RESEARCH REPORT

Advisory Board

The surprise billing legislative landscape

What can we learn from states' experiences?

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Introduction

Surprise billing is not only about affordability

Surprise billing continues to garner significant media scrutiny, with stories of unexpected medical bills in the thousands of dollars exacerbating patient fear and frustration around health care affordability. Next to drug pricing surprise billing has become the core health care issue for federal legislators and consumers alike. Federal efforts have focused on the broader issues of health care affordability and examining private equity's investment in stalling surprise billing initiatives. The attention has spurred debate around potential government fixes at the federal level. However, state's continue to enact legislation while providers and insurers (and their respective lobbyists) square off, each advocating for different solutions, while patients are stuck in the middle.

In fact, it is payer and provider disagreement that started surprise bills. **At its root, surprise billing is a result of network inadequacy.** Surprise bills occur when a patient gets an unexpected bill from an out-of-network provider for care they received at an in-network facility. Fundamentally, it's a mismatch: the emergency room where the patient sought care was covered by their insurer, but the emergency physician providing the care was not.

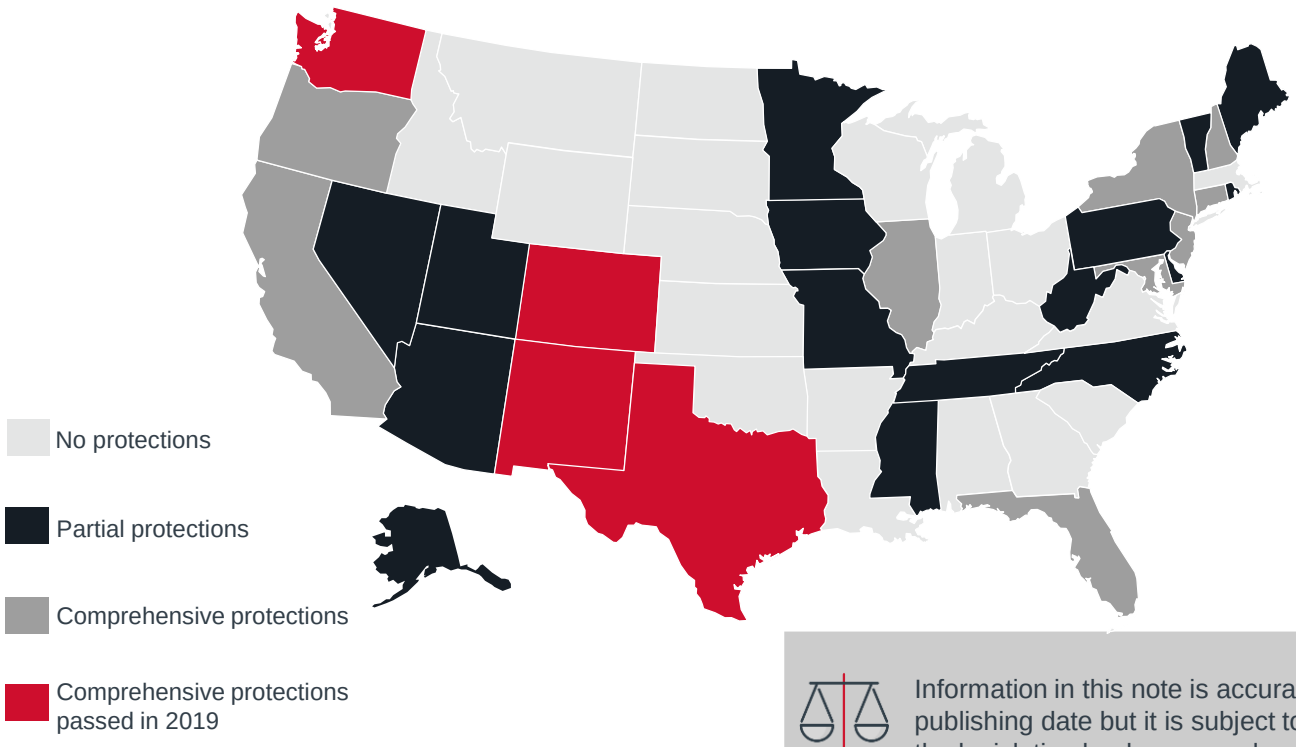
Network inadequacy is not a new issue. Surprise billing or balance billing by another name actually began with the rise of HMOs and network narrowing across the country.[1] This new wave of attention is a result of both the size of surprise bills and the frequency with which they occur.

Why is surprise billing in the news now?

Media coverage of balance billing horror stories has increased awareness of rising health care costs, and legislatures have reacted, introducing and passing legislation to mitigate patient impact.

But even legislation isn't new; Alaska passed the first surprise billing legislation in 2004, and since then, 30 states have followed suit. While legislative specifics and protections vary widely state-to-state, legislation has generally been classified into two categories: comprehensive and partial.

Current landscape of state legislation



Information in this note is accurate of its publishing date but it is subject to change as the legislative landscape evolves

1. Health Maintenance Organization

Three factors driving surprise billing

1

Increasing penalties and costs for out-of-network care

As more employers shifted to high deductible health plans (HDHPs), patient out-of-pocket spending skyrocketed. The average deductible has increased dramatically over the past decade and continues to rise annually.[1] While in-network obligations have continued to rise, out-of-network coverage has decreased by nearly half over the past three years. Today, the median individual plan out-of-network deductible is $12,000.[2]

2

Increasingly outsourced provider networks

Outsourcing emergency physician staffing is another mechanism health systems have used to ensure coverage and manage costs. Most surprise bills originate in the emergency room because the treating physician(s) may or may not be in the same networks as the facility where the patient is seeking treatment. While this can happen even when emergency room physician coverage is not outsourced, it does raise the likelihood of the physician being out-of-network for patients.

3

Declining network adequacy of health plan products

Narrow network plans are on average 16% cheaper than broad network offerings because they allow payers to cut costs and shift savings onto the consumer. However, most patients aren't aware of the network configuration of the plan they're purchasing, only that premiums are much smaller.

Though narrow network plans haven't proliferated to the extent that was predicted several years ago, these products comprise 20% of plans on the exchange. According to the Kaiser Family Foundation's 2018 Employer Health Benefits survey, among companies with 5,000 or more workers, 18% said they offer at least one narrow network plan. Ten percent of companies with 1,000 or more workers offer these types of plans.[3]

1. Healthcare Innovation; From 2017-2018 the average deductible rose 4.5%
2. Center for Health Journalism
3. Kaiser Family Foundation

Source: Kaiser Family Foundation, "2018 Employer Health Benefits Survey," https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey; Lieberman, Trudy, "Why skyrocketing out-of-pocket expenses are the real crisis in the American health insurance system," Center for Health Journalism, https://www.centerforhealthjournalism.org/2017/11/03/why-skyrocketing-out-pocket-expenses-are-real-crisis-american-health-insurance-system/; Mag, HMT, "Kaiser Study Finds Employee Health Insurance deductibles rise 4.5," https://www.hcinnovationgroup.com/clinical-it/article/13010934/kaiser-study-finds-employee-health-insurance-deductibles-rise-45

Solutions focus on notification, bill resolution

Legislation ignores the root cause of network inadequacy

The issue of affordability and patient obligations continue to dominate the discussion-and the law-around surprise billing. While these are critical issues, solutions that only focus on mitigating the impact of surprise bills after they occur are incomplete. Preventing surprise bills will require agreement among payers and providers to focus on the issue of network adequacy, along with mitigation strategies when surprise bills do occur.

As of December 2019, the focus of surprise billing legislation has been almost entirely on mitigation: patient notification of out-of-network costs, payment shields, and payment resolution. In fact, any impact on provider networks has been as a secondary result (see page 11).

While we feel that many of these legislative solutions are incomplete, it is still critical to understand how states have addressed the issue, and which of these levers have proven to be impactful. The remainder of this paper will discuss specific levers states have pulled to address surprise billing, and the potential or reported impact of each, to further inform key stakeholders as discussion on potential federal legislation continues.

The current surprise billing legislative menu

While much of the analysis on state surprise billing legislation divides laws into comprehensive versus partial, Advisory Board found analyzing the types of provisions included to be more helpful to assess the strength of each law, and informing efforts on the federal level.

Three elements of "comprehensive" protections

Patient payment shields

In these states, patients are legally shielded from having to pay a surprise medical bill

Payment resolution

Legislation offers an alternative method for providers to receive payment

Coverage settings

Care is covered regardless of the setting the patient receives it

Going beyond the fundamental elements

Patient notification requirements

Insurers or providers are required to notify patients of their out-of-network rights

Dual notification requirements

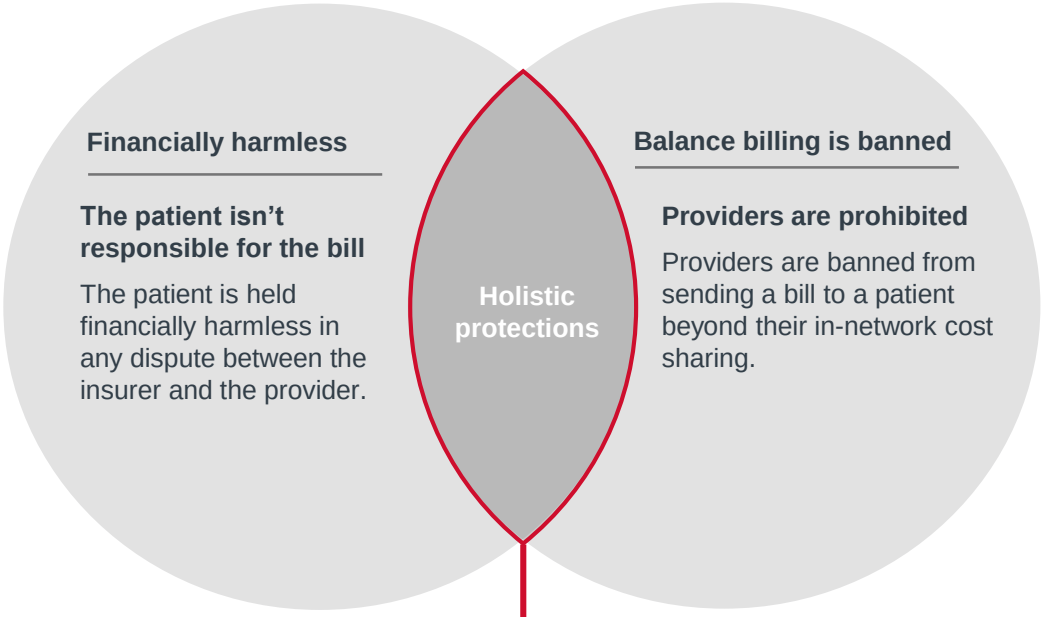
Insurers and providers are required to notify patients of their out-of-network benefits

Ambulance coverage

Very few states cover ground ambulance surprises bills and air ambulances are federally regulated

Category 1: Patient payment shields

Patient payment shields refer to legislation blocking patients from paying a surprise bill. This legislation contains two vital components: the patient is held financially harmless and balance billing is not allowed.



In these states, both are true– the patient is held harmless and providers are banned from sending a bill.

States with holistic protections	
California	New Jersey
Colorado	New Mexico
Connecticut	New York
Delaware	Nevada
Florida	North Carolina
Indiana	Oregon
Maryland	Texas
Mississippi	Washington
Missouri	
New Hampshire	

DISCUSSION

29% of states with surprise billing legislation provide only one of the two components of patient shields; 10% do not provide either.

Legislation that doesn't hold patients financially harmless **and** explicitly prohibit providers from sending a bill to a patient beyond their in-network cost sharing is incomplete.

While patients are held harmless legally, balance billing may still occur, potentially confusing patients as to what they owe.

Category 2: Coverage settings

Variation in patient protections across care settings

Some states offer payment shields to patients regardless of the care setting, acknowledging that both emergency and non-emergency episodes may result in a surprise bill. However, some states limit patient protection from surprise bills to certain types of care or care settings.

1 Non-emergency coverage states

These states only protect patients from surprise bills that originate from non-emergency care

States
Delaware
Maine
Massachusetts
Minnesota

2 Emergency coverage states

These states only include provisions for patients who receive a surprise bill from emergency care

States
Indiana
Iowa
Nevada
Pennsylvania
Vermont

3 Emergency and non-emergency

The law establishes coverage for patients regardless of the type of care that is received

States	
Alaska	North Carolina
Arizona	New Hampshire
California	New Jersey
Colorado	New Mexico
Connecticut	New York
Florida	Oregon
Illinois	Rhode Island
Maryland	Texas
Missouri	Washington
Mississippi	West Virginia

DATA SPOTLIGHT

States have split their focus on setting coverage

29%

Of states only protect patients from receiving surprise bills in one type of setting.[1]

70%

Of surprise bills originate from emergency services.[2]

42%

Of in-patient admissions resulted in a surprise bill in 2016.[3]

1. This calculation is based on all states that have at least one surprise billing protection.
2. Health Affairs; 51% of ambulance bills are billed out of network and 19% of emergency room visits are billed out of network.
3. Journal of American Medical Association

Source: Garmon, Christopher, Chartock, Benjamin, "One In Five Inpatient Emergency Department Cases May Lead To Surprise Bills," Health Affairs, https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0970; Sun, Eric, Mello, Michelle, et al, "Assessment of Out-of-Network Billing for Privately Insured Patients Receiving Care in In-Network Hospitals," Journal of American Medical Association, https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2740802?guestAccessKey=9fba6e0c-f029-401a-9675-737db3e67b5d&utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_content=tfl&utm_term=081219

Category 3: Patient notification requirements

Some states require providers or payers to notify patients of their rights and obligations for out-of-network care. Most states follow the basic notification types but certain states deviate to further protect patients by placing a greater burden on payers or providers.

Types of notification requirements[1]

Insurers

Description of out-of-network coverage and risks

State law requires insurers to provide patients with disclosures of the risks associated with receiving out of network care.

Note: Insurers are required to post consumer rights on their websites in Washington.

Network directory updates

State law dictates that insurers digitally update their online directories once a month to reflect any contractual changes.

Note: Maine requires insurers to audit their directories and provide print copies for patients upon request.

Providers

Network notifications

These requirements vary by state but often require providers to give patients a written disclosure prior to treatment that notifies them that they may receive out-of-network care.

Note: New Mexico requires providers to notify the insurer if they have provided emergency treatment to an out-of-network patient within 24 hours of stabilization.

Patient permission

State laws require that a patient gives written authorization to be treated by out-of-network providers and that they assume all financial risks associated with their care.

Note: New Mexico's law prohibits providers from offering patients financial incentives to authorize out-of-network care.

Pre-service estimate

Depending on the state law, providers are required to give patients written cost estimates associated with out-of-network care prior to treatment.

Note: In Colorado, a provider must provide a written cost estimate for out-of-network care to a patient within three business days after the request was made.

DISCUSSION

In states with notification requirements, the burden most frequently falls to providers. The most common requirement for providers is to notify a patient that out-of-network fees could be associated with their care. While providers are the front line for patient interaction, Washington State's law distributes responsibility:

"Facilities, providers, and health insurance carriers all share responsibility to ensure consumers have transparent information on network providers and benefit coverage."

Balance Billing Protection Act (will take effect Jan.1 2020)

1. The National Academy for State Health Policy originally categorized these protections by insurers and providers to outline the multiple provisions taken within law. We have used the methodology and applied it to all states that have at least one surprise billing protection rather than just comprehensive states.

Source: House Bill, "Out-of-network Health Care Services Billing," http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/1065-S2.SL.pdf; The National Academy for State Health, "Highlights of States' 'Surprise' Medical Balance Billing Laws," https://nashp.org/highlights-of-seven-states-surprise-medical-balance-billing-laws/

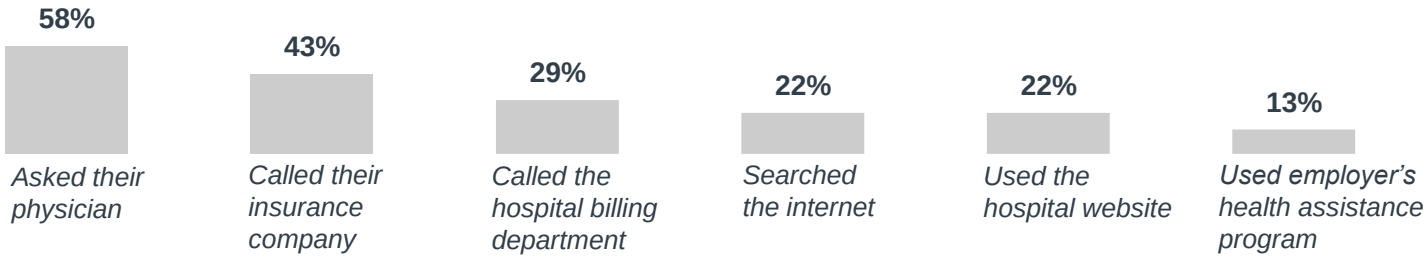
Category 4: Dual notification requirements

Providers and payers share responsibility for patient notification

To be most effective, notification requirements must include both payer and provider responsibility with multiple patient touchpoints to maximize patient understanding of benefits. Advisory Board research has shown that patients typically rely upon multiple resources for health care cost information.

Methods used by price shoppers[1]

When looking for cost information, how did you try to find out what you would pay out of pocket?
n=180



Because patients most often **seek price information from providers and insurers,** it is crucial to provide it from a variety of sources. All stakeholders share the responsibility of notifying patients of their rights and obligations. States with dual notification requirements require **at least one measure for providers and insurers** to notify patients of their rights when receiving out-of-network care.

Types of notification requirements for providers and insurers


Description of out-of-network coverage and risks


Network directory updates


Network notifications


Patient permission


Pre-service estimate

DISCUSSION

Notification requirements have limited applicability

While inpatient surprise bills are on the rise, emergency services constitute the bulk of surprise bills, meaning there is insufficient time for patients to check network status of hospitals and physicians.

Dual requirements, while not a perfect solution, ensure patient education around benefits is distributed regularly, and providers can offer a reminder around the potential for out-of-network bills if they are likely to occur.

STATE IN BRIEF

Delaware's bill **includes templates for providers to distribute to patients** that informs them of their rights and the obligations associated with out-of-network care. Providers are required to obtain written consent from patients at least three days prior to their scheduled visit.

Delaware's inclusion of a template in the legislation is unique. Other state legislation requiring similar network disclosures leaves the responsibility of producing templates on providers. **Lack of standardization results in inconsistencies in semantics and transparency**, leaving patients who visit separate providers confused.

1. 2018 Consumer Financial Experience Survey; respondents could select more than one method

Source: Department of insurance, "1317 Network Disclosure and Transparency," http://regulations.delaware.gov/register/september2016/proposed/20%20DE%20Reg%20155%2009-01-16.pdf

Category 5: Payment resolution

No agreement on optimal resolution across industry

Three types of payment resolution

Providers, payers, and legislators disagree about the most appropriate way to resolve payment disputes because each form has historically benefited one party over the other. States have typically adopted one of three models:

Model #1

Arbitration

The insurer and the provider submit a suggested settlement amount to an independent arbiter. The arbiter selects an amount after reviewing the case.

STATES ENACTED

- Arizona
- Delaware
- Minnesota
- Missouri
- New Jersey
- New York
- Rhode Island
- Texas

Model #2

Payment standard

This process establishes a pre-calculated rate that providers will be reimbursed; however, each state determines *how* payments will be calculated.

STATES ENACTED

- Alaska
- Connecticut
- Illinois
- Maine
- Maryland
- New Mexico
- North Carolina
- Oregon

Model #3

Blended approach

19% of states combine the two approaches: a minimum payment must be made to the provider, but if the provider feels it is inadequate, they can proceed to arbitration.

STATES ENACTED

- California
- Colorado
- Florida
- Nevada
- New Hampshire
- Washington

STATE IN BRIEF

New York popularized the arbitration method when they enacted the law in 2015. The law protects consumers from egregious out-of-network bills and dictates third-party arbitration as a payment resolution process. New York's method has successfully **decreased out-of-network bills by 34%** and **in-network emergency room doctors' charges by 9%.**[1]

Economists argue that the arbitration process results in a price that is closer to the free market rate however, new research suggests that the guidance to consider the 80th percentile of billed charges has resulted in high out-of-network reimbursements that could effect negotiations between providers and insurers. The full effects of arbitration on health care costs is beginning to unfold as new data is released.

Source: Cooper, Zach, "Surprise! Out-of-network Billing for Emergency Care in the United States," National Bureau of Economic Research, https://www.nber.org/papers/w23623.pdf

1. National Bureau of Economic Research

Examining payment standards in practice

Standards are highly contested, but results are worthy of discussion

1 Alaska saw impact on state health care spending

8-25% Increase in health care spending from 2005-2014 attributable to the rule.[1]

In 2004, Alaska enacted the 80th percentile rule, requiring payers to base payment for out-of-network services at or above 80% of what all providers charge for that service in a specific geographic area.

The rule's goal was to provide transparency around reimbursement and result in lower out-of-pocket obligations for patients. However, critics argue that the rule has contributed to rising health care spending in Alaska because providers have been able to increase their charges over time and payers are required to keep pace. The Alaska case analysis did not evaluate the effects payment standards could have on network adequacy or out-of-pocket obligations.

2 California's out-of-network payment standard results in larger networks

16% Growth in physician networks post 2017 surprise billing legislation

Unlike the Alaska case analysis, California conducted an evaluation on how its 2017 law impacted network adequacy. The law outlines an out-of-network payment standard based on the larger amount of either local contracted rates or 125% of Medicare.

Providers' fears that benchmark rates would further exacerbate network inadequacy have not come to fruition. Physician networks grew 16%, with emergency medicine in-network rates increasing 10% and anesthesiology rising 18%.[2]

DISCUSSION

What does California tell us about payment standards and the impact on networks?

Many providers caution against using payment standards to pre-determine reimbursement for out-of-network care in federal regulation; part of the skepticism is a result of provider and payer distrust and fears that network inadequacy would increase as a result of benchmark rates. Providers argue that payment standards discourage payers from contracting with providers who charge more than the contracted rate.[3]

A study from the American Journal of Managed Care points out that there are qualitative measures that physicians are concerned about: changed negotiation dynamics, physician consolidation, recruitment, and decreased reimbursements.[3] Although the study raises important concerns about the long term impact of payment standards, the scope of the analysis was limited to interviews with 28 stakeholders across the first 12 months of the law's implementation.

The methodology of the study is limited and data gathered by opposing studies indicates that out-of-network care decreased in California. However, the study did expose providers' anxiety that payment standards could affect their own reimbursements. Payment standards rectify the market failure that has led providers with inelastic demand to artificially inflate their charges. Because providers have been able to manipulate their charges, payment standards pose a real threat to their own reimbursements.

1. The range is large because the rule's effect on overall health care spending in Alaska depends on the basis of comparison. Alaska was compared to a variety of states based on factors like previous spending patters, the influence of the Affordable care act, and oil wealth.
2. The specific changes in in-network providers in California after the passage of the law are outlined in the American Journal of Managed Care's study "Can We Stop Surprise Medical Bills AND Strengthen Provider Networks? California Did."
3. Although each case study is nuanced by differing state economies, both California and Maryland have concluded that payment standards do not exacerbate narrowing networks. Maryland has a similar payment rate standard in place to resolve surprise medical bills. Their analysis of the law's effect on network breadth was similar to California's findings.

Source: American Journal of Managed Care, "Can We Stop Surprise Medical Bills AND Strengthen Provider Networks? California Did, "https://www.ajmc.com/contributor/america's-health-insurance-plans/2019/08/can-we-stop-surprise-medical-bills-and-strengthen-provider-networks-california-did; American Journal of Managed Care, "Influence of Out-of-Network Payment Standards on Insurer–Provider Bargaining: California's Experience," https://www.ajmc.com/journals/issue/2019/2019-vol25-n8/influence-of-outofnetwork-payment-standards-on-insurer-provider-bargaining-californias-experience?p=3; Maryland Health Care Commission, "Chapter 537, 2010 Laws of Maryland- Health Insurance- Assignment of Benefits and Reimbursement of Non-preferred Providers," https://mhcc.maryland.gov/mhcc/pages/plr/plr/documents/LGSPT_AOB_rpt_20150115.pdf; University of Alaska Anchorage, "how Has the 80th Percentile Rule Affected Alaska's Health-Care Expenditures?,"://www.commerce.alaska.gov/web/Portals/11/pub/INS_ISER_2018Study.80thPercentile.pdf

Where legislation surpasses traditional protections

Some are paving the way for holistic protections for patients

While 31 states have enforced surprise billing protections, few have moved beyond the levers and protections we previously discussed. However, Connecticut, New Jersey, Nevada, and New Mexico are the exception. They have each enacted certain measures that go well beyond standard protections.

Connecticut expands protections across settings and provider disclosures[1]

In 2020, updated legislation will:

- Prohibit surprise billing for laboratory fees that aren't in-network even if the provider sends out-of-network samples.
- Require public disclosure of the unregulated trauma activation fees that are associated with a patient in serious condition that needs treatment from a trauma team.
- Establish a task force to study the effect of high deductible health plans.

New Jersey insurers are instructed to audit themselves[2]

Insurers are required to anticipate and calculate expected savings from the decline in out-of-network claims.

- Additionally, insurers' provider networks are audited annually by an independent firm that evaluates network adequacy and compliance.
- The data is submitted to the Health Commissioner who subsequently posts the results on the Department of Health's website.

Nevada requires providers and insurers to notify each other[3]

Nevada requires providers to notify the insurer if they have provided emergency treatment to an out-of-network patient within 24 hours of stabilization.

- After the insurer is notified, they must arrange transfer for the patient to an in-network facility within 24 hours.

New Mexico commits to full transparency for all stakeholders[4]

New Mexico's law takes effect in 2020 and requires collection agencies to provide clarity for patients and hospitals to notify insurers.

- Medical collection agencies are required to post a notice of consumer rights dictated under the law on their websites.
- Providers are required to notify the insurer if they have provided emergency treatment to an out-of-network patient within 24 hours of stabilization. However, it does not require the patient to be transported.

1. State of Connecticut
2. Epstein Becker Green
3. Nevada State Legislature
4. State of New Mexico

Source: Epstein Becker Green, "New Jersey's Surprise Medical Bill Law: Implications and National Trends," https://www.ebglaw.com/news/new-jerseys-surprise-medical-bill-law-implications-and-national-trends/; Nevada State Legislature, "Assembly Bill No.469," https://legiscan.com/NV/text/AB469/2019; State of Connecticut, "Senate Bill No. 811," https://www.cga.ct.gov/2015/act/pa/pdf/2015PA-00146-R00SB-00811-PA.pdf ; State of New Mexico, "The Act," https://nmlegis.gov/Sessions/19%20Regular/final/SB0337.pdf

The special case of emergency transport

Ambulances make up 51% of unexpected medical bills. Air ambulances are often run by private companies and their median charge per trip increased by $15,000 for Medicare patients between 2012-2016.[1] Most patients with private insurance do not know if the ambulance services they receive are in-network or not; with rising costs, an out-of-network ambulance ride could lead to an exorbitant surprise medical bill.

Ground ambulance

Few states regulate ground ambulance charges

- Most patients with private insurance are not aware if the ambulance services they receive are in-network or not
- Patients are unable to control which ambulance is directed to their call
- Ground ambulances are often regulated by local governments and proposed federal bills do not include ground ambulance protections

Only three states protect patients from surprise ground ambulance bills…

Connecticut Maryland Utah

… with set reimbursement standards

Air ambulances

Air ambulances are subject to federal regulation

- Federal legislation has proposed limiting patients' out-of-pocket costs for transportation to in-network cost sharing rates
- Air ambulance coverage has been floated in federal legislation but not all bills protect patients from a surprise bill for emergency transport

Current federal bills to end surprise billing

	The Lower Health Care Costs Act of 2019[3]	*End Surprise Billing Act of 2019*[3]
Protections for air ambulance services	✓	✗
Protections for ground ambulance services	✗	✗
Itemized list of charges	✗	✓

What federal legislation can do that state legislation cannot

The ERISA preemption

State laws do not protect nearly 61% of patients that have insurance plans that are regulated by Employee Retirement Income Security Act of 1974 (ERISA). [2]

Emergency transport coverage

Protecting patients from egregious bills from emergency transport is the federal government's purview.

Bolster protections in all states

There are 19 states that currently have zero protections in place for patients that receive a surprise bill. Federal law will protect all patients.

1. Health Affairs
2. Health Affairs
3. 116th Congress

Source: 116th Congress, "H.R.861- End of Surprise Billing Act of 2019," https://congress.gov/bill/116th-congress/house-bill/861/text; 116th Congress, "S.1895- Lower Health Care Costs Act," https://www.congress.gov/bill/116th-congress/senate-bill/1895/text; Bai, Ge, "Air Ambulances with Sky-High Charges," Health Affairs https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2018.05375; Garmon, Christopher, "One In Five Inpatient Emergency Department Cases May Lead To Surprise Bills," Health Affairs, https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0970

Federal legislation is necessary

But compromise is necessary to get legislation passed before 2020

Continued media attention on surprise billing has drawn bipartisan Congressional attention.There are currently **8 federal bills** addressing surprise billing with H.R. 3630 (No Surprises Act) , S.1895 (Lower Health Care Costs Act), and H.R. 2328 (Reauthorizing and Extending America's Community Health Act) gaining the most attention.[1]

The bills were introduced in the spring and summer of 2019 and implement comprehensive protections that are modeled after states. The federal legislation incorporates provisions to review revenue sharing, establish a state payer claims database, and regulate payment for air ambulances.

	 *Air ambulance coverage*	 *Includes arbitration*	 *Payment standards*	 *CBO Estimate*[2]
The Lower Health Care Costs Act of 2019 (S. 1895)	✓	✗	• Health plans median in-network payment rate	• $23.8 billion in savings
No Surprises Act of 2019 (H.R. 3630)	✓	✓	• Health plans median in-network contracted rate that increases annually with the CPI-u	✗
Reauthorizing and Extending America's Community Health Act (H.R. 2328)	✗	✓	• Health plans median in-network payment rate, indexed to CPI-u after 2021	• $20.9 billion in savings

The payment resolution mechanism has become the core of surprise billing legislation scrutiny

The point of contention for payers and providers is the type of payment resolution each bill outlines. All three include a benchmark payment process that providers aggressively pushed back on; with dark money groups funded by private equity physician staffing firms spending $30 million on ads that target surprise billing legislation.

However, most providers approve of an arbitration method and are supportive of passing legislation by the close of 2019. For successful passage, legislators will most likely have to compromise on an arbitration backstop.

DISCUSSION

Not all bills are created equal

Although the bills share common themes, S. 1895 and H.R. 2328 provide a more holistic approach to lowering health care costs, improving care quality, and expanding access. H.R. 3630 comparatively provides a limited approach to surprise billing and ignores key root cause areas.

S. 1895 focuses on broader market issues that have led to negative patient financial experience such as: contract regulations between providers and insurers, limited services for minority populations, inefficient health care data exchanges, and limited preventive health programs. Similarly, H.R. 2328's surprise billing initiative is part of a broader commitment to extending funding for public health programs.

1. 116th Congress
2. Congressional Budget Office

Source:; 116th Congress, "Reauthorizing and Extending America's Community Health Act (H.R. 2328)," https://www.congress.gov/bill/116th-congress/house-bill/2328?q=%7B%22search%22%3A%5B%222328%22%5D%7D&s=3&r=1; Congressional Budget Office, "CBO estimates," https://www.cbo.gov/cost-estimates

State and federal legislation is only a partial fix

Providers must deliver a positive patient financial experience

Protections incorporated in state legislation can only do so much

Industry pressures continue to influence federal legislation timelines. Private equity's interest in the conversation has laid out a broader national debate for their role in contributing to the health care affordability crisis. However, the implications of these larger debates may take years to come to fruition. Comparatively, state legislation has moved rapidly to disentangle surprise billing and hold providers and insurers accountable. Regardless of what happens at the federal level, providers and payers have a responsibility to deliver a patient financial experience that alleviates fears around affordability and results in less bad debt. Our research has revealed the six financial flashpoints where providers specifically are called on to alleviate patient concerns and provide superior service.

The Patient Financial Journey

For more on the patient financial experience, see our resources:

- The Patient Financial Experience Toolkit
- Financial Experience Consumer Profiles

Appendix: protections by state

Comprehensive protection states have most commonly been analyzed and categorized but even those state with partial protections should be mapped by protection type to observe patterns and commonalties between states. Below all states with at least one surprise billing protection are mapped according to protection type they implement.[1]

States	Emergency services	Non-emergency services	Providers are banned	Transparency requirements for insurers	Transparency requirements for providers	Arbitration	Set payment rates
Alaska	X	X					X
Arizona	X	X			X	X	
California	X	X	X	X	X	X	X
Colorado	X	X	X	X	X	X	X
Connecticut	X	X	X	X	X		X
Delaware		X	X	X	X	X	
Florida	X	X	X	X	X	X	X
Iowa	X						
Illinois	X	X	X	X	X		X
Indiana	X		X				
Maine		X	X	X			X
Maryland	X	X	X				X
Massachusetts		X					
Minnesota		X	X		X	X	
Missouri	X	X	X			X	
Mississippi	X	X	X				
North Carolina	X	X	X		X		X
New Hampshire	X	X	X			X	X
New Jersey	X	X	X	X	X	X	
New Mexico	X	X	X		X		X

1. The National Academy for State Health Policy and The Commonwealth Fund originally categorized these protections by setting, plan, and service protected. We have used the methodology and applied it to all states that have at least one surprise billing protection. We have also included states that have recently adopted legislation.

Source: Hoadley, Jack, "State Efforts to Protect Consumers from Balance Billing," The Commonwealth Fund, https://www.commonwealthfund.org/blog/2019/state-efforts-protect-consumers-balance-billing; The National Academy for State Health, "Highlights of States' 'Surprise' Medical Balance Billing Laws," https://nashp.org/highlights-of-seven-states-surprise-medical-balance-billing-laws/

States	Emergency services	Non-emergency care	Providers are banned	Transparency requirements for insurers	Transparency requirements for providers	Arbitration	Set payment rates
New York	X	X	X	X	X	X	
Nevada	X		X			X	X
Oregon	X	X	X		X		X
Pennsylvania	X			X	X		
Tennessee			X	X	X		
Rhode Island	X	X			X	X	
Texas	X	X	X		X	X	
Vermont	X						
West Virginia	X	X		X	X		
Washington	X	X	X	X		X	X
Utah[1]							

1. Utah only protects patients from surprise bills that derive from ground ambulances.

Revenue Cycle Advancement Center

Project Director

Robin Brand

BrandRo@advisory.com

Research Team

Lauren Elyse Robinson

Analyst

Program Leadership

Eric Fontana

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