or deductible rates.<sup>165</sup> Providers will be guaranteed at least what they would have received if they were in network, and possibly more if they are able to negotiate additional payment with the insurer during a binding arbitration process.<sup>166</sup>

#### **F. Private Solutions – Contract Law**

Current hospital employment contracts for individual physicians or physician practice groups tend to address common employment concerns including compensation, term and scope of employment, on-call duties, grounds for termination, regulation of outside activities, restrictive covenants, and other relevant provisions.<sup>167</sup> If hospitals are already able to control or influence the actions of individual physicians or physician groups through their existing contract policies, can hospitals also use that leverage to address the balance billing issue? Patient advocates would likely see this as the simple solution to the balance billing dilemma, but it is unlikely that physicians or hospitals would agree. Hospitals currently have no incentive to influence what insurance their contract providers accept – balance billing by physicians does nothing to affect their bottom line. In fact, were hospitals to include mandatory provisions for specific insurer acceptance in their contracts, it could be construed as another form of control over either employees or independent contractors, potentially adding to their liability in a legal dispute. As it stands

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arbitration versus in Texas where the patient is responsible for submitting a request for mediation to the state department of insurance).

<sup>165</sup> Chen, *supra* note 160.

<sup>166</sup> *Id.*

<sup>167</sup> Kern Augustine Conroy & Schoppmann, P.C., *Understanding Physician Employment Contracts When Joining A Hospital*, <http://www.drlaw.com/Articles/Understanding-Physician-Employment-Contracts-When-.aspx> (last visited Nov. 14, 2014).

now, physicians see themselves as having a disadvantage when negotiating with third party insurers for reimbursement – if they were required to enroll with a particular insurer or set of insurers as part of their contract with a hospital they could lose any possible leverage they would have had.<sup>168</sup> Moreover, if physicians did choose to accept such a contract, they would be limiting their ability to balance bill and ultimately their reimbursement potential. Ultimately, hospitals have an interest in maintaining their bottom line and decreasing potential legal liabilities and patients have effectively no leverage to demand balance billing protection from providers by requesting protections be built into hospital contracts.

Additionally, insurers want to make money and if they had an entire set of physicians who were required to enroll with them, they would have no incentive or reason to allow the physicians to negotiate higher reimbursement rates. The arrangement could also threaten competition by making it more difficult for new insurance companies to make inroads at hospitals that had already required their contracted physicians to enroll in other plans. Although this practice would close the balance billing loophole through private contracts rather than through legislation, it could have some anticompetitive effects by potentially lessening physician leverage in negotiations with third party insurers.

#### **IV: Conclusion – Without Substantial Balance Billing Reform Patients and Insurers Alike May See Increasing Costs**

Concerns of patient rights and protection, cost control, and the ability for hospitals and insurers to make a profit all come to the forefront when policymakers examine potential solutions to balance billing. The insurance commissioner of Louisiana described it as, “a hornet’s nest of financial interests” that is extremely difficult to address as a

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<sup>168</sup> Christine L. Jones & Terry L. Mills, *Negotiating a Contract With a Health Plan*, Family Practice Management, (Dec. 2006), <http://www.aafp.org/fpm/2006/1100/p49.html>.

policymaker.<sup>169</sup> Some patient advocates argue it is immoral to put someone into crushing debt simply to stay alive or maintain decent quality of life and have gone so far to suggest a federal regulation that prohibits any balance billing by providers.<sup>170</sup> Insurers and providers alike argue that further regulation would cut into their profit margins and decrease their ability to compete because of high costs and what they already consider to be inadequate reimbursements from Medicaid and Medicare. Despite this argument, practically and economically, all signs point to the need to eliminate all balance billing. If balance billing is prohibited across the board, providers will be forced to accept out-of-network reimbursement rates set by insurers or clearly disclose to patients up front that they would be responsible for the entire bill. Patients should have all the facts to make decisions about their treatment, and that includes full disclosure of potential financial liability.

Because there have been no national initiatives to restrict out-of-network balance billing and increase provider pricing transparency, a great deal of information is still unavailable to industry players, consumers in the public, and policymakers alike. However, policymakers can look to the initiatives in New Hampshire regarding transparency and bundled cost estimates and in New York limiting compensation and mandating in-network pricing when out-of-network status is not disclosed or an in-network provider is unavailable. The extremely high number of people struggling to pay medical bills and declaring bankruptcy as a result of medical debt is a clear indication that the states and the federal government are not doing enough to limit questionable billing practices by

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<sup>169</sup> Rosenthal, *supra* note 46.

<sup>170</sup> David Palmer, *Balance billing: It makes you sick*, CITIZENVOX, (Nov. 19, 2014), <http://www.citizenvox.org/2013/11/19/balance-billing-it-makes-you-sick/>.

both individual providers and hospitals – there is no reason for the cost of care to vary by thousands of dollars depending on who your insurer is or because your in-network surgeon calls in an out-of-network assistant at the last moment. Ultimately, a service or procedure *costs* the provider the same no matter what, only their reimbursement varies. Providers across the country engage in balance billing simply because the law generally permits it – these providers are essentially permitted to prey on patients at their most vulnerable moments when they need healthcare and may not be able to make an educated provider choice. Hoping that providers choose to “do the right thing” by disclosing out-of-network status or negotiating lower bills is not an acceptable or practical solution.

A large-scale remedy from Congress would be the most helpful change, but because Congressional action can be difficult to achieve as a result of partisan allegiances, it is more likely that action will continue to be taken in individual states. Judging by the uptick in the media coverage on balance billing issues, more states will begin listening to their consumers and aim to fix the problems on their own. It is likely that the New York Surprise Bill Law will act at least as a partial model for balance billing reform once it is fully enacted in 2015 and the state has the opportunity to work out any kinks in its application. Other states should follow the New York approach to restrict balance billing at least in emergencies and when patients are unable to choose their own doctors. Patients should not be responsible for negotiating additional payment to a provider when they were diligent and secured insurance. Providers and insurers should be able to negotiate amongst themselves what a fair price is for life-saving medical care – the patient should be removed from that equation. If patients pay premiums and must meet a deductible as per their insurer, they should be able to sleep soundly knowing that their insurance is in fact

protecting them from a catastrophic financial loss. The highly specific criteria required to seek mediation in Texas prohibits patients who are unable to understand the regulation from seeking a remedy, and even those who do understand the complexities may not be eligible. Forcing providers and insurers to negotiate reasonable out of network reimbursement rates in emergency situations will prevent patients from financial ruin, guarantee providers receive adequate, market-value compensation for their services, and ensure that insurers are not paying out excessive claims while maintaining their commitment to their enrollees.

Critics would argue that patients should get better insurance, make their preferences known at the time of intake, or simply pay the extra associated costs with emergency care. However, patient advocates agree that patients should not be punished for unforeseen circumstances especially when they believed their medical insurance would protect them from unreasonable or unforeseeable expenditures. Balancing the needs of all the players in the United States' healthcare system is a delicate endeavor, but ultimately, providers need to stop bankrupting individuals for an extra payday.