Balance Billing: How Did We Get Here and Where Are We Headed?

Hospitals and Insurers Can't Agree on Fair Prices—and Patients Have Suffered the Consequences. Now Congress is Stepping In

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How much does it cost to have a heart attack? The price tag was nearly $165,000 for Ironman triathlete Drew Calver in 2017. A neighbor rushed Calver, then aged 44 years, to the nearest emergency department (ED), at St. David's Medical Center in Austin, TX. The facility was "out of network" for Calver, but he was savvy enough to ask from his hospital bed whether his insurance would cover his care. He was assured that it would. Cardiologists later implanted a stent in his clogged artery and kept him at the center for 4 days—to the tune of $164,941. And yet his insurer, Aetna, paid only $55,840 of the tab. The hospital subsequently sent Calver a bill for the balance, practically giving him another heart attack. This practice, known as "balance billing," refers to bills given to patients for care they received from an out-of-network physician or facility for the portion of the care not covered by the patient's insurance company. (This is somewhat different from "surprise billing," which is when a patient goes to an in-network facility but happens to receive care from a physician at that facility who is—unbeknownst to the patient—actually out of network, and then receives an unexpected bill.) Calver's particular story ended well—but only after it appeared on NPR's *Morning Edition* as part of a joint effort with Kaiser Health News.[1] St. David's eventually corrected his bill so that, in the end, he was charged a mere $332.29. It turned out that Calver qualified for a "financial assistance discount."

Why exactly are out-of-pocket bills for medical care, even among insured patients, so unpredictable and often sky-high in these cases?

In a recent *New York Times* op-ed,[2] Glenn Melnick, PhD, professor of public policy at the University of Southern California in Los Angeles, and also the Blue Cross California Chair in Health Care Finance, offered an explanation that raised the hackles of many leaders in the field of emergency medicine. He wrote that "the most powerful forces driving cost increases" were regulations that apply to emergency care. "[M]ost states require health care plans to tell their members to go to the nearest hospital in an emergency and…insurance will cover the visit—even if their plan does not have a contract with that hospital and the emergency care they receive will be out of network." Such requirements give hospitals leverage over insurers when charging for *in-network* treatment. "[I]f they demand higher prices from health plans and do not get them, the hospitals can just cancel their contract," Dr. Melnick explained in his piece. "They will still get paid for treating emergency patients under those plans—and in fact will be paid more, because those patients will be out of network. (While this applies only to emergency patients, about half of all hospital admissions come through emergency departments.)" Dr. Melnick contended, "These regulations have granted hospitals what is essentially a monopoly over ED patients, allowing them to charge basically whatever they want."

Do insurance companies play any part in forcing up costs? Many emergency physicians would argue that they do by skewing regulations in regard to emergency care to their advantage. "Insurers know their policy holders will always be able to get emergency care, so they have no incentive to keep a robust network of emergency physicians," said Laura Wooster, MPH, associate executive director of public affairs for the American College of Emergency Physicians (ACEP). The lack of such a network can mean that insurers save money—on the backs of their policy holders. "Most insurance plans have a higher deductible for out-of-network care," Wooster said. "So if the patient's emergency visit is out of network, the patient will have to pay more of the bill before they meet that higher deductible. In a case like that, especially if there is a high deductible, the policy holder might pay most of the bill before the deductible is met and the insurer takes over—and then the insurance company essentially saves money."

Agreeing on what constitutes a fair price for any given medical service has been a key sticking point in this debate. Both hospitals and insurers tend to concur that patients should not be caught in the crosshairs of billing disputes. "Patients need assurance care will be covered when determining if they should go to the [ED]," Wooster said. "We don't want them to second-guess their decision to seek care." Beyond that, however, there is not much agreement.

To help resolve this issue, legislators have started to step into the fray. Twenty-five states now provide some protection against surprise or balance billing, 22 of which have guidelines in place in regard to emergency care, according to a recent report published by the Commonwealth Fund, a private foundation whose mission is to improve the US health care system.[3] Which states have the best approach? *Annals* asked one of the coauthors of the Commonwealth Fund report to weigh in. "There are merits to New York's use of binding arbitration as both a means to resolve payment disputes and an incentive to settle the disputes without going to arbitration," said Jack Hoadley, PhD, research professor emeritus, Health Policy Institute, at Georgetown University's McCourt School of Public Policy in Washington, DC. "There are merits to the types of payment formulas that are used by California and Maryland. But it's important in each state to find an approach that matches the market conditions in that state."

The *Times* op-ed writer, Dr. Melnick, singled out another state for praise. Maryland caps billed charges at 125% of contracted prices, which "would keep hospitals from exploiting their [ED] advantage" and "would result in immediate price reductions and savings to consumers exceeding many billions of dollars," according to Dr. Melnick. What's more, Maryland's practice will "begin to restore some competition that would help keep prices down in the long run," he said.

Emergency physicians seem more impressed by another aspect of Maryland's approach. "It prevents shifting the burden to patients with unexpected out-of-network provider charges for emergency care *and* requires insurers to provide payment for the out-of-network services," said Jessica Galarraga, MD, MPH, an attending emergency physician in the Department of Emergency Medicine, MedStar Washington Hospital Center, in Washington, DC, and physician investigator for MedStar Health Research Institute in Hyattsville, MD. And yet Dr. Galarraga thinks Maryland isn't perfect, either. "Although [Maryland's legislation is] a step in the right direction to decrease the financial burden on patients and ensure payment by insurers for out-of-network services," she said, "it is also important to be mindful of the fact that emergency care providers may need to subsidize unreimbursed or underreimbursed care through avenues such as balance billing to stay financially salient. This is particularly so for emergency care since it serves as a safety net for communities and provides care to patients regardless of their ability to pay."

Maryland could improve its approach, according to Dr. Galarraga, by tightening the reins on insurers so that they can't undercut reimbursements. "That would help lessen the amount of financial pressure to subsidize costs by emergency physicians," she noted. Her colleague, Jesse Pines, MD, MBA, national director of clinical innovation for US Acute Care Solutions, based in Canton, OH, agreed. "Insurers should have to pay a reasonable amount for emergency services and should not try to undercut payments to physicians," he noted. "This is also going on, but gets less press."

But although observers like Dr. Melnick support capping bills at the 125% rate, that concerns Dr. Pines because that is only good policy if baseline prices aren't exorbitant to begin with. As Dr. Pines said, "If [insurance] plans have latitude to determine the baseline price based on what they paid to providers for a similar service, then this could work in insurers' favor to undercut payments for physician services. What needs to happen is the use of some sort of external standard for what fair payment is. One of these is called the Fair Health database." The database collects information from all 50 states about what they charge for medical services in different geographic areas.

All this said, a bigger fix for the problem of balance billing may soon emerge on Capitol Hill. In September, a group of bipartisan leaders led by Senator Bill Cassidy, MD, a Louisiana Republican, rolled out a draft of a bill that would prohibit balance billing. In October, Senator Maggie Hassan, JD, a New Hampshire Democrat, introduced her No More Surprise Medical Bills Act of 2018, which "would help eliminate surprise medical bills for people with employer-sponsored health plans," according to a press release.[4] Subsequently, Hassan began working with the bipartisan group; they're folding her proposal into a bill that may be introduced by the early spring, after this piece has gone to press. And yet the most important figure on Capitol Hill in regard to this issue may be Senator Lamar Alexander, JD. The Tennessee Republican chairs the powerful

Health, Education, Labor and Pensions Committee, a group that would play a key role in getting any relevant legislation passed. Alexander will be retiring in 2020 and, as he wrote in a December opinion piece for *The Knoxville News Sentinel*, his "top focus as chairman of the Senate health committee for the next 2 years will be to reduce the cost of health care in the United States."[5] He went on to say, "The issue of surprise billing is a widely recognized problem as highlighted in a report from the White House on health care costs released earlier this month. High health care costs are a drain on taxpayer dollars, eat up employer budgets, and—most important—are a top financial concern for American families." ACEP anticipates that Alexander will release surprise billing legislation of his own this spring and that a vote on it could take place before the end of the year.

What would ideal legislation look like? "It would take into account the unique nature of emergency care and take the patient out of the middle," said ACEP's Wooster. "It would ensure that a patient [would receive] only…a single bill, from his or her health insurance provider, rather than a number of bills—from hospitals, health care providers, and so on. If a proposal bans balance billing for out-of-network, we want to make sure it also requires a minimum benefit standard to ensure physicians get a fair reimbursement. We also think it's important that any legislative approach provides [*sic*] greater transparency for the patients as to what their health insurance actually covers. Greater clarity around that would be helpful, like a plain English explanation of these very complicated things."

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