PROTECTING CONSUMERS FROM SURPRISE MEDICAL BILLS

Considerations for Governors

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EXECUTIVE SUMMARY

Governors and state legislators are increasingly focused on the impact that surprise medical bills have on consumers. In a 2018 Kaiser Family Foundation consumer survey, 39% of respondents said that they had received an unexpected medical bill; 41% of those bills were over $500.[1] A 2016 Yale University study found that 22% of all emergency department (ED) care was likely to lead to a surprise medical bill. Out-of-network ED physicians had average charges of nearly 800% of Medicare, as compared to in-network ED physicians, who were paid close to 300% of Medicare.[2]

In response, an increasing number of states have enacted consumer protection laws to shield individuals from the high costs associated with surprise medical bills. Eleven states have enacted new legislation since 2017, including six states that enacted laws in 2019. To support governors who are seeking new strategies to address this issue, on Oct. 25 and Nov. 1, 2018, the National Governors Association Center for Best Practices Health Division hosted expert roundtables in Washington, D.C., with a broad group of stakeholders. State officials, national experts, health plan representatives, providers, hospitals, consumers and researchers representing **California, Colorado, Delaware, Florida, Maryland, Missouri, New Hampshire, New York, Oregon, Pennsylvania, Tennessee, Utah, Wisconsin** and **Washington** discussed key challenges and opportunities for states to protect consumers from surprise medical bills. This report summarizes key considerations that emerged during the roundtables and through subsequent expert interviews and research.

Key Considerations for Governors

Governors can support and implement policies that protect consumers from surprise medical bills. As the highest executive authority, working closely with the legislative branch and holding significant consensus-building power, governors have an opportunity to lead the way in how consumers are protected in their states. The following summary of considerations offers insights for governors and other state leaders as they work across the executive and legislative branches and with key stakeholder groups to design and implement strategies that limit surprise billing and maximize consumer protections.

To better protect consumers, governors may support a comprehensive approach that addresses aspects of surprise medical billing such as:

ENGAGING KEY STAKEHOLDERS BY:

- Working with legislative, industry and consumer groups to understand unique perspectives.
- Collecting data and projections from stakeholder groups to understand the impact on cost and coverage.

ESTABLISHING COMPREHENSIVE CONSUMER PROTECTIONS BY:

- Prohibiting surprise medical billing by providers in out-of-network emergency situations, by out-of-network providers in nonemergency situations at in-network facilities and by ground ambulance providers.
- Limiting consumer financial responsibility to in-network cost-sharing amounts for out-of-network emergency situations and in nonemergency situations for out-of-network providers at in-network facilities, and counting these contributions toward a consumer's deductible and out-of-pocket maximum.

ESTABLISHING LIMITS ON REIMBURSEMENT FOR SURPRISE MEDICAL BILLS BY:

- Establishing a set benchmark for reimbursement for providers; and/or
- Creating a binding dispute resolution process for providers and insurers.

EXPANDING APPLICATION AND ENFORCEMENT OF SURPRISE MEDICAL BILLING PROTECTIONS BY:

- Allowing self-insured employers and their employees to opt into surprise medical billing.
- Providing enforcement authority for surprise medical billing.

INTRODUCTION

Governors and state legislators are increasingly focused on the impact that surprise medical bills have on consumers. These bills can place a significant financial burden on individuals with private health insurance coverage, who make up more than 67% of those covered in the United States either through employer-sponsored coverage or coverage purchased through the individual insurance market.[3]

Enrollees in private health insurance pay a monthly premium and a portion of the cost of health care services through copayments, coinsurance and deductibles in exchange for reduced payments for overall health care expenses. Health plans contract with facilities, health care providers, medical transportation companies and other entities to establish a network of providers who accept a negotiated rate. A health care provider or facility that does not contract with an insurance company is considered out of network. An enrollee who chooses to see an out-of-network provider is responsible for a larger portion (or, in the case of some types of plans, all) of the total bill for services.

In an emergency, consumers may not have the ability to choose their health care providers. In other circumstances, consumers may be unaware that an out-of-network provider is part of their otherwise in-network care team. In such instances, the consumer may receive a bill from an out-of-network provider, often referred to as a "balance bill" or "surprise medical bill." A balance bill is the difference between what the insurer is willing to pay for a covered service and what the provider is charging for that service. The term "surprise bill" is used because consumers are often unaware that they have received out-of-network health care services. Throughout this paper, we use the term "surprise medical bill," which includes unexpected balance bills.

Surprise medical billing has become an increasingly prominent issue, with many news outlets releasing stories about individuals who have received bills in excess of tens of thousands of dollars. According to a 2018 Kaiser Family Foundation survey, 39% of respondents said that they had received a surprise medical bill.[4] A 2016 Yale University study found that 22% of all emergency department (ED) care was likely to lead to a surprise medical bill.[5] In addition, a 2014 study of commercial claims and encounter data revealed that 14% of outpatient ED visits were likely to lead to a surprise medical bill, rising to 20% if the patient was admitted to the hospital. The same study found that 9% of elective inpatient services were likely to lead to a surprise medical bill, often because of an ancillary provider (such as anesthesiologists, radiologists, pathologists, and assistant surgeons) being out of network.[6]

States have been leading the way on protecting consumers from surprise medical bills. According to a report by the Commonwealth Fund, as of July 2019, 27 states had implemented either

When Consumers Could Receive a Surprise Medical Bill

Scenario 1: Emergency Situation

An insured consumer is in an emergency situation and receives services at an in-network facility with providers who are out of network or receives services at an out-of-network facility.

Scenario 2: In-Network Facility

An insured consumer receives a nonemergency inpatient or outpatient service at an in-network facility, but some of the providers are out of network, or an in-network provider orders an ancillary service, such as laboratory testing, radiology or diagnostic imaging, from a provider who is out of network.

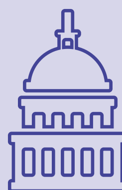
Scenario 3: Ground Medical Transport

An insured consumer is transported in an emergency situation or between facilities in a nonemergency situation by a ground medical transport provider that is out of network.

comprehensive or limited consumer protections against surprise medical billing.[7] Across the nation, this focus has intensified over the past three years; 11 states have enacted laws during that time period, including six states (**Colorado**, **Missouri**, **Nevada**, **New Mexico**, **Texas** and **Washington**) that enacted major legislation in 2019. In addition, three states which previously had some protections (**Colorado**, **Texas** and **New Jersey**) have enacted more comprehensive legislation, illustrating a trend toward more comprehensive protections for consumers.

States, however, are limited in their application of surprise billing laws. Under the Employee Retirement Income Security Act of 1974 (ERISA), states are preempted from regulating insurance policies that private employers offer through self-insurance, where the employer bears the primary risk for employee health care costs and contracts with a private insurance company to act as plan administrator.[8] With as many as 60% of individuals with employer-sponsored coverage enrolled in self-insured plans,[9] states are unable to require that surprise billing protections extend to all residents.

Need for Federal Action



Congressional action is needed to address the parts of the insurance market where states cannot act. The National Governors Association (NGA) has released principles to Congress and the Administration that include requesting congressional action on surprise medical billing.* As of July 22, 2019, several bipartisan bills had been formerly introduced that offer surprise medical billing protections for both fully and self-insured individuals. If federal legislation is enacted, states would need to consider the impact on any state laws governing surprise medical billing.

*NGA's "2019 Principles for Federal Action to Address Health Care Costs" can be found at https://www.nga.org/wp-content/uploads/dlm_uploads/2019/05/NGA-Health-Care-Costs-Principles-FINAL.pdf.

STRATEGIES FOR GOVERNORS

Engage Key Stakeholders

CONSIDERATIONS FOR GOVERNORS

Surprise medical billing policies affect a wide array of stakeholders, including legislators, providers, insurers, hospitals and other facilities, ambulance services, and most importantly, consumers. Governors seeking to support policy change may consider:

- **Working with legislative, industry and consumer groups to understand their unique perspectives.**
- **Collecting data and projections from stakeholder groups to understand the impact on cost and coverage.**

STRATEGY: ***Work With Legislative, Industry and Consumer Groups to Understand Their Unique Perspectives***

Most states that have enacted surprise medical billing laws have engaged in robust stakeholder engagement. Although surprise medical billing policies have received widespread bipartisan support throughout state legislatures, individual stakeholder groups have typically been the source of greatest opposition.

In most states, legislation establishes key components of surprise medical billing requirements, which the executive branch then implements and enforces through regulation and guidance. The process may begin with the executive branch working with industry stakeholders to flesh out concepts for legislation that are then promoted by a legislative champion who sponsors a bill. Typically, the state's department of insurance, which oversees insurance regulation, plays a major role in policy development. In other cases, a legislator who has a significant interest in the issue may initiate the process.

In addition to legislators, key stakeholder groups that should participate in discussions include insurers, providers, hospitals and other facilities, consumers and employers. Through stakeholder engagement, governors can gain a clearer perspective on both the intended goal of proposed surprise medical billing protections and potential consequences.

Some states have taken the approach of conducting large stakeholder forums, and then sharing iterative drafts of either policy concepts or legislative language, including stakeholder comments. This approach, although time intensive, provides full transparency and limits the number of unexpected proposals for stakeholders. Other states have held individual stakeholder meetings to understand stakeholders' unique perspectives. This strategy can potentially result in honest and frank conversations. However, it can also result in extensive back-and-forth discussions as the state collects information. A number of factors impact stakeholders' perspectives and willingness to compromise, including the number of health insurance plans offering coverage in the individual market, the number of narrow network health plans, the extent to which providers choose not to participate in health insurance networks, and billing trends.

STRATEGY: ***Collect Data and Projections From Stakeholder Groups to Understand the Impact on Cost and Coverage***

States have unique challenges, but establishing a reimbursement methodology (see "Strategy: Establish a Set Benchmark for Reimbursement" for more information) is commonly one of the most contentious pieces of surprise medical billing legislation. Using data throughout the process to better understand the reimbursement landscape has been one tactic states have used to add a level of objectivity to the policymaking process. For instance, a benchmark that is significantly different from current contracted rates could have an impact on the negotiating power and contracting relationship between providers, facilities and insurers. In addition, different types of providers

may historically have highly variable negotiated reimbursement arrangements. For example, 130% of Medicare may represent significantly more or less than the contracted amount of a specific provider type. State policymakers will need to consider these variations when establishing benchmarks. States can collect data from stakeholders or use data sources such as all payers claims databases (see the box "Potential Data Sources for Establishing Payment Rates" for more information about data sources) to understand historical provider payments.

Establish Comprehensive Consumer Protections

CONSIDERATIONS FOR GOVERNORS

Governors seeking to ensure that consumers are protected against receiving surprise medical bills may consider supporting policies that are comprehensive in their approach. Such polices include:

- **Prohibiting surprise medical billing by out-of-network providers.**
- **Limiting consumer responsibility to in-network cost-sharing amounts.**

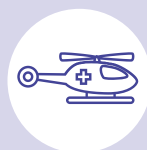
STRATEGY: ***Prohibit Surprise Medical Billing by Out-of-Network Providers***

Several states have implemented billing practice requirements to protect consumers from surprise medical bills. The most protective of these strategies, which is becoming increasingly common, is prohibiting surprise medical billing entirely. These prohibitions bar providers from billing consumers above their predetermined copayment, coinsurance and deductible levels. These prohibitions apply to both emergency services at in-network and out-of-network facilities as well as to all out-of-network providers at in-network facilities. **California**,[20,21] **New York**,[22] **New Jersey**,[23] **Connecticut**[24] and **Maryland**[25] have all taken this approach.

Surprise Medical Bills for Ambulance Services

Consumers do not typically select a ground or air ambulance provider, and an increasing number of consumers have reported receiving surprise medical bills for these services.[10] According to a 2014 study conducted by the University of Missouri, out-of-network ground ambulance services paid for by large group employer plans represented half of ambulance services.[11] The Government Accountability Office states that over two-thirds of air ambulance transports of privately insured patients are out of network.[12] Surprise medical billing is an issue in both air and ground medical transport, but state authority to provide policy solutions varies.

AIR AMBULANCE



Air ambulance services can play a critical role in emergency situations and for individuals in remote settings, but services can be expensive for consumers when providers are out of network. The Airline Deregulation Act of 1978 (ADA) prohibits states from regulating the price, route or service of any air carrier, including air ambulance services, giving the Federal Aviation Administration regulatory jurisdiction over all air providers.[13] Most attempts by states to regulate air ambulance billing have been struck down by courts on the basis of federal preemption under the ADA.[14] In NGA's Principles for Congress and the Administration, governors request that Congress provide states with the authority to regulate air ambulance billing or impose a federal prohibition on surprise medical billing by air ambulance providers.

GROUND AMBULANCE

Unlike air ambulance states may have the authority to directly regulate ground medical transportation. However, few states have addressed ground medical transportation in surprise medical billing laws. **Connecticut**[15] and **Utah**[16] both set reimbursement rates for ground ambulance statewide. **Maryland** has a surprise medical billing prohibition that is specific to ambulance companies that are under the jurisdiction of a political subdivision of the state (such as city, town or county).[17]

One potential reason for the lack of state action is that ground ambulance policies are frequently set at the local level. According to the National Association of Emergency Medical Technicians, more than 65% of ground ambulance services in the United States are provided through local public ambulance services, such as fire departments, police departments or other local government agencies.[18] The **Florida** Emergency Medical Transportation Working Group found that local government provided about 97% of ground ambulance services in the state.[19] Jurisdictional issues may be one reason why most states have not taken statewide legislative action.

States have also enacted hold-harmless protections, which are distinct from and less protective than surprise medical billing prohibitions. Stand-alone hold-harmless provisions protect consumers from the legal responsibility to pay a surprise medical bill, but they do not stop providers from sending such bills. In this circumstance, consumers can send a surprise medical bill to their insurer and the insurer will cover the total cost of the bill above the patient's predetermined cost-sharing amount. Hold-harmless policies are effective, however, only if consumers understand that they are protected and should contact their insurer to cover the bill. If consumers do not understand this, they may pay the bills, causing unnecessary financial hardship and stress.

For many years, **New Jersey** and **Colorado** both had stand-alone hold-harmless provisions, but in 2018 and 2019, respectively, these states enacted more comprehensive laws that include billing prohibitions. Similarly, **Texas** previously had a hold-harmless provision and a mediation process for individuals, though protection varied depending on the type of insurance plan the individual had. In June 2019, **Texas** enacted a more comprehensive billing protection, with a full ban on surprise medical billing.[26] Often, states that have billing prohibitions also have hold-harmless protections so that consumers who may be erroneously billed are protected. **California**,[27] **New York**,[28] **New Jersey**[29] and **New Hampshire**[30] all have billing prohibitions and hold-harmless protections.

STRATEGY: ***Limit Consumer Responsibility to In-Network Cost-Sharing Amounts***

States with billing practice requirements must also consider consumers' financial responsibility related to bills. Most states with a billing prohibition limit consumer responsibility to in-network cost-sharing levels. Several states, including **California**,[31] **New York**[32] and **New Jersey**[33] also specify that all payments a consumer makes in a surprise out-of-network medical billing situation must count toward that consumer's deductible and out-of-pocket maximum. **California** further protects consumers from any bankruptcy or liens that could result from an out-of-network medical bill.[34] In addition, several states, including **California**,[35] **Colorado**,[36] **New Mexico**[37] and **Washington**,[38] require providers to refund payments that consumers make in error in surprise medical billing scenarios.

Establish Limits on Reimbursement for Surprise Medical Bills

Governors seeking to ensure that providers receive reimbursement with upper limits as part of a strategy to address surprise medical billing may consider supporting policies that:

- **Establish a set benchmark for reimbursement; and/or**
- **Create a binding dispute resolution process for providers and insurers.**

STRATEGY: ***Establish a Set Benchmark for Reimbursement***

Many states that have billing prohibitions have set payment rates, payment formulas or dispute resolution processes to determine

Assignment of Benefits

States can also consider how to address assignment of benefits with a surprise medical billing prohibition. Under assignment of benefits, consumers authorize out-of-network providers to receive reimbursement directly from insurers. Without assignment of benefits, a consumer would have to pay the provider for services and then seek reimbursement of the allowed amount from their insurer.

Medicare has historically used assignment of benefits to prohibit balance billing by requiring participating providers to agree not to balance-bill Medicare patients.[39] Several states have tied surprise medical billing prohibitions to assignment of benefits processes to remove the consumer from the reimbursement process. **New York**, for example, bans surprise medical billing practices when consumers have assigned benefits to their provider and requires that both health insurance plans and providers inform consumers of this ban prior to billing.[40]

a payment amount for out-of-network providers.[41] Determining a reimbursement rate or methodology for resolution of out-of-network bills has been the most controversial part of new legislation in many states because stakeholders, including providers, hospitals, insurance plans and consumer groups, have varying positions on approaches.[42]

Providers frequently cite the usual, customary and reasonable (UCR) rate of total charges as a preferred methodology for determining reimbursement. The UCR is the rate that providers charge for a particular service in a given geographic area. However, charged amounts can be inflated and are typically much higher than the allowed amount that insurance companies will pay for a service. A 2016 Yale University study found that 22% of all emergency department (ED) care was likely to lead to a surprise medical bill. Out-of-network ED physicians had average charges of nearly 800% of Medicare, as compared to in-network ED physicians, who were paid close to 300% of Medicare.[43] Therefore, using a percent of billed charges as a benchmark for reimbursement could significantly increase reimbursements and costs to insurers, which would likely get passed onto consumers in higher premiums and cost-sharing.

Insurance plans typically favor a percentage of contracted or allowed amounts because that percentage reflects a negotiated amount.[44] Paying a percentage of Medicare rates is an administratively simple option; however, Medicare rates vary significantly across specialties and in some cases may be substantially different from contracted or noncontracted commercial rates. For example, an analysis from the Brookings Institution found that the average contracted payment for anesthesiologists and ED physicians was 344% and 306% of Medicare reimbursement rates, respectively, whereas for all physicians overall, the average contracted rate was 128% of Medicare.[45] Therefore, it is worth analyzing payment rates across payers and provider types when considering appropriate reimbursement as policymakers may wish to lower certain rates but need to consider broader cost and network participation implications.

Potential Data Sources for Establishing Payment Rates

As states evaluate methodologies for establishing reimbursement rates, they should consider the completeness, accuracy and availability of different data sources.

All-payer claims databases (APCDs) are state-run databases that collect provider data and claims data from all payers in a state. These databases are sometimes cited as a reference point for states that use allowed amounts to determine payment rates under surprise medical billing legislation. **Oregon**,[46] for example, uses its APCD as the reference for determining the median contracted rate for services. **New Hampshire**[47] and **Washington**[48] use their APCDs to determine a “commercially reasonable” rate.

Twenty states currently have or are implementing an APCD to collect and analyze health care cost and utilization data.[49] However, in 2016, the U.S. Supreme Court ruled in *Gobeille v. Liberty Mutual* that self-insured plans are not required to report their data to state APCDs because these plans are exempt from state regulation through ERISA.[50] This ruling can present a challenge in states that have a large self-insured market and lack voluntary employer reporting because the database may lack a significant percentage of paid claims data. States should consider how well their APCD reflects the market when considering how to use it as a data source.

FAIR Health is another data source that some states use to determine reimbursement rates.[51] This independent, not-for-profit database contains the health care claims data from many of the largest private health insurance payers in the United States, including Medicare. The database contains predominantly charge data, but it also includes some data on negotiated rates; states can use the database to understand health care costs and utilization. States should consider whether the payers in their market have contributed to FAIR Health and whether there is adequate charge and negotiated rate data available to confirm that it accurately reflects their market.

Table 1, on following page, shows examples of state strategies to set reimbursement levels.

TABLE 1: State Strategies to Set Reimbursement Levels

Reimbursement level	Definition	Example	State	Data sources
Percentage or percentile of contracted rates	A portion of the in-network payment rate that providers and insurers in a geographic region have agreed to previously	100% of the median contracted rate for commercial claims	**Oregon**[52]	• APCD
		60th percentile of the contracted rate in a geographic area, with a minimum reimbursement of 150% of the Medicare rate	**New Mexico**[53]	• FAIR Health data on contracted rates
	A percentage of the in-network payment that a provider has accepted from an insurer in another commercial product type or commercial health plan	100% of the contracted rate that a provider has accepted from an insurer in another commercial product type	**Missouri**[54]	• Insurer data
	Percentage of the contracted rate for providers who previously held a contract with a consumer's insurer	In emergency scenarios: • 108% of the contracted rate if a provider has contracted with the insurer in the past 12 months • 115% of the contracted rate if a provider has contracted with the insurer in the past 12 to 24 months*	**Nevada**[55]	• Insurer data
Greatest of or least of...	The mandated reimbursement rate is the highest or lowest rate based on multiple reimbursement options	The greatest of: • 100% of the contracted rate that the insurer would pay for in-network services • 80% of full charges as reported by FAIR Health • 100% of Medicare	**Connecticut**[56]	• Insurer Data • FAIR Health data on charges • Medicare
		For nonemergency scenarios, the greater of: • 110% of the contracted rate that the insurer would pay for in-network services • The 60th percentile of the contracted rate for an in-network provider in a given geographic area	**Colorado**[57]	• APCD
		The greater of: • 125% of the Medicare rate for similar services • The average contracted rate in a given geographic area	**California**[58]	• Insurer data • Medicare
Commercially reasonable	The reimbursement amount corresponding to commonly accepted commercial practices	Commercially reasonable value based on payments for similar services from state insurers to providers	**New Hampshire**[59] **Washington**[60]	APCD

*Nevada's surprise medical billing law includes an additional benchmark for providers who have not contracted with a consumer's insurer in the past 24 months. For these providers, the insurer is required to give a best offer to the provider. If the provider and the insurer cannot agree on a best offer, then they have the option to go through arbitration.

STRATEGY: ***Create a Binding Dispute Resolution Process for Providers and Insurers***

Some states have instituted a dispute resolution process to determine a fair rate of payment for out-of-network providers in surprise medical billing scenarios. During dispute resolution, each party presents specific information, and a neutral third party helps to come to a determination on the reimbursement amount. The two most common forms of dispute resolution are arbitration and mediation. Some states have state officials who serve as arbitrators or mediators; others use an independent third party.

Some states that have set reimbursement levels also have a dispute resolution process if either an insurer or a provider is dissatisfied with the reimbursement amount determined by the state's reimbursement standard. **California**[61] and **Missouri**[62] both have independent dispute resolution processes in which an independent arbitrator rules on a final reimbursement amount in the event of a challenge from an insurer or a provider.

MEDIATION

"Mediation" is a formal process in which a neutral third party helps the disputing parties determine a final reimbursement level. It is the disputing parties rather than the mediator that ultimately chooses the final reimbursement amount. Mediation can be — but is not always — a binding process.[63] Examples of states that use mediation as a dispute resolution process include **New Hampshire**[64] and **Texas**. **Texas** has a mediation process for facility-based out-of-network claims (from hospitals and free-standing EDs) and an arbitration process for non-facility-based claims (from non-facility-based physicians).[65]

ARBITRATION

"Arbitration" is a formal process in which a neutral third party determines a fair rate of payment. The disputing parties can negotiate with one another and with the arbitrator on reimbursement amounts, but it is ultimately the arbitrator who chooses the final reimbursement, which is typically binding.[66] Arbitrators are frequently given data sources – to refer to when determining the final amount.

States have different policies used by arbitration officials to determine the final reimbursement amount. One form of arbitration is final offer, or "baseball" arbitration, during which both parties give a payment offer to the arbitrator, who chooses between them. The process is called baseball arbitration because it is the process that Major League Baseball uses for salary negotiations with its players. **New York**,[67] **New Jersey**,[68] **Washington**[69] and **Texas**[70] all use baseball arbitration.

Dispute resolution can be a long and arduous process and costly for the parties involved, particularly if they are required to pay the cost of the arbitrator or mediator. Many states have found that parties often come to an informal agreement before completing the formal process. Some states require insurers and providers to complete mediation before participating in the formal process. Missouri[71] requires informal mediation prior to the formal dispute resolution process.

Expanding Application and Enforcement of Surprise Medical Billing Protections

Governors seeking to extend protection from surprise medical billing to as many consumers as possible and to ensure that insurers, facilities and providers comply with protections may consider supporting policies that:

- **Allow self-insured employers and their employees to opt into surprise medical billing protections.**
- **Provide enforcement authority for surprise medical billing protections.**

STRATEGY: ***Allow Self-insured Employers and Their Employees to Opt Into Surprise Medical Billing Protections***

Although states cannot require self-insured employers to comply with surprise medical billing laws because of ERISA, states can offer an opportunity for employers and their employees to opt into the protections. **New York** allows employees with self-insured plans to enter into a dispute resolution process with their provider (a process that is different from that offered to

Other Considerations for Governors: The Impact of Consumer Transparency Requirements

Several states have disclosure requirements, which direct insurers or providers to disclose information to consumers about the potential to receive out-of-network bills and how to check network status to avoid going out of network. As a baseline, under the Patient Protection and Affordable Care Act, insurers are required to explain the consequences of seeking out-of-network care to consumers on the standardized summary of benefits form.[77] Beyond this standard, some states require insurers to provide additional information to consumers about out-of-network coverage. **New Jersey**, for example, requires insurers to provide patients with descriptions of out-of-network benefits, including examples of anticipated out-of-pocket costs for frequently billed services.[78] Some states have also required disclosure requirements for providers and facilities. For example, **New Jersey** requires providers to disclose their network status when consumers book their appointments.[79]

States have implemented other policies intended to increase transparency and consumer understanding. For example, **Washington** requires carriers to update provider network websites within 30 days of a contract change[80]; and **New Jersey** has a similar requirement.[81]

As states seek to implement policies that encourage consumers to make informed decisions for their health care, sharing relevant information will be increasingly important. However, in many scenarios, consumers may be unable to change their behavior, such as in an emergency or when consumers are unaware of who is on their care team. In those situations, disclosure and transparency will not be effective.

Billing Consumers for Facility Fees

Facility fees are service charges that providers bill patients for their use of hospital facilities and equipment. Because facility fees are not related to the physician services that a consumer receives, consumers may be surprised when the fees appear on their bill. A recent survey by NORC found that 43% of respondents had received a hospital or health care facility fee that they had not expected on a medical bill.[82] To date, few states have addressed facility fees as part of surprise medical billing policies. **Connecticut** was one of the first states to require providers to disclose on any bill that included a facility fee the Medicare facility fee reimbursement rate for comparison, what the fee is intended to cover and that the patient would not have been charged a facility fee at a nonhospital-owned facility.[83]

individuals in fully-insured plans). Because the insurer is not required to participate, the arbitrator negotiates between the consumer and the provider and ultimately decides the consumer's required payment to the provider.[72] **New Jersey** also allows employees in self-insured plans to enter arbitration with the provider. In addition, in **New Jersey**, self-insured plans can opt into the full authority of the **New Jersey** balance billing law in the same way a fully-insured plan would.[73] Similarly, **Washington** allows self-insured plans to opt into the full authority of the state's balance billing law.[74] See "Limits on Reimbursement in Surprise Medical Billing Scenarios" for more information about dispute resolution.

STRATEGY: *Provide Enforcement Authority for Surprise Medical Billing Protections*

When developing new surprise billing requirements, states should consider enforcement authority. As state insurance departments typically do not have enforcement authority over providers, states must consider how to enforce surprise medical billing laws. Therefore, states must consider how to enforce surprise medical billing laws. **New Mexico**'s 2019 legislation expanded the enforcement authority of insurance regulators to include jurisdiction over providers for purposes of surprise medical billing.[75] Alternatively, insurance regulators can coordinate with other regulatory bodies, such as state medical boards, which are typically responsible for the licensure and oversight of providers. In **Washington**, the 2019 legislation defined multiple unresolved violations of the surprise medical billing prohibition as "unprofessional conduct" under the state's Uniform Disciplinary Act, and the Washington State Office of the Insurance Commissioner can refer these violations to the entities that oversee professional conduct: the state department of health, which oversees facilities, and the Medical Quality Assurance Commission (MQAC), which oversees physicians and physician assistants. The department of health and MQAC can then take formal or informal disciplinary actions against the provider or facility for "unprofessional conduct."[76]

CONCLUSION

Governors have a significant opportunity to protect consumers from receiving and having to pay surprise medical bills using a range of approaches. As increasing numbers of states implement new and innovative policies, there is a growing number of examples from which others can learn. If Congress takes action, as proposed in NGA's principles to Congress and the Administration, it will likely create a baseline protection for all consumers on which states can build. If this happens, it will be important for states to evaluate their own policies and federal policies over time to understand the impact on contracts, network access and cost of care to consumers as measured through premiums and other cost sharing.

ENDNOTES

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