

Surprise Medical Bills

What they are and how to stop them, while ensuring access to needed services and adequate payment to providers.



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NJ For Health Care is a broad-based coalition of over 60 consumer, health care, civil rights, disability, faith based, labor, senior, women's and social justice organizations representing over 2 million members across New Jersey. Convened by New Jersey Citizen Action, the coalition works to bring guaranteed, high quality, affordable health care to all New Jersey residents.

Consumers Union (CU) Consumers Union is the policy and advocacy division of Consumer Reports. Founded in 1936, Consumer Reports is an expert, independent, nonprofit organization whose mission is to work for a fair, just, and safe marketplace for all consumers. As its policy and advocacy division, Consumers Union works on behalf of consumers on health care, financial services, food and product safety, telecommunications and other consumer issues in Washington, D.C., the states, and the marketplace.

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STATEMENT OF PRINCIPLES

Health care consumers need accurate and timely cost information in order make decisions about their care. What those costs are, and who is responsible for paying them should not come as a surprise. But often such information does come as a surprise because federal and state law does not adequately protect consumers from bills for services that they *inadvertently* receive from providers that do not have a contract with their insurer. Today, even consumers who make extensive efforts to ensure that the physician or hospital they select is “in-network” with their insurer may nevertheless receive a surprise medical bill for thousands of dollars.

These charges are often the result of provider business models that promote out-of-network practices to increase the provider’s profits. We need to require prominent, easy-to-understand disclosures by providers to ensure that consumers get the information they need to avoid unintended out-of-network charges in the first place. And, we need protections that hold consumers harmless for the generally much higher out-of-network charges that are billed, when no other appropriate “in-network” provider is available. At the same time, we must provide dispute resolution mechanisms to ensure that provider payments are reasonable so as to preclude higher costs from being passed by insurers to consumers through higher premiums. It is a fundamental principle of our Coalition that consumers who make a good faith effort to receive necessary care from in-network providers should be responsible only for the same costs they would have incurred had the provider been in-network.

NJ for Health Care supports legislation that puts consumers first and provides the transparency and protections they need to avoid the unfair and unexpected financial burdens attendant with out-of-network charges. Such legislation must require:

- Accurate disclosure of network participation status of providers involved in care;
- Disclosure by provider of estimated cost of care;
- Consumers are held harmless for out-of-network charges unless they have deliberately, voluntarily and specifically selected an out-of-network provider to perform all the health related services they receive;
- Consumer cost sharing for services unknowingly received from an out-of-network provider must be limited to their cost sharing had the provider been in-network;
- Independent “baseball” arbitration to promptly resolve the out-of-network reimbursement billing dispute, when providers and health plans disagree;
- Establishment of range in which legitimate out-of-network charges can be billed;
- Establishment of a Healthcare Price Index that will facilitate the organization, study and transparency of medical service charges and reimbursements; and
- Mechanism for consumers who receive prohibited bills to notify their insurance company, and be protected from becoming embroiled in a protracted billing dispute between the provider and the health plan.

INTRODUCTION

A hefty bill from a physician, hospital or other healthcare provider can come as a surprise to consumers who do not deliberately chose to receive services from a provider or facility that has no contractual relationship with their health insurance plan (*i.e.*, an out-of-network provider). As insurers offer more plans with narrower provider networks under the face of improving quality and reducing premiums, the chance of consumers receiving such bills, often known as balance bills, continues to grow. In some instances, New Jersey regulated health plans are required to protect their members from having to pay such bills; however, there is no broad protection against balanced billing either under federal¹ or New Jersey law.² Out of network billing presents a significant problem not just for consumers, but also the entire health care system in the State. If left unaddressed, the spiraling costs associated with out-of-network charges could lead to even larger surprise bills for consumers and higher costs for health premiums for employers, government, families and individuals. This paper sets forth the Coalition's reasoning in support of expanded protections for all insured consumers that we believe are required to ensure patients' access to affordable, quality health care while satisfying the legitimate interests of health plans and health care providers.³

WHAT IS AN OUT-OF-NETWORK CHARGE?

Most New Jerseyans secure health insurance, either directly or through their employer, to protect themselves against the significant cost of care for a major illness or chronic care condition. Yet even with insurance, some consumers still face large bills representing the difference between an insurer's payment to the provider and the provider's charges. These balance bills typically occur when a consumer receives services that are otherwise covered under the terms of the health plan, but are provided by an out-of-network physician or facility. These out-of-network charges are in addition to any co-pays or co-insurance payments for which the consumer is responsible; and payment of such charges is often not applied toward fulfilling the consumer's deductible.

What does it mean to be out-of-network? Most New Jersey health plans involve a set provider network. For state regulated plans, detailed regulations require those networks to be "adequate" (though we are uncertain as to whether such regulations are rigorously enforced).⁴ Networks are either closed (such as HMOs or EPOs), where the plan only pays for care delivered by a network provider (meaning there is no out-of-network benefit); or open (such as a PPO or point-of-service plan), where the plan covers the care, but typically imposes higher cost sharing or a higher deductible when the consumer selects an out-of-network provider. In either case, consumers weigh the cost of care (including the cost of the premium) against their preference, if any, to have access to providers outside of a plan's network. Some consumers may decide to enroll in plans with more restricted networks, at lower premiums, while others are willing to pay a higher premium to have access to the provider of their choice. However, at the

point of delivery, it becomes more difficult for consumers to make choices. The information consumers need to compare the cost of a service obtained from an in-network provider versus an out-of-network provider, and their respective share of that cost, is not always transparent. Therefore, to enable an informed consumer, both insurance plans and providers must play a role in making sure that patients understand the costs of a given procedure or treatment and the financial consequence of obtaining care from an out-of-network provider based on the specific terms of their plan.

WHEN DOES AN OUT-OF-NETWORK CHARGE OCCUR?

For most consumers, it is generally almost always better to take advantage of health plan network design and use in-network providers whenever possible. Doing so can help consumers avoid additional cost-sharing and billing hassles that frequently arise with out-of-network providers. Nevertheless, there are a variety of situations in which patients may receive out-of-network services. Some of these encounters with out-of-network providers may be voluntarily, intentionally and freely chosen, while others may be inadvertent, unwanted and/or unavoidable, because of shortcomings in the health plan, health care delivery system or both.

When A Consumer Choses An Out-of-Network Provider

In the most straightforward situation, a patient makes a deliberate and informed decision to intentionally use the services of an out-of-network provider or facility. In such circumstances, consumers have typically researched the qualifications of a particular physician or the safety record of a hospital and make a voluntary choice to secure the services from an out-of-network provider. Ideally, those consumers are also able to make that decision based on sufficient information given to them by their insurance plan and physician as to the cost of treatment and responsibility for payment. That is, in order for a decision to be considered voluntary and informed, consumers must be aware of the fact that they will be responsible for the entire bill (if enrolled in a closed network); OR will pay both a higher share of the cost and possibly be billed for the difference between the amount the provider charges and the payment their insurance plan makes for such out-of-network care (if enrolled in a plan with out-of-network benefits). A consumer's decision cannot be deemed voluntary if made at the point of service on the day of treatment, with no advance warning, or, under other circumstances, where the consumer is not given a meaningful choice to receive the needed health services from an in-network provider.

Emergency Use of an Out-of-Network Provider

Out-of-network bills are becoming a routine occurrence in some parts of New Jersey. This is due in part to certain hospital facilities aggressively advertising their emergency

services, and some physicians having patients report to the emergency room for pre-scheduled surgeries. Notwithstanding this particular trend, out-of-network bills are happening throughout the State when consumers have a medical emergency, and are taken to the closest hospital for emergency care, whether or not it is an in-network facility or the emergency room staff is in-network. As noted above, federal law requires health plans to reimburse the non-network provider in most emergency situations at a certain level, but allows the provider to balance bill the consumer for any additional charges. New Jersey rules, which additionally regulate fully-funded large group plans and individual and small group plans (but not self-funded employer plans), go a step further. The State requires these health plans to hold their members harmless for the balance of any out of network charges in such emergency situations. New Jersey's rules appropriately recognize that the consumer has little or no ability to choose a network physician or non-network provider in these situations. Disclosure is not helpful in an emergency room setting, because the consumer needs prompt treatment, and has no time to contact the health plan, and/or navigate to other providers in the local area. Nonetheless, despite this protection consumers can and do receive balance bills for emergency care, which are not explicitly prohibited under current New Jersey law. These consumers may not know of their plan's responsibilities or protection they are entitled to under the law, and believe that they must pay those bills. In any event, in these emergency circumstances, plans often pay the higher (sometimes excessive) charges demanded by non-network providers. These costs ultimately get passed through to consumers, in the form of higher premiums or other health system costs. These higher costs are also often factored into the medical-loss ratio, the calculation that permits insurers to raise premiums as the costs of paid claims increases.

How do we know that surprise bills for emergency care are a problem? Consumers Union and the New Jersey for Health Care Coalition have heard from consumers incurring out-of-network charges upon receiving emergency care. Below, we describe some of those stories. Others are included in the Appendix.

Maria

Jersey City

I am insured through my husband's health plan that we receive through the Painters Union. I had severe cramps, and my gastroenterologist told me to go to the emergency room at my local hospital, because he thought I might need emergency surgery to remove my gall bladder. I walked myself to the Christ Hospital emergency room. A physician gave me pain medication intravenously, administered a sonogram and did some blood work. He saw the gall stones, but said I did not need surgery and sent me home. I got a bill for \$18,000, which my insurance initially denied entirely. I appealed the denial of coverage internally. The insurer did not understand that my treatment was a genuine emergency. After explaining what happened, the plan told me to pay my

emergency co-payment of \$150, and it paid the hospital \$6,000. I continue to be balance billed for over \$7,000. (Story shared 2014)

Teri Vetter

Howell

In February of this year, I was scheduled for surgery. My obstetrician, the physician in charge, arranged all the pre-authorizations. He specifically told me that he needed to solicit the services of a urologist to assist him during the procedure. Two days prior to the surgery, I signed certain authorizations and made my insurance co-payment of \$150.00. All went well until a few months after surgery. I received the Explanation of Benefits (EOB). It noted that the hospital, obstetrician, urologist, anesthesiologist and pathologist were all in-network providers, and had been paid by the insurance company. I received another EOB for \$4,277 for assistant surgeon services. No doctor's name was listed on this EOB, only a medical billing service name was provided. I inquired with my obstetrician's office about this unknown provider. They have ignored requests to help negotiate with this provider. Although I have out-of-network benefits under my plan, because there was no prior authorization obtained for this unknown provider by my obstetrician, my self-funded insurance plan refuses to pay any portion of the claim. I was advised by my insurance plan to pay the maximum reimbursable charge it would allow for this provider which was \$299. I made this payment in good faith. There is still however an outstanding debt of \$3,978 that needs to be addressed. If left unpaid, this balance could go into collections.

Cheryl

Manalapan Township

I took my daughter to the local emergency room let year. She was having trouble breathing. I received a bill for a little over \$1,000.00 from the attending physician. It turned out that the hospital accepted my insurance but not the doctor. It took me a few months to pay this. In the meantime, I kept receiving notices about late payment from the doctor's office. It was a completely unexpected bill that I could not afford to pay. (Story shared April, 2015)

Arthur

North Arlington

I cut the top of my thumb off. When I went to the emergency room, they took me in and a doctor sewed my thumb back together. Not only did I pay my co-pay in cash, I lost the receipt. Well, I ended up having to pay the doctor \$2,500.00 above the amount the insurance paid. Subsequently, the hospital did not submit its bill on time, so I now owe them \$5200.00. So even though I was fully insured, this will cost me \$7,700.00. The hospital is fully aware that doctors are fishing for clients in their emergency room even though they themselves don't accept any -- I said any -- insurance. (Story shared December, 2014)

George

Pennsville Township

[I] went to [the] local county hospital emergency room because of stroke symptoms. [I] lay on a cot for 2 1/2 hours before a doctor came to check me out. I could have had the stroke or died by then. No medications or any sort of treatment. Episode passed, I was checked out, and [was] released with run of the mill instructions. .My insurance provider paid the customary fees - YES. [However], all the ER services at the hospital were provided by an out of network Medical Group. The insurance provider washed hands of the event, and stated they had paid hospital the agreed fees. The Medical Group has now come after me for \$1,900, on the basis that they are private practitioners providing all the hospital's ER services under a contract. Talk about a charade! This type of subterfuge in our New Jersey MUST be curtailed. (Story shared April, 2015)

Linda

East Brunswick

My daughter was running a temperature, had pain on her side and had dark urine. I brought her to the pediatrician. He suspected a kidney infection but wanted an additional test so sent us to the ER. The pediatrician of course is in-network and so is the hospital he sent us to. After a few hours in the ER, they hooked her up to an IV and took some blood and urine. In addition, they did a sonogram, gave her something for the nausea and finally an antibiotic. Of course this was done by nurses and technicians. Finally, a doctor came in and examined her briefly saying she would return later with test results. Hours later she did return and told us everything was fine. I paid my \$50 co-pay and the hospital accepted the insurance company's payment for everything. Unfortunately, the doctor was out-of-network. Since the doctor is not under contract with the insurance company they do not have to accept what the insurance company pays them. The doctor billed \$1322 of which my insurance paid \$557. They are billing me for the balance of \$765. (Story shared December, 2014)

Alan

Fair Lawn

As a pet groomer there are certain hazards that can occur at any time. About a year ago, I groomed a cat that suddenly bit me and bit hard. Eventually the bleeding stopped but I went to the emergency room at [hospital] since cat bites can be dangerous. I was prescribed antibiotics and all was well. Or so I thought. I received a bill in the mail from the doctor who treated me. What a surprise, especially since I went to an "in network" hospital and paid my copayment. Should I have shopped around first or interviewed the doctors on staff to see who, if any was part of my insurance network? Why is it called an emergency room if I have to do that? Needless to say, the bill was a surprise but I refused to pay it. Even if it were only a few dollars, on principle I felt that it should have been part of the emergency room service. To this day, the doctor's bill is unpaid and will remain that way. (Story shared December, 2014)

Betsy

Leonia

My daughter had an emergency appendectomy. We couldn't choose the doctors who treated her, and were surprised when we got a bill from one of the doctors who was in the emergency room. (Story shared March, 2015)

Sheryl

Medford

I accidentally slit my thumb while carving a pumpkin. As it wouldn't stop bleeding, I asked my neighbor what she thought as she is an emergency room nurse. She thought it should have stitches so I drove myself to the emergency room. One of the people who worked on me must not have taken my health insurance [insurance company] and I was sent a bill for his work. (Story shared March, 2015)

Unknowing Use of an Out-of-Network Provider in an In-Network Facility

In addition to charges arising from the emergency room context, consumers find themselves faced with bills from out-of-network providers delivering services in an in-network facility or at the request of an in-network physician. This situation could occur even when an individual identifies an in-network hospital and provider to perform a particular procedure, only to find the anesthesiologist, assistant surgeon or radiologist performing attendant services is not in network. Similarly, a person who finds herself or himself in a hospital following an emergency room encounter may be provided an out-of-network specialist, physical therapist or psychologist *without* any opportunity to receive care from a network provider. Bills from out-of-network laboratories for tests ordered by a network provider or from ambulatory care centers where a network provider performed services may also give rise to such out-of-network charges. Under these scenarios, the non-network provider or facility is permitted to bill the patient. Furthermore, there is no guarantee how much the insurer will pay (if at all) for coverage of these types of inadvertent charges. Again, under New Jersey law, state regulated plans are required to hold patients harmless for services delivered in an in-network facility, but many consumers do not know this. Despite this protection, the cost the plan pays to settle the claim may ultimately be passed on to the consumer through higher premiums.

How prevalent is this problem? Although the data on the extent and impact of balance billing by out-of-network providers who deliver services to patients who sought treatment from an in-network facility or provider is not available to advocates and policy makers, Consumers Union and the New Jersey for Health Care Coalition have heard from many consumers incurring such charges. Below are some of their stories. Others are included in the Appendix.

Amy

Fair Lawn

I was pregnant. I was having a C-section. My hospital was in network, my doctor was in network. But the anesthesia group was not in network. How am I supposed to have a c- section without anesthesia? I was billed \$800. (Story shared December, 2014)

Bruce

Cherry Hill

I broke my arm in 2010 and required an open humerus reduction with placement of an intramedullary rod. I was covered by [insurance company] PPO, and thought that the surgeon's bill would be fully covered, and it was, However, I later received a bill for \$1250.00 (enclosed in a handwritten envelope), from a person who called herself a "surgical assistant" which also came with a warning that I was responsible and if I didn't pay my account would be forwarded to a collection agency. After numerous frustrating phone calls and letters to my insurance company, it became clear that they wouldn't pay for the bulk of the bill and since the procedure was done by an out of network provider in an "outpatient surgical center" conveniently located on hospital grounds outside of the main hospital ([hospital name]). This billing practice was legal, despite the fact that I was never told that such a person would be present at my operation. I ended up paying the bill as I didn't want to have my credit wrecked. (Story shared March, 2015)

Connie

Rocky Hill

My son had his torn labrum repaired in Oct 2014. We selected a highly reputable doctor in our network. The surgery was around \$35,000.00 -- all supposedly covered by our insurance. I thought everything was fine and then a few months later the insurer sent a description of benefits explaining that it was our responsibility to pay the surgical assistant because she was out of network. I called the insurance provider and they said they sent me \$30 which was 70% of what remained after they subtracted the deductible for out-of-network expenses. I told them I would pursue the matter through the orthopedist as they chose the assistant. Their office told me initially I would have to pay it but I was emphatic that it wasn't my mistake and I didn't authorize them to go out of network. Subsequently, when the bill came from the surgical assistant I called back and the doctor's office felt that it was a mistake and that the insurance should cover it. They told me to call the surgical assistant. They agreed that it was strange and they looked into it and called me back to say the insurance provider was reevaluating and would send me a check. They said whatever the insurance paid they would accept as the total payment. I just got a third warning from the surgical assistant but I was told yesterday that a check was coming next week for \$600. I am satisfied that this matter will be resolved. It was, however, a completely unnecessary headache. I am very happy that

Consumers Union is advocating for a law to prevent this. I fear that some people would pay a bill like this with no questions asked. (Story shared March, 2015)

Geri

Chatham

I am an RN with more than 40 years experience and I am pretty savvy about navigating the healthcare ins and outs. My husband had 4 vessel heart by-pass [surgical procedures on] September 19, 2013. He recovered well and since it was late in the insurance year [and our deductibles were met], almost everything was covered by my [private] insurance and his Medicare. In December, 2014 -- more than a year after the surgery, and long after the acceptable window for submitting bills for 2013 -- we are receiving bills from a person involved in the surgery whom we never met and cannot identify. The insurance people are very nice but refuse to pay it. The billing people are now sending us bills with interest charges! Certainly nothing compared to the man with the \$117,000 bill, but frustrating and upsetting. What is to prevent anyone sending a bill years after the fact that you will then be dunned or, and cannot dispute? (Story shared March, 2015)

Anthony

Piscataway

My primary care doctor referred me to a specialist at the same facility where I was originally told they all accept my [insurance company] insurance. After seeing this doctor I got billed much higher out of network charges. I was later informed that this doctor is an outside doctor that visits once a week and he does not accept [insurance company]. After a long battle I paid the higher copay. About a year later I received a corrected EOB from [insurance company] showing he should have charged in-network rate. However, the facility, [medical practice] group, refused to return the difference that I paid. Apparently his charge should have been in-network at the start. (Story shared March, 2015)

Lydia

Brick

I was scheduled for an endoscopy. I verified that the surgical center and the doctor performing the procedure were approved by my insurance. A few weeks later I get a bill from the anesthesiologist. I called the insurance company to find out why there were not covering this cost and they told me the anesthesiologist was out of network. Although I had confirmed with the insurance company about the surgical center, the anesthesiologist is separate from the center and files their own bills. I thought the anesthesiologist would be part of the center but obviously not and this information was communicated to me. I ended up having to pay the anesthesiologists out of pocket. (Story shared December, 2014)

Hilary

Oakland

My husband had knee surgery in a NJ hospital in our insurance scheme; and required a venous check after the surgery because he was still in pain. 6 months after the surgery we received a bill from a medical office we had never heard of for a charge that had been refused by the medical insurance company.

When we enquired, the 'service' was reading the results of the scan by a person who did not accept our plan. [Our] complaints to [the hospital] received the reply that the law allowed them to use someone not in the plan and we had to pay or risk our credit score: and that we had accepted that when we signed before the operation to say that we would be responsible for any unpaid charge. (Story shared December, 2014)

Margaret

Matawan

I had a diagnostic procedure done in June of 2013. My doctor was in network as well as [the same hospital]. Turns out the anesthesiologist was not and did not discover until several months later when I received a bill for \$1200! However the anesthesiologist's office asked me to contact [my insurance company] and [the insurance company] did in fact pay me to pay them. (Story shared December, 2014)

Gerald

Montclair

I had an endoscopy of my esophagus with an in-network doctor at an in-network outpatient surgery center. I was under anesthesia and unconscious and did not know that biopsies would be ordered and sent outside. The biopsy provider billed me for \$10,000 because even though the test was an appropriate procedure and normally covered, the provider was out of network (even though it was in network with [insurance company] in general, supposedly not with my specific [insurance company] plan. Thankfully, the office of the doctor who did the endoscopy and selected the providers handled the issue and I never had to pay the \$10,000. But I received bills for 3 months before it stopped. I am still unsure of what happened. (Story shared March, 2015)

Donald

Martinsville

I continually get bills for out of network reading of EKG despite specific instructions that all providers must be in network. These bills originate from hospitals and doctors who are in network, and I am never asked to approve the out of network charges. (Story shared March, 2015)

The Out-of-Network Exception

In New Jersey, one often hears from consumers that they are unable to identify a specialist, and in particular, a psychologist or psychiatrist, that is accessible and within their health plan's network. Whether this is a function of provider networks that by design are too narrow, inaccurate network directories or a reluctance of certain physician specialties to serve patients at in-network reimbursement rates, we cannot answer. Nonetheless, there are situations in which consumers need to consult with or receive health services from a provider who is not in the plan's network. Under such circumstances, patients covered by health plans regulated by the State may request an out-of-network exception allowing them to access physicians outside of the network, at in-network rates if approved by their health plans. In fact, consumers are able to appeal denials of such requests (for treatment by a non-network provider) through the medical utilization appeal process.⁵

BASIC COMPONENTS OF CONSUMER PROTECTIONS

Although insurers have data to document how frequently the above four scenarios occur it is not available to other health care stakeholders or policy makers. However, states across the country are moving forward to enact legislation to protect consumers from balance billing. Some states are taking a minimalist approach and simply focusing on requiring that plans and providers make consumers aware of the potential financial consequences of going out-of-network, but offering no protection for balance billing. Others seek to remove the consumer from payment disputes between the plans and the providers by providing either a dispute resolution process or regulating the amount the plan must pay to a provider for surprise out-of-network charges. Still others, such as New York, have taken a more comprehensive approach. The Coalition is advocating a similar approach here in New Jersey. Consumers receive surprise medical bills for many different reasons. A comprehensive approach is needed to prevent these surprise bills. We must systematically reduce and eliminate the causes and circumstances under which they are generated, and create mechanisms to promptly and fairly resolve billing disputes. It is our position that proposed legislation must be multi-pronged, address several aspects of the "out-of-network" problem and balance the interests of consumers, plans and providers in a way that improves the quality and financial sustainability of the New Jersey health care system as a whole. We, as consumers, have a role to play as well and need to be educated and informed in order to make responsible, cost effective decisions about our health care. Beyond the immediate costs of care, we are concerned about the less direct costs to consumers and employers (who provide health insurance to their employees) in the form of higher premiums.

Disclosure and Transparency

Several states have adopted measures designed to ensure that consumers understand that they might face balance bills in emergency situations or when they receive services from a team of providers even if using an in-network facility or physician. Such measures include requiring insurers to include language in notices or plan summaries, or requiring providers to give notices to consumers at the point of service of such financial possibilities. Other states, including New Jersey, require insurers to provide accurate and easily available network directories, while a smaller number of states require disclosure of specific information on the cost of using a non-network provider.

However, consumers need more than a pro forma disclosure that simply tells them that they may face a balance bill under certain circumstances not within their control. Consumers need to be told early in the process :1) whether a facility or provider is in-network or out-of-network,; and 2) how much the service or procedure will cost, so they can understand any potential cost-sharing, and 3) have adequate time and opportunity to make a choice to receive care from an in-network provider. Despite the benefits of receiving such information, mere disclosure, is not sufficient to protect consumers from the prospect of facing inordinately high out-of-network charges, especially in situations in which the consumer cannot exercise choice. Other protections are needed.

Balance Billing Prohibitions and Hold Harmless Provisions

Two additional protections include prohibiting balance billing altogether in certain situations, and holding consumers harmless from having to pay the balanced bill. These often take the form of an outright prohibition on billing consumers beyond any in-network cost sharing when the patient receives services in an in-network facility, or in emergency situations, regardless of the network participation status of the facility. In some states, the ban applies only if the out-of-network provider agrees to accept payment from the insurer directly and accepts that payment as a payment in full. Other states, such as New Jersey, currently require health plans regulated by the State to hold their members harmless in these situations, regardless of whether the provider agrees to accept the payment as payment in full or not. Holding harmless means that the plan must pay the provider his or her billed charges (or some lower amount that is acceptable to the provider) and must shield the consumer from a balance bill. A key deficiency with both of these protections is the assumption that consumers will know to send any bill they do receive from the provider to the insurer. As the stories indicate, many consumers simply do not know this, or understand why it should be necessary. In either case, if higher costs are incurred by the health plan that are out-of-line with what comparable providers are charging, they will eventually be passed to consumers in the form of higher premiums. Accordingly, while balanced billing bans and hold harmless

rules help protect the consumer from billing disputes, they may fail to adequately prevent provider overcharges and achieve cost containment goals.

Mediation and Dispute Resolution to Ensure Adequate Payment

Not only do balance billing prohibitions and hold harmless provisions not adequately protect consumers in the long run, they often leave insurers and providers in a dispute over the issue of what constitutes an adequate payment. There are a variety of benchmarks used by health plans to guide reimbursements for out-of-network payments. These include: a percentage of Medicare rates for specific services, such as 140% of the Medicare rate; the usual and customary rate (UCR) for the service, often based on the national database maintained by FairHealth, Inc, a nonprofit based in New York; and a variety of third-party or proprietary benchmarks developed by the health plans themselves. Thus, there is a range of external benchmarks available to guide payments for out-of-network services. However, the problem is complicated by the fact that the “Usual and Customary” rates provided by FairHealth are based on billed charges, and not negotiated rates, and thus may exceed market norms for what providers routinely accept for payment for specific procedures. Better transparency for health payments could help create better reimbursement benchmarks that would ensure that health plans and consumers do not over-pay for comparable health care services.

Under the Affordable Care Act, the federal government created guidelines intended to reduce balance billing disputes from emergency care. Plans must pay the greatest of these three amounts:

- The amount the plan would pay in-network providers;
- A payment that is calculated using the method the plan normally uses to pay for other out-of-network services (such as usual, customary and reasonable charges), but applying the in-network cost-sharing provisions; or
- The amount Medicare would pay for the service.

Other states, including New York, refer billing disputes between health plans and providers over surprise out-of-network bills to an independent dispute resolution process rather than set a specific rate. These alternative dispute resolution mechanisms assist consumers insofar as they are protected from being in the middle of the payment conflict between the provider and the plan. Moreover, New York’s decision to use baseball arbitration seeks to encourage plans and providers to each submit their best offer, to encourage both health plans and providers to be reasonable, and facilitate voluntary settlements prior to the actual arbitration. The Coalition proposes a hybrid of the different state methods to ensure an adequate payment. We recommend baseball arbitration, where the independent reviewer can consider a host of factors, including the

median rates paid by New Jersey plans for specific services (as presented in a Health Price Index compiled by the State).

Adequate Networks

The best way for consumers to avoid balance billing is to be covered by health plans with adequate networks. However, in recent years insurers have changed the designs of their provider networks, and many plans appear to be offering narrower networks. Accordingly, more and more New Jerseyans may be increasingly faced with surprise billing situations. This may be for an encounter with an out-of-network provider delivering services at an in-network facility, or when they are referred to non-network specialists by their in-network primary care physician. The trend to narrower networks may also lead to more situations in which medically suitable providers are unavailable, either because providers are not taking new patients or certain types of physicians are not adequately represented in the network. In the latter case, plans must be willing to permit patients to see non-network physicians at in-network rates, and be amenable to negotiating single case agreements. At minimum, states must routinely audit the adequacy of regulated health plan networks to ensure that consumers have the opportunity to remain in-network.

Health Payment Transparency

New Jersey has the distinction of being among the several states that do not have transparent processes when it comes to setting and capturing data regarding health care rates, charges and reimbursements. Moreover, those concerned with researching this data often run into roadblocks in their efforts to obtain information under the Open Public Records Act. Health care costs and cost remedies cannot be explored in the absence of this data, or when the claims of “proprietary information” are used to deny publication of any data in existence. A system of collecting and organizing the information is vital to make health care data available to policy makers and to researchers to improve health care quality, reduce health care costs, and increase pricing transparency. It should be noted that most stakeholders involved in the issue of out-of-network balance billing agree that such macro-data transparency is a positive step toward securing equitable, affordable and quality health care in NJ, and the Healthcare Price Index is a very positive a step in this direction.

CONCLUSION

In order to meet the challenges highlighted here by the phenomenon identified as unexpected balance billing or out-of-network charges, New Jersey must respond in a comprehensive manner to protect consumers at the same time as meeting the legitimate interests of health plans and providers. Moreover, to fully protect all New

Jersey consumers, any and all provisions adopted by the State to address the issue of surprise medical bills must be made available to consumers who are covered under federally regulated (self-insured) health plans through which the majority of New Jersey consumers are insured.

¹ The Affordable Care Act patient protections with respect to out-of-network charges are limited to patients receiving emergency services. Pursuant to section 2719A of the Public Health Service Act, as amended by the ACA, plans may not require preauthorization whether the facility or provider is in-network or out-of-network. Copayments and coinsurance must be the same for emergency services whether in-network or out-of-network; and deductibles or out-of-pocket maximums applicable to out-of-network services may only be applied to emergency services if the requirement applies generally to out-of-network care, and must be applied towards the overall non-network services cost sharing requirements of the plan. To reduce the occurrence of balance billing for emergency services, the plan must pay the greatest of three amounts; however, providers may balance bill patients for charges not paid by the health plan. The regulations set forth minimum payment standards and plans must pay a “reasonable” amount to providers before a patient is held responsible. 29 C.F.R. § 2590.715-2719A and 45 C.F.R. §147.138.

² Under current New Jersey regulations, consumers who receive care from out-of-network providers whom they have no ability to choose or avoid are partially protected from paying resulting charges. These rules (applicable to fully insured HMOs and other non-HMO network based plans, and are voluntarily followed by many self-insured employer plans operating in the State) require that coverage be provided to consumers for out-of-network services at in-network levels for : (a) emergency services rendered by out-of-network providers, including ambulances, N.J.A.C. 11:24-5.3; (b) treatment at an in-network facility by an out-of-network specialist or other provider, N.J.A.C. 11:22-5.8(b); or treatment by an out-of-network provider when the consumer tries to locate an in-network facility or provider, but access to medically necessary services is limited so they must select or be referred by their plan to an out-of-network provider, N.J.A.C. 11:24-5.1(a) and N.J.A.C. 11:24-9.1(d).

³ This paper relies, in part, in structure and content on “Balanced Billing: How Are States Protecting Consumers from Unexpected Charges?” By Jack Hoadley, Sandy Ahn and Kevin Lucia (The Center on Health Insurance Reforms, Georgetown University Policy Institute, June 2015).

⁴ See generally, N.J.S.A. 17B:27A-4.7 (individual market) and N.J.S.A. 17B:27A-19.11 (small group) and implementing regulations, N.J.A.C. 11:24-6.2-6.3 (HMOs) and N.J.A.C. 11:24A-4.10 (managed care plans where there is a difference between in and

out-of-network benefits for one or more covered services and there is a gateway system).

⁵ See N.J.A.C 11:24A-4.6(a) permitting one to file medical utilization appeal when denied access to out-of-network provider when no appropriate in-network provider is available