Policy Topic: Surprise Medical Bills

State: Pennsylvania

What is a Surprise Medical Bill?

Any medical bill for which a health insurer paid less than the patient expected. Surprise bills can come from in-network or out-of-network providers and can take many forms.

How Do Surprise Medical Bills Occur?

There are many reasons surprise bills occur: enrollees not fully understanding the terms of their health coverage; errors in their health plan’s “directory” of in-network doctors and hospitals; insufficient network adequacy and restrictive coverage policies; inadequate disclosure about out-of-network providers; and poor protections for consumers.

What’s the Consumer Harm from Surprise Medical Bills?

For most families in Pennsylvania, affording the out-of-pocket costs associated with healthcare is very difficult. Even worse is when these families cannot budget for the expense because of bills they did not expect. A 2018 survey found that 31% of privately insured Pennsylvania adults reported receiving a medical bill that included an unexpected expense in the prior 12 months. More than one-third indicated that the issue was not resolved to their satisfaction.

Surprise Bills from Out-of-Network Providers More Prevalent Among Those with Private Health Insurance

One type of surprise medical bill is a surprise out-of-network bill. These bills can affect anyone but they are particularly prevalent for those with private health insurance. Unlike traditional Medicare, with almost all providers accepting Medicare payments and strong balance billing protections, private health plans have more limited provider networks, and little in the way of balance billing protections.

Alarmingly, across the U.S., 1 in 7 privately insured patients received a surprise medical bill despite obtaining care at an in-network hospital because they were treated by an out-of-network doctor. Sick patients often do not have the ability to choose the doctors who treat them in a hospital setting.

What is Balance Billing?

Balance billing occurs when you are charged the balance that is owed in a dispute between an insurer and provider. When you use an in-network provider, they are capped on what they can bill you because they have a contract with the health plan.

However, when you receive services from a doctor or hospital that does not participate in your insurer’s network, that provider is not obligated to accept the insurer’s payment as payment in full and may bill you for the remaining, unpaid amount.

In the example at right, if the provider was in-network, the patient would only owe $150. But if the provider is out-of-network, the provider can bill for $150+$200=$350.

<table>
<thead>
<tr>
<th></th>
<th>Provider Charge</th>
<th>Plan Allowed Amount</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Bill</td>
<td>$500</td>
<td>$300</td>
<td>$200</td>
</tr>
<tr>
<td>Plan Pays</td>
<td>$150 (50%)</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Patient Pays</td>
<td>$150</td>
<td>$200</td>
<td></td>
</tr>
</tbody>
</table>

*See the companion glossary for help with this complex policy topic.*
ADDRESSING SURPRISE MEDICAL BILLS

Many patients, legislators and regulators believe these surprise bills are very unfair. Both states and the federal government are looking at a range of solutions to address the problem. States can regulate private health plans that are sold to individuals and smaller employers, but the U.S. Department of Labor is in charge of the plans offered by larger employers.

STATE SOLUTION 1: ENSURE PROVIDER DIRECTORIES ARE ACCURATE

Accurate provider directories are essential for finding in-network doctors and hospitals to get needed care. Provider directory errors are exceedingly common and can lead consumers to incur unexpected out-of-pocket costs and surprise medical bills. The federal government has minimum standards for private health plans sold on the Obamacare Marketplaces:

- Provider directories must be updated monthly and up-to-date information from providers collected quarterly.

Several states, but not Pennsylvania, have rules requiring more frequent updates to online provider directories and/or apply those rules to more types of health plans. Moreover, update requirements are helpful but may be insufficient if health plans don’t take additional measures to ensure the accuracy of the information. Steps like:

- Conduct regular audits of provider directories, with directory edits based on findings
- Contact inactive providers
- Guarantee to honor provider directory information

CA, TX, NJ and DC are examples of states that have passed stronger measures. The National Association of Insurance Commissioners has a model law that includes:

- Mechanism for the public to report directory inaccuracies to health plans and a requirement that insurers to periodically audit their directories.

But most states have not adopted this model language. Another consumer-friendly feature of this model law is continuity of care protections for enrollees who are in the middle of an active course of treatment, if their providers leave or are removed from their health plan’s network.

STATE SOLUTION 2: ENSURE PROVIDER NETWORKS ARE ADEQUATE

A general rule is that a plan’s provider network must be adequate to deliver benefits promised under the plan. For example, the network must have enough OB-GYNs to meet the needs of woman enrolled in the plan. This standard is particularly important as private health plans narrow the size of their networks to rein in premium increases. Network adequacy standards can and should balance consumer protection principles with the goals of reduced costs and accessible, quality care.

Unfortunately, comprehensive network adequacy standards are missing in many states. Many state-level policies are outdated, developed years ago to regulate managed care networks (primarily Health Maintenance Organizations or HMOs). Strong network adequacy standards ensure that consumers have meaningful access to providers and include:

- Minimum enrollee-to-provider ratios, with specific provision for counting providers that are accepting new patients.
- Geographic access: Maximum travel times and/or distance standards (miles) that patients can be required to travel.
- Timely access: Maximum appointment wait-time standards for in-network providers, distinguishing between urgent and non-urgent care.
- Provisions for auditing and oversight by the state.

See the companion glossary for help with this complex policy topic.
For managed care plans, Pennsylvania has rules in place specifying both time and distance maximums for geographic access (with a variation that accounts for population density). Health plans must meet these standards for 90% of their members. The state does not have standards for appointment wait times or provider/enrollee ratios.

**State Solution 3: Better Disclosure at the Point of Insurance Shopping**

It is very difficult for consumers to have a good sense of the provider network when shopping for health plans. We are aware of no states have summary indicators signaling the narrowness or breadth of the provider network even though researchers have developed methodologies for doing this. Moreover, no states inform shoppers about how likely they are to get an out-of-network bill while getting care at an in-network hospital or other facility. Again, researchers have developed claims data analyses that tease out this information, proving feasibility. Only Texas has a law that requires health plans to report how often in-network hospitals don’t feature in-network ER docs but this information is only actionable when a Texas Advocacy group created a summary table for consumers.

**State Solution 4: Protect Consumers from Inadvertent Surprise Out-of-Network Medical Bills**

Only nine states—California, Connecticut, Florida, Illinois, Maryland, New Hampshire, New Jersey, Oregon and New York—have laws providing “comprehensive” protections against balance billing from surprise out-of-network bills. These are bills that occur because an out-of-network doctor was unexpectedly working at an in-network hospital or the emergency care was needed and there wasn’t time to get to an in-network hospital. Comprehensive protections against balance billing include:

- Extend protections to both emergency department and in-network hospital settings
- Apply laws to all types of insurance, including both HMOs and PPOs
- Protect consumers both by holding them harmless from extra provider charges—meaning they are not responsible for the charges—and prohibiting providers from balance billing, and
- Adopt an adequate payment standard—a rule to determine how much the insurer pays the provider — or a dispute-resolution process to resolve payment disputes between providers and insurers.

Pennsylvania has limited protections. It holds consumers harmless for out-of-network emergency care received from an HMO or a PPOs that require gatekeepers.

**Find people also concerned about this issue:**

(to be filled in by local engagement partner/backbone organization)

**Take an action/contact your state representative:**

(to be filled in by local engagement partner/backbone organization)

These materials were created by Altarum, a nonprofit health solutions company, working in partnership with Public Agenda, and supported by the Robert Wood Johnson Foundation. Please send any corrections or suggestions for improvement to Sabah at Sabah.bhatnagar@altarum.org.
Notes


2. Note: This is from the unpublished survey.


9. Ibid.


