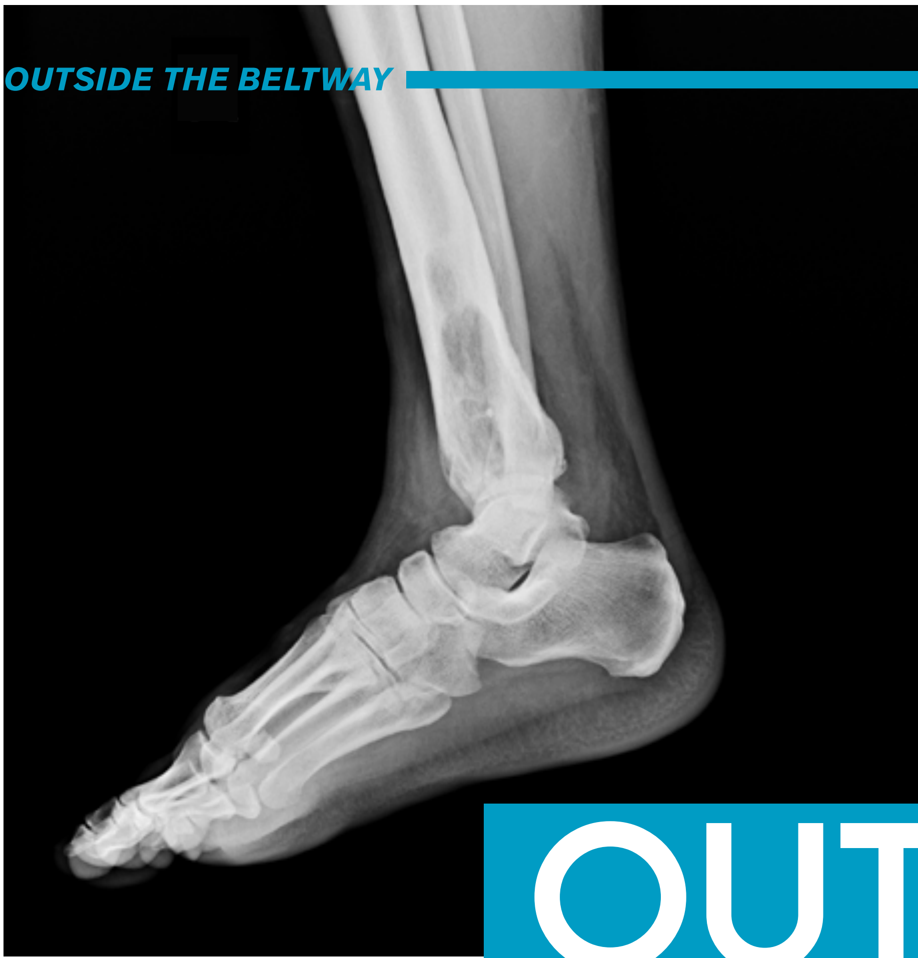

OUTSIDE THE BELTWAY

Written By Joanne Wojcik

Imagine you fell off a ladder and sprained your ankle while cleaning out your gutters. Your wife drives you to the emergency room at the nearest hospital, which you checked to make sure was in your health plan's provider network. The ER doctors examine you, take a bunch of X-rays, wrap your ankle with an ACE bandage and send you on your way with a prescription for painkillers. Then, a couple of weeks after your sprain has healed, you receive an astronomical bill in the mail from the radiologist who read your X-ray. It turns out he was not in network, so you're on the hook for paying the bill. Depending on which state you live in, you may not be responsible since several states have enacted "hold harmless" laws protecting patients from balance billing. But what if you are a member of a self-insured benefit plan?

Although states are barred from regulating self-insured health plans under the Employee Retirement Income Security Act, ERISA plan members may be able to take advantage of laws in some states that shield patients from provider balance billing—as long as they apply directly to providers and not just to insurers.

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The term "surprise medical bill" describes fees charged when a patient receives care from non-network providers or services not covered by their health benefits. Surprise medical bills occur in 18% of emergency room visits and 15% of in-network hospital stays, according to an analysis of 2017 claims data from large employer plans conducted by the Kaiser Family Foundation. Three national studies—one using data from a large, national commercial insurer and two using a large data sample from self-insured employer plans—all found that more than half of all ambulance cases involved an out-of-network ambulance company.

When they occur, surprise medical bills are often substantial, averaging 800% of what Medicare pays for the same service, while in-network rates average about 300% of Medicare reimbursement rates. Particularly egregious are out-of-network bills from helicopter emergency medical services, or HEMS. Since air ambulance services are governed by the federal Airline Deregulation Act, which pre-empts states from regulating any part of the air industry, air ambulances have been free to charge what the market will bear, sometimes over $100,000 per flight. But Wyoming officials are seeking to change all that by channeling all medical air transportation through its Medicaid program (see related story).

As of September 2019, 29 states have enacted laws offering some form of balance-billing protection to their residents, according to research by the Commonwealth Fund and Zelis Healthcare, a Bedminster, N.J.-based firm that manages out-of-network claims for both insured and self-insured plans (see map).

Because state laws do not pertain to ERISA plans, which cover approximately 100 million Americans, members of Congress also have introduced legislation to counteract surprise medical billing. Two of these measures, currently wending their way through the House and Senate with bipartisan support are:

- Before leaving for the Labor Day recess, the House Energy & Commerce Committee passed the "No Surprises Act", a proposal introduced by Chairman Frank Pallone (D-NJ) and Ranking Member Greg Walden (R-OR) that would have prohibited out-of-network providers from sending surprise medical bills to patients and require them to accept in-network median rates based on geography for both emergency and non-emergency care that is provided in network facilities. However, under pressure from physician lobbyists, coupled with Republican concerns about setting a government benchmark, the committee amended the legislation to require that bills over $1,250 be subject to arbitration.
- In July, the Senate Health, Education, Labor & Pensions Committee also passed the "Lower Health Care Costs" Act introduced in June by HELP Committee Chairman Sen. Lamar Alexander (R-TN) and Ranking Member Sen. Patty Murray (D-WA), that sets a reimbursement benchmark based on in-network median rates. This measure also addresses prescription drug costs and price transparency.

But even if state balance billing statutes cannot legally apply to self-funded ERISA plans, they may work to the benefit of self-funded plans and their members if they target providers, rather than insurers, according to Christen Linke Young, a Fellow with the Schaeffer Initiative at the Brookings Institution, and co-author of a February 2019 white paper on "State Approaches to Mitigating Surprise Out-of-Network Billing". "States could regulate providers when dealing with members of all types of plans, though that is not what most state laws enacted to date have done."

Of the 29 states that have enacted balance billing legislation, 19 include some type of provider prohibition (see map). For example, laws in Colorado, Florida and Oregon prohibit out-of-network providers from billing enrollees in HMO and PPOs for any amount beyond in-network level of cost sharing for both emergency and non-emergency care that is administered at in-network facilities, whereas in Texas,

the prohibition on providers from balance billing applies to HMO, PPO and EPO enrollees. By contrast, California's balance-billing protections only apply to providers in those plans regulated by the California Department of Managed Care, which includes HMOs and most PPOs.

Regardless of whether a statute pertains to insurers or providers, in most cases "a provider doesn't know when they're seeing a self-insured plan member or an insured plan member," suggested Matthew Albright, Chief Legislative Affairs Officer at Zelis Healthcare.

"Most providers just assume that out-of-network prohibitions on balance billing are applicable to all of their patients, regardless of the type of plan they are covered by," he said. Moreover, all providers typically see is their patient's insurance card, which usually identifies an insurance company, and that insurer could be the administrator of a self-insured health benefit plan.

Some states have set reimbursement levels for out-of-network services that can be useful to self-funded plans when negotiating payments to providers. "If you have TPAs that have both insured and self-insured ASO business, it may be the case that as state laws reshape the negotiating landscape between the insured segment of the market and providers, that those benefits are going to spill over to the ASO contracts," observed Young.

Notification requirements also can benefit self-insured plan members, noted Albright. At least eight states now require providers to provide notices to patients about possible out-of-network charges for nonemergency services. If the provider doesn't know whether a patient is enrolled in a self-insured plan or one that is state-regulated, it is very possible that such notices will go to some ERISA plan members, he said.

In some states, such as New York, members of all plans—including self-funded ERISA plans—have access to a dispute resolution process for settling payment of surprise bills for both emergency and non-emergency care. In New Jersey, self-insured employers have the option to access the dispute resolution process over egregious bills from out-of-network providers.

Until federal legislation prohibiting surprise medical billing is enacted, self-insured

plans should keep tabs on balance billing statutes in the states where they operate to determine if they can use them as leverage to protect their plan members, both Young and Albright recommend.

"Another potential role for payers is educating consumers about the potential for surprise billing," Young said. "If consumers are aware that there is some risk of out-of-network billing, it will put some pressure on providers and hospitals." ■

With the cost of emergency airlifts soaring, the state of Wyoming is seeking federal approval to make air ambulance services more affordable by channeling all medical air transportation in the state through its Medicaid program.

The cost of air ambulance services, which sometimes top $100,000 per flight, also is being targeted in proposed federal legislation addressing surprise medical billing. Air ambulances charged private payers between about 4 and 9.5 times more than what Medicare actually paid for those services in 2016, according to a Health Affairs study by researchers at Johns Hopkins School of Medicine and Johns Hopkins Carey Business School. The Alexander-Murray bill would levy a $10,000 fine on air ambulance service providers each time they charge more than the median in-network rate for a particular geographic region set by HHS.

Because all air travel in this country is regulated by the Airline Deregulation Act, states are preempted from regulating any part of the air industry. So Wyoming officials are asking the Centers for Medicare & Medicaid Services for a waiver that would enable it to expand Wyoming Medicaid to all state residents for the specific purpose of air ambulance transportation. According to a website the state created seeking public comment, waiver goals include: the elimination of surprise billing of patients; reduction of the cost of ambulance flights while ensuring a set level of access and quality; and increasing price transparency for patients and employer groups.

Under the plan, the Wyoming Department of Health would competitively bid for a selected network of air ambulance providers, make periodic flat payments similar to a gym membership to the contracted providers, and then recoup the revenue needed to fund the system from the insurers and individuals already paying for transports.

In public comments mostly supporting the proposal posted on the WDH's website, Wyoming residents described their experiences with the use of air ambulances, in some cases noting that because of their isolated and remote locations it was the only form of transportation available to get them to a hospital in time of emergency.

Nationally, the average helicopter emergency medical service (HEMS) bill has more than doubled since 2010 to $40,000, according to a 2019 report from the federal Government Accountability Office. A 2017 industry report estimates air ambulance operating costs at approximately $11,000 per flight. In Wyoming, Medicare pays an average of $6,000 per flight, and Medicaid pays even less, so air ambulance companies have been shifting these uncompensated costs to private payers.

Meanwhile, the air ambulance industry has grown steadily from about 1,100 aircraft in 2007 to more than 2014 in 2018, and two-thirds of them are owned by private equity firms, according to the GAO. "The presence of private equity in the air ambulance industry indicates that investors see profit opportunities in the industry," the report stated.

--Joanne Wojcik