

AVOIDING STICKER SHOCK: LEGISLATIVE APPROACHES TO PROTECT CONSUMERS FROM SURPRISE MEDICAL BILLS

ABSTRACT

Consumers are increasingly receiving surprise medical bills, where an insured patient is unexpectedly billed directly for medical services received at an in-network health care facility from an out-of-network provider. These situations often arise in emergency rooms, operating rooms, and delivery rooms, despite the efforts of patients to receive care only from in-network providers. Surprise medical bills commonly leave consumers on the hook for thousands of dollars for out-of-network services that they had no opportunity to refuse. This article explores how the steady rise of narrow provider network health plans and the often-corresponding lack of transparency regarding which providers are included in the network has led to an increase in surprise medical bills. It then examines various legislative approaches at both the federal and state level to protect consumers from these unexpected bills. This article ultimately proposes a statutory framework based on a modified version of New York's law that would effectively remove consumers from surprise medical bill disputes, leaving reimbursement arguments to health plans and providers.

I. INTRODUCTION

Mr. Peter Drier was prepared.¹ He had been anticipating this surgery for months. After presenting with excruciating pain in his upper back and numbness in his hand, a scan revealed that Mr. Drier had herniated disks in his back. He needed spinal fusion surgery. Mr. Drier did his homework, diligently researching his insurance plan to ensure the implants and surgical screws were covered and that his surgeon, anesthesiologist, orthopedist, and the hospital where the surgical procedure was scheduled were all either inside his provider network or willing to settle on a reimbursement rate with his health plan. Mr. Drier knew the procedure would be expensive, and he was prepared for the bills as they began to arrive. Despite his meticulous preparation, he was astounded when he received the \$117,000 bill from an “assistant surgeon” whom he had never met. This surgeon, who happened to be the chief of neurosurgery at another hospital, had unexpectedly participated in Mr. Drier’s care without his knowledge, and Mr. Drier was sent the bill. A second pair of hands was apparently needed during Mr. Drier’s spinal fusion, which is usually provided by a hospital employee such as a resident, nurse, or physician assistant for no additional charge. When no such provider was available, the neurosurgeon came to help unexpectedly. Mr. Drier thought he had done everything he possibly could have to be informed and prepared. He expressed his feeling of helplessness, saying, “[T]his was just so wrong—I had no choice and no negotiating power.”²

Mr. Drier is not alone. Consumers are increasingly receiving these “surprise” medical bills, where an insured patient is unexpectedly billed for care received at an in-network health care facility from an out-of-network provider.³ According to a national survey, thirty percent of privately insured Americans received a surprise medical bill from 2013 to 2015.⁴ Many consumers receive surprise medical bills despite their due diligence in attempting to receive care only from in-network providers; one in seven insured Americans has been surprised to discover that a provider they thought was in-network was actually considered out-of-network.⁵ Consumer Reports, an independent, nonprofit

1. Elisabeth Rosenthal, *After Surgery, Surprise \$117,000 Medical Bill from Doctor He Didn't Know*, N.Y. TIMES (Sept. 20, 2014), <https://www.nytimes.com/2014/09/21/us/drive-by-doc-toring-surprise-medical-bills.html> (last visited July 24, 2017).

2. *Id.*

3. Elisabeth Ponsot & Daniel Moritz-Rabson, *Americans Who Confronted 'Surprise' Medical Bills Share Their Stories*, PBS NEWSHOUR (June 26, 2016, 2:53 PM), www.pbs.org/news-hour/updates/americans-who-confronted-surprise-medical-bills-share-their-stories/ (last visited July 24, 2017).

4. CONSUMER REPORTS NAT'L RESEARCH CTR., SURPRISE MEDICAL BILLS SURVEY 8 (2015), consumersunion.org/wp-content/uploads/2015/05/CY-2015-SURPRISE-MEDICAL-BILLS-SURVEY-REPORT-PUBLIC.pdf.

5. *Id.*

organization that promotes the interests of consumers,⁶ has collected over 4000 stories from consumers who have struggled to pay surprise medical bills.⁷

The surprise bill itself usually involves two components. The first component “reflects the difference in patient cost-sharing between in-network and out-of-network providers.”⁸ The second component reflects balance billing, where the beneficiary is charged the difference between the plan’s negotiated, discounted fee it has agreed to pay for a given service with its in-network providers and the full fee the out-of-network provider charges for the service.⁹ Surprise medical bills usually occur: (1) in an emergency situation when a patient has no control over the emergency room, treating physicians, or ambulance selected¹⁰ or (2) in a non-emergency situation when a patient plans to receive care from an in-network facility, but out-of-network providers unexpectedly participate in the patient’s care in either the inpatient context¹¹ or the outpatient context.¹² The first scenario occurs because, as the American

6. CONSUMER REPORTS, <https://www.consumerreports.org/cro/about-us/index.htm> (last visited July 23, 2017).

7. Donna Rosato, *5 Doctors Most Likely to Stick You with Surprise Medical Bills*, CONSUMER REPORTS (Jan. 17, 2017), <https://www.consumerreports.org/medical-billing/5-doctors-likely-to-stick-you-with-surprise-medical-bills/> (last visited July 23, 2017).

8. Karen Pollitz, *Surprise Medical Bills*, KAISER FAM. FOUND. (Mar. 17, 2016), www.kff.org/private-insurance/issue-brief/surprise-medical-bills/ (last visited July 23, 2016).

9. *Id.*; see also U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., *Balance Billing*, HEALTHCARE.GOV: GLOSSARY, <https://www.healthcare.gov/glossary/balance-billing/> (last visited July 23, 2017).

10. Zack Cooper & Fiona Scott Morton, *Out-of-Network Emergency-Physician Bills — An Unwelcome Surprise*, 375 NEW ENG. J. MED. 1915, 1916 (2016) (finding from a national data sample of 2.2 million emergency room visits, twenty-two percent of patients who went to in-network emergency rooms were balance billed for care received from an out-of-network physician); see also, e.g., BENJAMIN LAWSKY, N.Y. STATE DEP’T OF FIN. SERVS., AN UNWELCOME SURPRISE: HOW NEW YORKERS ARE GETTING STUCK WITH UNEXPECTED MEDICAL BILLS FROM OUT-OF-NETWORK PROVIDERS 19 (2012) (reporting that the average out-of-network emergency bill was \$7,006, and while insurers paid an average of \$3,228, consumers were left with a bill of “\$3,778 for an emergency in which they had no choice”). Consumers living in rural areas who require life-saving air ambulance flights are increasingly facing extraordinary balance billing when their insurance companies do not have an in-network air ambulance company, leading to formal complaints to state auditors. Corin Cates-Carney, *Insurers, Air Ambulance Companies Spar over Costs at Legislative Hearing*, MONT. PUB. RADIO (Feb. 4, 2016), mtptr.org/post/insurers-air-ambulance-companies-spar-over-costs-legislative-hearing (last visited July 23, 2017).

11. See, e.g., Rosenthal, *supra* note 1; see also Erin Taylor & Layla Parast, *A Tale of Two Deliveries, or an Out-of-Network Problem*, HEALTH AFF. BLOG (Nov. 3, 2015), healthaffairs.org/blog/2015/11/03/a-tale-of-two-deliveries-or-an-out-of-network-problem/ (last visited July 23, 2017) (telling the story of two women with the same health insurance plan who gave birth on different days at the same in-network hospital, but only one was billed \$1600 from an out-of-network anesthesiologist who happened to be working that day).

12. See, e.g., Stephanie O’Neill, *California Aims to Limit Surprise Medical Bills*, NPR (Sept. 11, 2016, 5:11 AM), www.npr.org/sections/health-shots/2016/09/11/493233748/california-aims-to-limit-surprise-medical-bills (last visited July 23, 2017) (telling the story of a woman who received

Medical Association (AMA) reports, out of all major specialties, emergency medicine physicians are most likely to be independent contractors,¹³ meaning they are more likely to have out-of-network status even when working at an in-network facility, and patients do not have the ability to refuse care or worry about the network status of their providers when in an emergency situation. One study reports that one in five hospitals that are in-network for the three largest health insurers by market share in Texas have zero in-network emergency room physicians,¹⁴ meaning all emergency services billed by these providers will be at the out-of-network rate. Although the Public Health Service Act requires that all non-grandfathered health plans only charge in-network cost sharing for emergency services provided by an out-of-network hospital,¹⁵ no federal legislation prohibits an out-of-network emergency room physician from balance billing the patient.¹⁶ The second scenario occurs because: (1) assistant physicians are pulled in unexpectedly to help the attending physician with a surgical procedure or for a consult, and (2) hospitals tend to “use physician outsourcing firms for anesthesiologists, emergency room physicians, hospitalists, pathologists and radiologists.”¹⁷ These physician specialties frequently do not participate in the same health plans as the hospital, meaning patients may strategically schedule procedures at an in-network hospital with an in-network attending physician but may still receive unexpected bills from out-of-network providers that participated in their care.¹⁸ Patients are often in scenarios where verifying the network status of every assisting provider that walks in the room would be either unreasonable (such as a patient in the middle

a mastectomy follow-up surgery from an in-network outpatient facility but unexpectedly received a \$580 bill for an out-of-network anesthesiologist).

13. See CAROL K. KANE & DAVID W. EMMONS, AM. MED. ASS'N, POLICY RESEARCH PERSPECTIVES: NEW DATA ON PHYSICIAN PRACTICE ARRANGEMENTS: PRIVATE PRACTICE REMAINS STRONG DESPITE SHIFTS TOWARD HOSPITAL EMPLOYMENT 10 ex. 2 (2013), https://www.ama-assn.org/sites/default/files/media-browser/premium/health-policy/prp-physician-practice-arrangements_0.pdf (American Medical Association 2012 Physician Practice Benchmark Survey).

14. STACEY POGUE & MEGAN RANDALL, CTR. FOR PUB. POLICY PRIORITIES, SURPRISE MEDICAL BILLS TAKE ADVANTAGE OF TEXANS: LITTLE-KNOWN PRACTICE CREATES A “SECOND EMERGENCY” FOR ER PATIENTS 4 (2014), forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf.

15. Public Health Service Act § 2719A(b)(1)(C)(ii)(II), 42 U.S.C. § 300gg-19a (2012) (“[I]f [emergency] services are provided [to a participant, beneficiary, or enrollee] out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network . . .”).

16. Pollitz, *supra* note 8.

17. Bob Herman, *Billing Squeeze: Hospitals in Middle as Insurers and Doctors Battle over Out-of-Network Charges*, MOD. HEALTHCARE (Aug. 29, 2015), www.modernhealthcare.com/article/20150829/MAGAZINE/308299987 (last visited July 23, 2017).

18. *Id.*

of childbirth) or impossible (such as an anesthetized patient in the middle of a surgical procedure).

In both scenarios, the health plan and out-of-network provider often enter a battle over the proper rate for services rendered, with the consumer usually on the losing end. At the heart of the dispute is who is financially responsible for costs associated with out-of-network care—the health plan could cover the entire out-of-network rate billed, the out-of-network provider could accept the health plan’s rate, or the consumer could pay the balance of the bill. Health plans and out-of-network providers are obstinately unwilling to negotiate with each other. UnitedHealthcare recently stated that it is “deeply concerned that some hospital-based physicians are establishing out-of-network strategies to seek excessively high reimbursement levels, sometimes more than 10 times what an in-network physician would charge for the same service,” and accordingly announced that it was lowering how much it would reimburse out-of-network providers, exposing consumers to potentially larger balance bills.¹⁹ Insurance companies are concerned that physicians may strategically refuse to join a health plan network in order to later bill that health plan, as an out-of-network provider, at a rate higher than the contracted reimbursement rate.²⁰ This strategy allows physicians to circumvent price competition and undermines a health plan’s ability to control costs and quality, which is the very basis of a network health plan as previously discussed. On the other side, out-of-network providers maintain that “the real crux of the problem is health insurers are refusing to pay fair market rates for the care and services provided It’s the insurer who refuses to negotiate in good faith and pay a fair rate.”²¹ With such polarized, but equally-stubborn, stances on medical billing rates, the consumer is left paying for the large difference in rates. Although the Department of Health and Human Services regulates the rate that insurers must pay out-of-network providers,²²

19. Jordan Shapiro, *Insurer’s Policy Change Could Leave Patients on the Hook for Bills*, ST. LOUIS POST-DISPATCH (Mar. 29, 2015), www.stltoday.com/business/local/insurer-s-policy-change-could-leave-patients-on-the-hook/article_2573dc50-33e6-5840-ac8f-3abcef0b12cb.html (last visited July 23, 2017).

20. *See id.*

21. Harris Meyer, *Vital Signs Blog: New AMA Leader Rejects Growing Movement to Regulate Out-of-Network Doc Bills*, MOD. HEALTHCARE (June 14, 2015), www.modernhealthcare.com/article/20150614/blog/150619956 (last visited July 23, 2017).

22. Patient Protection and Affordable Care Act, 75 Fed. Reg. 37,188, 37,194 (June 28, 2010) (to be codified at 45 C.F.R. pts. 144, 146, 147) (requiring that insurers pay out-of-network providers the greatest of (i) the in-network rate for emergency services, (ii) a payment based on the methods the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount), or (iii) the amount that Medicare would pay for the emergency services).

this does not prevent the provider from billing the patient the balance of the reimbursement requested and the reimbursement received from the insurer.²³

Section II explores why surprise medical billing has become more common—due to the increasing popularity and prevalence of narrow network health plans. As will be discussed, narrow networks are used by insurance companies as a strategy to lower premiums and exercise greater control over quality of care. However, as networks narrow, more providers are excluded from the network, which leads to surprise medical billing situations, as examined further. Section III describes federal law approaches to protecting consumers from surprise medical billing that ultimately fall short, including (1) the Centers for Medicare and Medicaid Services' (CMS') network adequacy standard for Marketplace Qualified Health Plans (QHPs) and (2) the National Association of Insurance Commissioners' (NAIC's) updated Health Benefit Plan Network Access and Adequacy Model Act (Model Act), which is meant to serve as model legislation for states to consider adopting. As this comment illustrates, states that have yet to adopt legislation addressing surprise balance billing ought to understand the shortcomings of these federal approaches and look to legislation that other states have implemented in order to determine which statutory framework best protects consumers. Section IV evaluates a spectrum of state laws aimed at protecting consumers from surprise medical bills. Statutes in Massachusetts, Texas, and New York are critically examined as examples of potential legislative approaches. Section V recommends and justifies a comprehensive legislative approach to protect consumers from surprise medical bills based on a modified version of New York's law.

Ultimately, this comment recommends the adoption of a statutory framework that includes the following provisions: (1) for emergency services, ban out-of-network providers from balance billing patients for costs beyond in-network cost sharing if services are rendered at an in-network facility; (2) for non-emergency services, hold patients harmless for out-of-pocket costs beyond in-network cost sharing if services are rendered at an in-network facility and patients submit an assignment of benefits form; (3) ban anti-assignment clauses from health plans in surprise medical billing contexts to ensure that patients can assign benefits to providers; (4) count cost sharing for services provided by an out-of-network provider towards annual out-of-pocket limits; and (5) establish an independent, state-run arbitration process that uses an external standard for dispute resolution. This statutory framework is aimed at insulating consumers from unfair financial responsibility arising from surprise medical bill situations, but should also work in conjunction with recommended disclosure and transparency requirements so as to prevent surprise billing situations from

23. *Id.* (“Out-of-network providers may, however, also balance bill patients for the difference between the providers’ charges and the amount collected from the plan or issuer and from the patient in the form of a copayment or coinsurance amount.”).

developing as often as possible and to protect informed consumer choice. The justification, implementation, and enforcement of the recommended legislation is explored.

Section VI briefly concludes that as narrow network plans proliferate, it is more important than ever before for states to enact legislation that protects vulnerable consumers from surprise medical bills they could not have avoided. Consumers should be removed from the equation in these situations so that the balance bill dispute can be left to those who are best equipped to fight it: health plans and providers.

II. THE PROLIFERATION OF NARROW NETWORK HEALTH PLANS AND THE CORRESPONDING INCREASE IN SURPRISE MEDICAL BILLS

Before discussing how to address the issue of surprise medical bills, it is useful to understand why they are becoming so common in the first place. Surprise medical bills are increasingly relevant because of the steady rise of narrow network insurance plans and the often-corresponding lack of transparency regarding which providers are included in the network. Due to the unique role that narrow networks play in the insurance market as a means to lower premiums and raise quality standards, narrow networks are likely here to stay, meaning that the issue of surprise medical bills will remain a concern for many individuals.

A. *The Rise of Narrow Networks*

A surprise medical bill fundamentally arises when an out-of-network provider provides care to a patient at an in-network facility. This scenario is becoming increasingly common as more and more providers are being excluded from provider networks due to a rise in narrow network plans. In 2017, nearly seventy-five percent of health insurance plans offered through the health insurance marketplace in eighteen states will have narrow networks, demonstrating an increase from sixty-four percent of plans in 2016 and fifty-one percent of plans in 2015.²⁴ Forty-nine percent of Marketplace plans are categorized as either narrow or ultra-narrow; specifically, twenty-two percent of plans are narrow, meaning that the plans limit their contracting to thirty-one to seventy percent of local hospitals, while seventeen percent of plans are ultra-

24. MCKINSEY CTR. FOR U.S. HEALTH SYS. REFORM, 2017 EXCHANGE MARKET: PLAN TYPE TRENDS 1 (2016), healthcare.mckinsey.com/sites/default/files/2017-OEP-Plan-Type-Trends-Info-graphic_VF.pdf.

For an example of how the public media is portraying this data, see Anna Wilde Mathews, *Insurers Move to Limit Options in Health-Care Exchange Plans: Losses on Affordable Care Act Exchanges Spur Narrower Choice of Doctors, Hospitals*, WALL ST. J. (Aug. 31, 2016), <https://www.wsj.com/articles/insurers-move-to-limit-options-in-health-care-exchange-plans-1472664663> (last visited July 23, 2017) (describing narrow network plans as the direct response to “intense pressure to curb costs that have led to losses on the Affordable Care Act exchanges”).

narrow, meaning that the plans limit their contracting to zero to thirty percent of local hospitals.²⁵ Narrow network plans restrict consumer choice of health care providers (e.g., physicians, hospitals, out-patient clinics, pharmacies, labs, etc.) in exchange for lower monthly premiums.²⁶ The general purpose behind narrow network plans is to steer beneficiaries towards lower-cost, higher-quality providers.²⁷

The Affordable Care Act (ACA) revitalized the attention on narrow networks, but the concept of a limited provider network is far from new. Health Maintenance Organizations (HMOs), one type of narrow network plan, first appeared on the health insurance scene in the 1920s and gained popularity in the 1970s and 1980s.²⁸ At times, HMOs were criticized by consumers and providers who were frustrated with either the lack of choices of health care providers or the prospect of lower reimbursement rates.²⁹ However, modern narrow network plans are more likely to thrive in terms of longevity and success because they are uniquely driven by the demands of individual consumers for lower-cost health insurance, as opposed to being purchased nearly exclusively by large or governmental employers.³⁰

Narrow network plans are growing in popularity for two main reasons: (1) they lower overall premiums because providers with high reimbursement rates are excluded from the network, meaning beneficiaries only receive health care services, with the exception of emergency care, from providers that have contractually agreed to lower reimbursement rates, and (2) they keep referrals to in-network providers who have contractually agreed to certain quality measures that contribute to coordinated care for beneficiaries.³¹ First, the ability to offer lower premiums is a valuable tool for attracting potential beneficiaries that are shopping for health insurance because price is cited as the most important factor in choosing a health plan, even more important than breadth of provider choice

25. NOAM BAUMAN ET AL., MCKINSEY CTR. FOR U.S. HEALTH SYS. REFORM, HOSPITAL NETWORKS: EVOLUTION OF THE CONFIGURATIONS ON THE 2015 EXCHANGES 1–2 (2015), healthcare.mckinsey.com/sites/default/files/2015HospitalNetworks.pdf.

26. Thomas H. Lee & Katherine Baicker, *Interview: Are High-Deductible Plans vs. Narrow Networks Really Our Two Options?*, NEW ENG. J. MED. CATALYST (Mar. 17, 2016), catalyst.nejm.org/high-deductible-plans-vs-narrow-networks-really-two-options/ (last visited July 25, 2017).

27. *Id.*

28. Vernellia R. Randall, *Managed Care Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, 17 U. PUGET SOUND L. REV. 1, 20–21 (1993).

29. William Sherman, *A News Reporter Explains His “HMO Horror Stories”*, MANAGED CARE (Sept. 1997), <https://www.managedcaremag.com/archives/9709/9709.reporterview.html> (last visited July 25, 2017).

30. Deborah Farringer, *Everything Old is New Again: Will Narrow Networks Succeed Where HMOs Failed?* 34 QUINNIPIAC L. REV. 299, 304–05 (2016).

31. JIM WATSON, PBC ADVISORS, BIG CHANGES IN 2016 TO MARKETPLACE PLANS 1 (2016), www.pbcgroup.com/wp-content/uploads/2015/04/Big-Changes-in-2016-Marketplace-Plans.pdf.

or range of covered services.³² This is significant in projecting the future success of narrow network plans considering the competitiveness of narrow network prices is increasing while the competitiveness of broad network prices is decreasing.³³ Narrow network plans are most likely “here to stay.”³⁴

Narrow provider networks are central to various insurance products. HMOs require beneficiaries to select an in-network primary care physician (PCP) who serves as a gatekeeper, providing referrals to in-network specialists as needed.³⁵ HMOs tend to not cover any health care services provided by out-of-network providers, with the exception of emergency care, meaning the beneficiary is generally responsible for the entire cost unless otherwise specified in the plan.³⁶ Point of Service (POS) plans also require beneficiaries to select an in-network PCP gatekeeper, and beneficiaries pay lower cost sharing for obtaining services from in-network providers and pay higher cost sharing for services received from out-of-network providers.³⁷ Exclusive Provider Organizations (EPOs) do not require specialist referrals from a PCP, but exclusively offer coverage of health care services received from an in-network provider like an HMO.³⁸ Preferred Provider Organizations (PPOs) also do not require specialist referrals from a PCP, but they offer lower cost sharing when services are obtained from an in-network provider and higher cost sharing when services are obtained from an out-of-network provider, similar to a POS plan.³⁹ Tiered network plans divide

32. LINDA J. BLUMBERG ET AL., URBAN INST. HEALTH POLICY CTR., HEALTH REFORM MONITORING SURVEY: FACTORS INFLUENCING HEALTH PLAN CHOICE AMONG THE MARKETPLACE TARGET POPULATION ON THE EVE OF HEALTH REFORM 2 (2013), hrms.urban.org/briefs/hrms_decision_factors.html (last visited July 25, 2017). Price has been shown to be the dominating decision factor on health plan choice at the state level as well. MARY L. SMILEY, CTR. FOR HEALTHCARE RESEARCH & TRANSFORMATION, HEALTH PLAN SELECTION: FACTORS INFLUENCING MICHIGANDERS’ CHOICE OF HEALTH INSURANCE 4 (2015), www.chrt.org/document/health-plan-selection-factors-influencing-michiganders-choice-of-health-insurance/ (last visited August 22, 2017).

33. MCKINSEY CTR. FOR U.S. HEALTH SYS. REFORM, *supra* note 24, at 1.

34. Sara Hansard, *Higher Cost-Sharing, Narrow Networks, Here to Stay in ACA Health Plans*, BLOOMBERG BNA HEALTH CARE BLOG (Oct. 6, 2015), <https://www.bna.com/higher-costsharing-narrow-b57982059160/> (last visited July 25, 2017); Merrill Gozner, *Building Narrow Networks that Work*, MOD. HEALTHCARE (Dec. 21, 2013), www.modernhealthcare.com/article/20131221/MAGAZINE/312219986 (last visited July 25, 2017).

35. U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., *Health Insurance Plan & Network Types: HMOs, PPOs, and More*, HEALTHCARE.GOV, <https://www.healthcare.gov/choose-a-plan/plan-types/> (last visited July 25, 2017).

36. *Id.*

37. *Id.*

38. *Id.*

39. *Id.*

in-network providers into various tiers, usually determined by cost or quality.⁴⁰ Beneficiaries pay lower cost sharing if they obtain health care services from providers in the preferred tier and pay higher cost sharing if they obtain services from providers in less-preferred tiers.⁴¹ Other plans use a reference pricing scheme, where the plan agrees to pay a fixed amount, or “reference price,” for a given health care service, and charge the excess bill (if there is any) to the beneficiary.⁴² Therefore, if a beneficiary selects a service or provider whose rate exceeds the reference price, the beneficiary is responsible for the whole difference between the reference price and that provider’s contracted rate.⁴³ The above plans financially incentivize beneficiaries to receive health care services from a limited network of providers that are either employed by or contracted with the insurer. The narrower a network becomes, the more likely a provider who is (even remotely) involved in the medical care of a patient may have an out-of-network status.

B. *The Lack of Transparency About Provider Networks*

Plans with narrow networks may lack transparency regarding which providers are included in the network, both when purchasing a plan and afterwards. There is often a persisting lack of clarity surrounding which providers are in the beneficiary’s network and which are not.⁴⁴ When consumers are not adequately informed about which providers are participating in a plan’s network, they cannot make informed decisions about their care, such as when attempting to schedule a surgical procedure with only in-network providers. Nearly seven in ten insured Americans who have unaffordable out-of-network medical bills did not know that the health care provider was considered out-of-network at the time of treatment.⁴⁵ Especially in narrow or tiered networks, clear communication regarding which providers are included in the plan’s network

40. PAUL FRONSTIN, EMP. BENEFIT RESEARCH INST., TIERED NETWORKS FOR HOSPITAL AND PHYSICIAN HEALTH CARE SERVICES 5 (2003), https://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=179 (last visited July 26, 2017).

41. *Id.*

42. PAUL FRONSTIN & M. CHRISTOPHER ROEBUCK, EMP. BENEFIT RESEARCH INST., REFERENCE PRICING FOR HEALTH CARE SERVICES: A NEW TWIST ON THE DEFINED CONTRIBUTION CONCEPT IN EMPLOYMENT-BASED HEALTH BENEFITS 5 (2014), https://www.ebri.org/pdf/briefspdf/ebri_ib_398_apr14.refprcng.pdf.

43. *Id.*

44. Kelly A. Kyanko et al., *Out-of-Network Physicians: How Prevalent Are Involuntary Use and Cost Transparency?*, 48 HEALTH SERVS. RES. 1154, 1154 (2013) (reporting that “52 percent[] of individuals using out-of-network services experienced at least one contact with an out-of-network physician where cost was not transparent at the time of care”).

45. LIZ HAMEL ET AL., KAISER FAM. FOUND., THE BURDEN OF MEDICAL DEBT: RESULTS FROM THE KAISER FAMILY FOUNDATION/NEW YORK TIMES MEDICAL BILLS SURVEY 12 (2016), <https://kaiserfamilyfoundation.files.wordpress.com/2016/01/8806-the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey.pdf>.

may not only be lacking between the insurer and beneficiary but also between the insurer and contracted physicians. Often, physicians may participate in an insurer's broader network but are unaware that they are categorized as out-of-network for patients in specific plans with narrow or tiered networks.⁴⁶ While most plans provide health provider directories, they often contain outdated or inaccurate information.⁴⁷

This lack of transparency regarding provider network status fundamentally undermines the very concept underlying narrow network plans—that consumers can benefit from lower cost sharing *if* they choose providers within the plan's network. For this structure to work, consumers need access to adequate information to have an opportunity to make informed choices about providers. The lack of transparency surrounding provider network status can lead to surprise medical billing situations, where consumers are uninformed about the out-of-network status of providers who render health care services. Narrow networks are not going anywhere, and it is essential to protect consumers from being caught in the middle of billing disputes that lie outside of their control.

III. FEDERAL LAW APPROACHES TO PROTECT CONSUMERS FROM SURPRISE MEDICAL BILLS THAT ARE ULTIMATELY INADEQUATE

In an effort to protect consumers from surprise medical billing, CMS and NAIC have developed their own approaches to address such scenarios in commercial health plans. While well-intended, both of these federal approaches ultimately fall short in offering consumer protections from surprise medical billing.

A. *CMS' Final 2017 Benefit and Payment Parameters Rule*

CMS issued the final 2017 Benefit and Payment Parameters Rule (Final Rule) for QHPs offered on the ACA Marketplaces, which specifically addresses surprise balance billing. For 2018 and later benefit years, “for a network to be deemed adequate, each QHP that uses a provider network must . . . count the cost sharing paid by an enrollee for an essential health benefit provided by an out-of-network ancillary provider in an in-network setting towards the enrollee's annual limitation on cost sharing or provide a written notice” that such charges, including balance billing charges, “may not count toward the in-network annual

46. Jon H. Sutton, *Health Care Networks: Surprise Billings for Surgical Patients*, BULL. AM. C. SURGEONS (July 1, 2016), bulletin.facs.org/2016/07/health-care-networks/ (last visited July 26, 2017).

47. TEX. MED. ASS'N, PUTTING THE PIECES TOGETHER: NETWORK INADEQUACY AND UNFAIR DISCRIMINATION IN INSURANCE 17 (2014) (reporting that “62 percent of physicians had detected cases in which they were listed as participating when they were not, and 58 percent of physicians had detected cases where they were not listed when they were participating in a plan”).

limitation on cost sharing.”⁴⁸ Alternatively, each QHP with a provider network must provide written notice to enrollees at least forty-eight hours before rendering a service scheduled at an in-network facility that the enrollee might receive a service from an out-of-network ancillary provider and that any additional charges may not count toward the in-network cost-sharing limit.⁴⁹ Regardless, the statutory definition of cost sharing “does not include . . . balance billing amounts for non-network providers.”⁵⁰

While it is promising that CMS at least addresses surprise balance billing as a matter of network adequacy, the American Hospital Association (AHA) aptly points out that because the “regulatory definition of cost sharing excludes balance billing, [this provision provides] little financial protection for consumers facing unexpected medical bills resulting from out-of-network providers at in-network facilities.”⁵¹ Although some have interpreted this to mean that CMS is attempting to include balancing billing in the definition of cost sharing,⁵² most perceive that the referenced cost sharing still does not include balance billing, as the statutory definition establishes.⁵³ Thus, CMS’ approach to surprise medical bills places the burden entirely on the consumer to simply pay the balance bill, and this bill amount does not even go towards the annual limitation on cost sharing. This regulation potentially discourages providers from joining health plan networks by incentivizing them to perform services at in-network facilities and then balance billing patients in order to make more money than the lower contract rate earned by in-network providers.⁵⁴ This is especially tempting considering the amount billed for out-of-network care in the emergency room, for example, was 798% of Medicare rates, compared to the average in-network

48. Qualified Health Plan Minimum Certification Standards, 45 C.F.R. § 156.230(e) (2016).

49. *Id.*

50. Patient Protection and Affordable Care Act, 42 U.S.C. § 18022(c)(3)(B) (2010).

51. American Hospital Association, Comment to the Proposed Rule Regarding HHS Notice of Benefit and Payment Parameters for 2017 Under the Patient Protection and Affordable Care Act (Dec. 18, 2015), www.aha.org/advocacy-issues/letter/2015/151218-cl-cms-9937-p-rin0938-aS57.pdf.

52. Chamber of Commerce of the United States of America, Comment to the Proposed Rule Regarding HHS Notice of Benefit and Payment Parameters for 2018 Under the Patient Protection and Affordable Care Act (Oct. 6, 2016), <https://www.uschamber.com/comment/comment-letter-hhs-benefit-and-payment-parameters-2018-proposed-rule> (last visited July 26, 2017).

53. See, e.g., Timothy Jost, *The Final 2018 Notice of Benefit and Payment Parameters (Part 2)*, HEALTH AFF. BLOG (Dec. 18, 2016), healthaffairs.org/blog/2016/12/18/the-final-2018-notice-of-benefit-and-payment-parameters-part-2/ (last visited July 26, 2017).

54. Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2017, 81 Fed. Reg. 12,204, 12,305 (Mar. 8, 2016) (to be codified at C.F.R. pts. 144, 147, 153, 154 155, 156, & 158) (Several commenters “requested that HHS adopt NAIC Network Adequacy Model Act provisions instead. Other commenters were concerned that the proposal may have unintended consequences, such as disincentivizing providers from contracting with issuers in order to be able to balance bill consumers, or incentivizing consumers and out-of-network providers to elect to perform procedures at an in-network facility.”).

amount of 297% of Medicare rates for the same service.⁵⁵ The AHA rightly recognizes this unfair burden on consumers who have no control over the out-of-network care they receive and thus recommends that CMS adopts the NAIC Network Adequacy Model Act,⁵⁶ which offers consumers more financial protection from surprise medical bills. While concerns voiced during the notice-and-comment phase about CMS' approach did not persuade the agency to change its rule, CMS did express its willingness to amend the policy in the future to address the surprise medical bill issue after first giving health plans and providers an opportunity to work through the issue by themselves.⁵⁷

The Final Rule was selected for review because it regulates a significant number of commercial health plans available in the private market. CMS has taken a more aggressive approach towards limiting surprise medical bills in other narrow contexts involving Medicare and Medicaid.⁵⁸ However, this writing is focused on how to best regulate the broad array of commercial insurance products, so those CMS regulations are outside the scope of this comment.

B. *The NAIC Network Adequacy Model Act*

The NAIC is a regulatory support organization, comprised of and administered by chief insurance regulators from all fifty states, the District of Columbia, and five U.S. territories, which recommends industry standards based on the collective views of domestic and international state insurance regulators.⁵⁹ In November 2015, the NAIC released its Health Benefit Plan Network Access and Adequacy Model Act (Model Act), a revised version of its 1996 Managed Care Plan Network Adequacy Model, in response to the trend toward narrow network plans.⁶⁰ As its name suggests, the Model Act is intended to provide states with model legislation to regulate insurance reasonably and to

55. Cooper & Morton, *supra* note 10, at 1917.

56. American Hospital Association, *supra* note 51, at 4.

57. Bob Herman, *Obama Administration Backs Off on ACA Rules for 2017 Health Plans*, MOD. HEALTHCARE (Feb. 29, 2016), www.modernhealthcare.com/article/20160229/NEWS/160229878 (last visited July 27, 2017) ("Our intent in establishing this policy beginning for the 2018 benefit year is to permit us to monitor ongoing efforts by issuers and providers to address the complex issue of surprise out-of-network cost sharing at in-network facilities across all CMS programs in a holistic manner, and amend our policy in the future to accommodate progress on this issue, if warranted.").

58. Social Security Act § 1902(n)(3)(B), 42 U.S.C. § 1396a(n)(3)(B) (2012) (banning Medicare providers from balance billing dually eligible individuals enrolled in the Qualified Medicare Beneficiary Program).

59. NAT'L ASS'N OF INS. COMM'RS, CTR. FOR INS. POLICY AND RESEARCH, STATE INSURANCE REGULATION 2 (2011), www.naic.org/documents/topics_white_paper_hist_ins_reg.pdf.

60. NAT'L ASS'N OF INS. COMM'RS, *Network Adequacy*, NAIC.ORG (July 14, 2015), www.naic.org/cipr_topics/topic_network_adequacy.htm (last visited July 26, 2017).

protect consumers.⁶¹ Accordingly, certain provisions of the Model Act provide protections against surprise medical bills.⁶²

In emergency situations, medical bills must include notice that enrollees are only responsible for paying “their applicable in-network cost-sharing amount, but ha[ve] no legal obligation to pay the remaining balance.”⁶³ However, enrollees are required to forward the bill to their health plan “if the difference in the billed charge and the plan’s allowable amount is more than [\$500.00]” for consideration under a mandated “Provider Mediation Process” orchestrated by the health plan.⁶⁴ This provision effectively removes consumers from the medical bill dispute, leaving the health plan and out-of-network provider to negotiate and agree upon a reasonable rate through the mediation process, effectively protecting consumers.

In non-emergency situations, providers are required to provide enrollees a written disclosure stating that services may be rendered by out-of-network providers, a range of charges for out-of-network care that enrollees may be responsible for covering, and that enrollees can obtain a list of in-network providers from their health plans that enrollees may request to participate in their care.⁶⁵ This notice is to be provided both at the time of scheduling or pre-certification and at the time of admission.⁶⁶ This approach is focused on transparency—making consumers aware that there may be out-of-network costs associated with care rendered at an in-network facility. The Model Act theoretically affords more control to consumers by providing an opportunity to obtain a list of in-network providers from their health plan and to request that only those listed providers render care.

However, this approach works better in theory than in practice, particularly with regard to requesting ancillary providers like anesthesiologists, radiologists, and pathologists. Such providers are usually assigned to the patient by the health care facility or physician group, and while there may be attempts to honor requests for a specific anesthesiologist, for example, health care facilities and physician groups often disclaim that fulfilling such requests may not be possible.⁶⁷ This places consumers in a difficult situation, forcing them to decide

61. *Id.*

62. *Id.*

63. HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY MODEL ACT § 7(C)(1) (NAT’L ASS’N OF INS. COMM’RS 2015), www.naic.org/store/free/MDL-74.pdf [hereinafter MODEL ACT].

64. *Id.*

65. *Id.* § 7(B).

66. *Id.* § 7(B)(1)–(2).

67. *See, e.g.*, HOSP. FOR SPECIAL SURGERY, *Anesthesia Frequently Asked Questions*, <https://www.hss.edu/anesthesiology-frequently-asked-questions.asp> (last visited July 28, 2017) (stating that a patient’s anesthesiologist will be assigned by the hospital on the day before the scheduled surgery and that the hospital “cannot promise a specific anesthesiologist . . . prior to surgery, [but] do[es] consider patients’ preferences”); SUTTER HEALTH, *Hospital Anesthesia*

whether to reschedule a procedure that they may have had scheduled for months or to proceed with the procedure and deal with the out-of-network bill later. Consumers may also not know how to navigate the search for a specialist or may understandably be more concerned with other aspects of an invasive procedure (surgical risks, post-operative rehabilitation, etc.) that do not involve provider network status. Additionally, consumers may not know all the types or number of providers that might participate in their scheduled procedure. Recall the story of Mr. Drier, who was blindsided by a bill from an assistant surgeon who unexpectedly participated in his neck surgery.⁶⁸ Providers may be pulled into the operating room at the last minute for a consult or to assist with the procedure upon request of the attending physician, without the anesthetized patient knowing until a bill arrives weeks later. Therefore, while this provision of the Model Act is well intended, it does little to protect consumers who have minimal bargaining power in scheduling ancillary providers like anesthesiologists or in controlling assistant providers who unexpectedly participate in their care.

Whenever a balance bill is received, the Model Act gives enrollees the option to pay the balance of the bill or “if the difference in the billed charge and the plan’s allowable amount is more than [\$500.00],” enrollees may send the bill to their health plans for processing under a mandated provider mediation process.⁶⁹ The Model Act requires that all health plans establish a provider mediation process for cases where out-of-network providers wish to protest the benchmark payment rate of the higher of the health plan’s in-network rate or a state-determined percentage of the Medicare payment rate in the geographic area for the same or similar services.⁷⁰ Unlike an arbitration process that concludes with a binding decision, in a mediation process, the health plan and out-of-network provider negotiate with the assistance of a neutral third party until both sides agree on a reimbursement price.⁷¹ While this mediation process, a unique proposal compared to CMS’ Final Rule, provides a mechanism to negotiate, out-of-network providers and health plans are not required to arrive at a mutually agreeable reimbursement rate at the end of the process. Furthermore, mediation

Frequently Asked Questions, <https://www.sutterhealth.org/hospital-anesthesia/index.html> (last visited July 28, 2017) (stating that “while [the hospital] will do [their] best to honor requests [for a specific anesthesiologist], this may not be possible”); CORE PHYSICIANS, *Anesthesia – Frequently Asked Questions*, <https://www.corephysicians.org/Services/Specialty-Care/Anesthesia/Anesthesia-Frequently-Asked-Questions> (last visited July 28, 2017) (stating that while the physician group “do[es their] best to honor these requests [for a specific anesthesiologist] . . . it may not be possible due to emergencies or scheduling issues”).

68. Rosenthal, *supra* note 1.

69. MODEL ACT § 7(D) (“Limitation on Balance Billing Covered Persons”).

70. *Id.* § 7F–7G(1) (“Provider Mediation Process” and “Benchmark for non-participating facility-based provider payments”).

71. *Id.* § 7G(1); JACK HOADLEY ET AL., THE CTR. ON HEALTH INS. REFORMS, GEO. UNIV. HEALTH POLICY INST., *BALANCE BILLING: HOW ARE STATES PROTECTING CONSUMERS FROM UNEXPECTED CHARGES?* 7 (2015).

does not necessarily result in a fair negotiated rate as one party may have greater bargaining power.

The Model Act has the potential to be very influential in the regulation of health insurance because CMS and most states tend to at least consider the provisions submitted by the NAIC, and the primary role of insurance regulation historically falls to the states, as reaffirmed by the McCarran-Ferguson Act of 1945.⁷² States that have yet to adopt legislation addressing surprise balance billing ought to understand the shortcomings of the Model Act and look to approaches other states have implemented, as explored in Section IV, in order to determine which statutory framework best protects consumers.

IV. A SPECTRUM OF STATE LAW APPROACHES THAT PROTECT CONSUMERS FROM SURPRISE MEDICAL BILLS

Aside from the federal approaches, there are various state approaches to limit the surprise medical billing of consumers. State legislation that addresses surprise medical billing tends to contain varying combinations of four key elements: (1) disclosure and transparency requirements, (2) balance billing prohibitions, (3) hold harmless provisions, and (4) creation of adequate provider payment schemes.⁷³ This comment focuses on three representative statutes selected as examples to demonstrate the general spectrum of state legislative frameworks that protect consumers from surprise medical billing, from least protective to most protective.

A. *Massachusetts: Hold Harmless Provisions for Emergency and Non-Emergency Care, Provider-Determined Out-of-Network Reimbursement Rates*

For emergency care, Massachusetts's state preferred provider plan law requires that insurers pay out-of-network providers "at the same [benefit] level and in the same manner" as if a preferred provider treated the patient if the patient could not "reasonably reach a preferred provider."⁷⁴ For non-emergency but medically necessary covered services rendered at an in-network facility, Massachusetts state law requires that insurers cover the cost of such services, even if partially performed by an out-of-network provider, with no greater cost sharing to the patients where they did not have a "reasonable opportunity to choose to have the service performed by [an in-network] provider."⁷⁵ Nothing

72. 15 U.S.C. § 1012 (2006) (explaining that "[t]he business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business" and that "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance").

73. HOADLEY ET AL., *supra* note 71, at 6–7.

74. MASS. GEN. LAWS ch. 176I, § 3(b) (2016).

75. MASS. GEN. LAWS ch. 176O, § 6(a)(4)(ii) (2016).

in this legislative approach prohibits balance billing. Thus, in practice, patients still receive balance bills but can usually resolve them by contesting the bill with the insurer, usually through an internal appeals process.⁷⁶

In theory, this approach shifts the burden to the insurer to indemnify the consumer and pay the out-of-network bill. However, in reality, consumers likely do not know this is an available option and end up paying the balance bills on their own. For the above consumer protection to work as intended, a method of notifying consumers of their option to affirmatively contest the bill with their insurer would be required. Even if consumers were notified of this option, the process of protesting a balance bill through an internal appeals process is confusing and burdensome, especially for someone who does not know the technicalities of insurance or medical billing.⁷⁷ This approach also does not incentivize communication or cooperation between the insurer, provider, and in-network facility regarding transparency of network participation. Several hospital officials reportedly said that “they have in-network contracts and anything beyond that is a matter for insurance companies to handle with individual doctors who are not under their control.”⁷⁸ Thus, health care facilities in Massachusetts have taken a hands-off approach instead of recognizing the role they could play in provider network formation.

B. Texas: Hold Harmless Provisions for Emergency Care, Consumer-Initiated Mediation Process, State-Determined Methodology for Out-of-Network Reimbursement Rates

Consumer protections in Texas vary depending on the type of health plan held by a consumer. HMOs and EPOs are regulated by hold harmless provisions. HMOs are required to “pay for emergency care performed by [out-of-network] physicians or providers at the usual and customary rate or at an agreed rate” if the care was necessary.⁷⁹ Similarly, EPOs are required to “fully reimburse a nonpreferred provider for . . . emergency care services at the usual and customary rate or at a rate agreed to” between the plan and provider if a consumer “cannot reasonably reach a preferred provider.”⁸⁰ This protection

76. Jack Sullivan, *Out-of-Network Billing Surprises: Patients Get Charged for Unexpected Services Not Covered by Their Insurance*, COMMONWEALTH (Spring 2016), <https://commonwealthmagazine.org/health-care/out-of-network-billing-surprises/> (quoting Matthew Day, senior vice president at Blue Cross Blue Shield of Massachusetts, “Our policy is to indemnify the member from that balance bill”) (last visited July 28, 2017).

77. CONSUMER REPORTS NAT’L RESEARCH CTR., *supra* note 4, at 9 (reporting that thirty-five percent of consumers who received surprise medical bills took no action to resolve their billing issue, citing reasons such as “I was confused about what to do or found it too complicated” or “I didn’t know how to take action/where to complain”).

78. Sullivan, *supra* note 76.

79. TEX. INS. CODE ANN. § 1271.155(a) (West 2017).

80. 28 TEX. ADMIN. CODE § 3.3725(a) (2017).

seems to include surprise medical billing scenarios where a patient may not be able to reasonably reach an in-network provider due to their emergency condition. Like Massachusetts's approach, here and in other states that instead use a state-defined fee schedule to determine provider payment rates, there is no ban on balance billing. Therefore, the out-of-network provider can simply send bills to consumers for the balance of the out-of-network rate and the "usual and customary rate." Consumers can then contest these bills through their insurers' internal appeals processes.

On the other hand, PPOs are regulated by transparency requirements and an independent mediation process. PPOs are required to provide a current and accurate directory of preferred providers online.⁸¹ If the directory is found to be inaccurate and consumers rely on it, consumers may have the out-of-pocket expenses associated with the care counted toward both the in-network deductible and out-of-pocket maximum.⁸² Additionally, consumers may initiate a mediation proceeding at no cost if they receive a balance bill for more than \$500 by an "out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, neonatologist, or assistant surgeon" by submitting a "mediation request form."⁸³ Then, the consumer (optional), health plan, and out-of-network provider participate in an informal settlement teleconference to attempt to agree on a reasonable rate for the service(s) rendered.⁸⁴ If this does not result in an agreement, the consumer (optional), health plan, and out-of-network provider participate in a formal mediation to again attempt to agree on a reasonable rate.⁸⁵ The parties are not required to reach an agreement at mediation, which means that the dispute may be referred to a special judge for final resolution.⁸⁶ PPOs must provide notice of the above rights to their beneficiaries.⁸⁷

The Texas regulation of HMOs and EPOs is concerning for reasons similar to the Massachusetts legislation. Consumers may be completely unaware that they have the option to contest a balance bill and end up paying the bill. An internal appeals process can be very confusing for and burdensome on the consumer.⁸⁸ The regulation of PPOs at least has an additional transparency element that informs consumers that they have the option to contest a surprise medical bill by requesting a mediation. However, the mediation process places the burden on consumers, who must initiate the process if they wish to contest a

81. *Id.* § 3.3705(f)(1) (2017).

82. *Id.*

83. *Id.* §§ 3.3705(f)(1), 21.5010 (2017).

84. *Id.* § 21.5012.

85. *See* TEX. INS. CODE ANN. § 1467.054 (West 2017).

86. TEX. DEP'T. OF INS., *Mediation for Out-of-Network Hospital-Based Health Care Provider Claims*, www.tdi.texas.gov/consumer/cpmmmediation.html (last visited July 28, 2017).

87. 28 TEX. ADMIN. CODE § 3.3705(f).

88. *See* CONSUMER REPORTS NAT'L RESEARCH CTR., *supra* note 4, at 9.

balance bill. The mediation process, which includes an informal teleconference and a formal mediation, is time consuming and intimidating to patients who have limited knowledge of insurance and medical billing. Consumers may choose not to participate in the teleconference and formal mediation, but then there is a concern that the insurer and provider have no incentive to find a fair reimbursement rate considering they are only arguing about what the patient will pay out of pocket for the out-of-network service rendered. Even after these proceedings, there is no requirement that an agreed upon rate is determined, yielding a significantly inefficient use of time and resources. Consumers can then bring the dispute to court, which will consume even more resources. The Texas mediation process at least provides a forum for the out-of-network rate to be disputed, but the process is burdensome and does not necessarily yield a result in the same way as an alternative dispute resolution process, like arbitration.

C. New York: Prohibition of Balance Billing, Assignment of Benefits Form, Extensive Disclosure and Transparency Requirements, State-Run Arbitration Process

New York led the way in taking the most comprehensive approach to protect consumers from surprise medical billing by holding patients harmless for bills received for both emergency and non-emergency out-of-network care provided at an in-network facility.⁸⁹ For emergency care, New York state law bans the balance billing of patients for costs beyond the in-network cost-sharing amounts that apply under their insurance plan.⁹⁰ For non-emergency care, patients who receive a surprise medical bill can submit an “assignment of benefits” form that authorizes the provider to bill the insurer directly, and are, accordingly, held harmless for any out-of-pocket costs beyond the in-network cost-sharing amounts that apply under their plan.⁹¹ This approach provides the greatest

89. See N.Y. COMP. CODES R. & REGS. tit. 23, § 400.5(h) (2017).

90. *Id.* § 400.5(h) (“A health care plan shall ensure that the insured shall incur no greater out-of-pocket costs for the services than the insured would have incurred with a participating physician or participating health care provider for emergency services . . .”).

91. *Id.* § 400.6(b) (“If an insured assigns benefits for a surprise bill in writing to a non-participating physician or non-participating referred health care provider that knows the insured is insured under a health care plan, the non-participating physician or non-participating referred health care provider shall not bill or seek payment from the insured except for any applicable copayment, coinsurance or deductible that would be owed if the insured utilized a participating physician.”); *id.* § 400.5(h)(2) (“A health care plan shall ensure that the insured shall incur no greater out-of-pocket costs for the services than the insured would have incurred with a participating physician or participating health care provider: . . . for a dispute involving a surprise bill when the insured has assigned benefits to a non-participating physician or a non-participating referred health care provider.”). The “Assignment of Benefits Form” is short and simple for consumers to complete. See N.Y. DEP’T OF FIN. SERVS., *New York State Out-of-Network Surprise Bill Assignment of Benefits Form* (May 26, 2015), www.dfs.ny.gov/insurance/health/OON_assignment_benefits_form.pdf.

protection to consumers by completely removing them from surprise billing disputes, leaving the provider and insurer to resolve the issue among themselves. While New York addresses balance billing in both the emergency and non-emergency contexts, some states have taken a more limited approach by only banning balance billing for emergency services.⁹²

In addition to the balance billing prohibition and hold harmless provision, New York law also has extensive disclosure and transparency requirements for (1) insurers, (2) providers, and (3) hospitals. First, under state law, all health plans are required to provide a “clear description of the methodology” that the insurer uses to calculate out-of-network reimbursement rates, examples of estimated out-of-pocket costs for “frequently billed out-of-network health care services,” and both written and online information that “reasonably permits” an enrollee to estimate their expected out-of-pocket costs for out-of-network care in a given location, determined by the difference between the insurer’s reimbursement rate and the usual and customary cost for out-of-network care.⁹³ Additionally, upon request, every health plan must “disclose the approximate dollar amount that the insurer will pay for a specific out-of-network health care service.”⁹⁴

Second, New York law requires out-of-network providers to give patients notice before scheduled non-emergency services that, upon request, they can obtain an estimate of anticipated costs for out-of-network services or a fee schedule.⁹⁵ Third, state law mandates that hospitals post information on their websites, including a list of plan networks in which the hospital participates; an explanation that physician services are not included in hospital charges, and therefore physicians may not participate in the same networks; a list of plan networks in which the hospital’s employed physicians participate and their contact information; and the contact information of physician groups with which the hospital has contracted for anesthesiology, pathology, and radiology services so that consumers can determine their network status.⁹⁶ This comprehensive approach makes disclosure to the consumer the priority. Although it is demanding on health care entities, it at least makes transparency the standard for insurers, providers, and health care facilities alike, instead of placing the majority of the disclosure burden on one party or another. Other states like Connecticut have similar legislation but unlike the New York law, those states only require disclosure and transparency from insurers and providers, not health care facilities.⁹⁷

92. *See, e.g.*, 18-1400-1403 DEL. ADMIN. CODE § 1403-11.3.3 (2007) (“Emergency and Urgent Care Services”).

93. N.Y. INS. LAW § 3217-a(a)(19)–(20) (McKinney 2015).

94. *Id.* § 3217-a(b)(14).

95. N.Y. PUB. HEALTH LAW § 24(2) (McKinney 2015).

96. *Id.*

97. *See, e.g.*, CONN. GEN. STAT. § 38a-591b (2012).

Banning out-of-network providers from balance billing the patient directly raises the previously-discussed concern that such providers may be unfairly reimbursed by health insurers for care provided. However, New York law addresses this concern by establishing a state-run arbitration process, the Independent Dispute Resolution Entity (IDRE), to which a provider can appeal to dispute the reasonableness of reimbursement.⁹⁸ The provider and insurer each submit a proposed fee or payment to the IDRE, which makes a binding decision by selecting the more reasonable fee.⁹⁹ If the dispute does not involve a health plan, the IDRE determines a reasonable fee on its own.¹⁰⁰ In deciding the most reasonable price for services rendered in both circumstances, the independent arbitrators consider factors such as provider education and experience, case circumstances and complexity, individual characteristics of the patient, and usual and customary charges.¹⁰¹ Theoretically, this type of “baseball arbitration” works by incentivizing both provider and insurer to submit reasonable proposals in order to avoid “being stuck with” the opposing party’s proposal.¹⁰² Physician groups such as the American College of Emergency Physicians support New York’s statutory approach of extracting consumers from the billing dispute resolution process.¹⁰³ Although state insurance law is expressly preempted by ERISA for self-funded employer plans,¹⁰⁴ beneficiaries of such plans and uninsured consumers can also appeal to the IDRE in an effort to reduce the medical bill balance.¹⁰⁵ This is important considering the U.S. Department of

98. N.Y. COMP. CODES R. & REGS. tit. 23, § 400.7(a)(2) (2015) (“Surprise bills: A health care plan, a non-participating physician, a non-participating referred health care provider, an insured who does not assign benefits, or a patient who is not an insured may submit a dispute regarding a surprise bill to the superintendent for review by an IDRE.”).

99. *Id.* § 400.8(h) (“For disputes involving a health care plan, in determining a reasonable fee for the services rendered, an IDRE shall select either the health care plan’s payment or the non-participating physician’s or, as applicable, the non-participating referred health care provider’s fee.”).

100. *Id.* (“For disputes that do not involve a health care plan, the IDRE shall determine a reasonable fee.”).

101. N.Y. FIN. SERV. LAW § 604 (2016) (“Criteria for determining a reasonable fee”).

102. Mark Scherzer, *New York’s New “Surprise Bill” Law Rolls Out New Health Insurance Protections for Consumers*, FAMILIES USA BLOG (Apr. 10, 2014), familiesusa.org/blog/2014/04/new-york%E2%80%99s-new-surprise-bill-law-rolls-out-new-health-insurance-protections-consumers (last visited July 28, 2017).

103. Michelle Andrews, *N.Y. Law Offers Model for Helping Consumers Avoid Surprise Out-of-Network Charges*, KAISER HEALTH NEWS (July 14, 2015), khn.org/news/n-y-law-offers-model-for-helping-consumers-avoid-surprise-out-of-network-charges/ (last visited July 28, 2017).

104. 29 U.S.C. § 1144(b)(2)(B) (2012).

105. *See* N.Y. COMP. CODES R. & REGS. tit. 23, § 400.7(a)(2) (2015).

Labor, which regulates self-funded plans, has not enacted any consumer protections against surprise medical billing.¹⁰⁶

Compared to a mandated mediation process administered by a health plan as recommended by the NAIC Model Act, the statutorily established independent arbitration process is more efficient because an impartial arbitrator can likely decide the reimbursement rate more quickly and fairly without spending weeks in stubborn negotiations. The arbitration process ends with a decision that binds both parties, as opposed to mediation that may never result in a mutually agreed upon reimbursement rate.¹⁰⁷ Additionally, an independent arbitrator reduces, or even eliminates, the bargaining power that one party may have over the other because the arbitrator has complete discretion to decide a reimbursement rate in dispute. Therefore, in surprise medical billing scenarios, arbitration is a more effective billing dispute resolution process than mediation.

Other states have followed in New York's footsteps by enacting similar legislation to protect consumers from surprise medical billing, including Florida,¹⁰⁸ California,¹⁰⁹ and Colorado.¹¹⁰

V. RECOMMENDATIONS FOR A LEGISLATIVE FRAMEWORK THAT MAXIMIZES CONSUMER PROTECTION

Consumers should not be caught in the middle of a medical billing dispute when they are unaware of or unable to prevent receiving care from out-of-network providers. The majority of consumers do not understand their legal rights or the technicalities of medical billing and insurance regulation, making them ill-equipped to navigate their options upon receiving surprise medical bills.¹¹¹ The primary goal of state legislation regarding surprise medical billing should be to protect vulnerable consumers by removing them from medical bill disputes altogether. Instead, these disputes should be resolved by providers and

106. CONSUMERS UNION, GETTING STARTED ON SURPRISE MEDICAL BILLS: AN ADVOCATE'S GUIDE 4 (2015), consumersunion.org/wp-content/uploads/2015/11/SurprisebillsAdvocatesGuide.pdf.

107. *Id.* at 10.

108. *See* FLA. STAT. § 641.3154 (2016) ("Organization liability; provider billing prohibited").

109. *See* CAL. HEALTH & SAFETY CODE § 1371.9 (2016) (legislation banning out-of-network providers from billing patients "more than the in-network cost-sharing amount for services" and counting this cost sharing toward annual out-of-pocket limits); CAL. HEALTH & SAFETY CODE § 1371.30 (2016) (legislation setting up an independent dispute resolution process).

110. COLO. REV. STAT. § 10-16-704 (3)(a)(II) (2016) (legislation holding "consumer[s] harmless for additional charges from out-of-network providers for care rendered in [an in-network] facility").

111. CONSUMER REPORTS NAT'L RESEARCH CTR., *supra* note 4, at 12 (reporting that sixty-seven percent of privately insured Americans did not know the state entity responsible for resolving health insurance billing issues, and eighty-seven percent did not know which state governmental agency handles complaints about health insurance).

insurance companies who are better equipped to reach an agreement due to their specialized knowledge of medical billing.

Accordingly, the best legislative approach to protect consumers and ensure fair negotiations between insurance plans and providers is a modified version of New York's comprehensive approach. State legislatures who value consumer protection should adopt a statutory framework that includes the following five provisions: (1) for emergency services, ban out-of-network providers from balance billing patients for costs beyond in-network cost sharing if services are rendered at an in-network facility; (2) for non-emergency services, hold patients harmless for out-of-pocket costs beyond in-network cost sharing if services are rendered at an in-network facility if patients submit an assignment of benefits form; (3) ban anti-assignment clauses from health plans in surprise medical billing contexts to ensure that patients can assign benefits to providers; (4) count cost sharing for services provided by an out-of-network provider towards annual out-of-pocket limits; and (5) establish an independent, state-run dispute resolution process that uses an external standard and is accessible by health plans, out-of-network physicians, and both insured and uninsured patients. These provisions best insulate consumers from unfair financial responsibility arising from surprise medical billing situations, as explored further below. To work in conjunction with the above five provisions, state legislatures should additionally adopt disclosure and transparency requirements to prevent surprise medical billing situations as often as possible and to protect informed consumer choice.

A. *Outline and Justification of the Recommended Legislation*

The five recommended provisions of this proposed comprehensive statute realistically acknowledge the context of surprise medical billing and set up an effective infrastructure to protect consumers and leave complex billing disputes to those best positioned to determine a fair price: insurers and providers. By primarily protecting the consumer above all other parties, this approach encourages communication and negotiation between insurers, health facilities, and providers.

1. Provision One

Provision One bans out-of-network providers from balance billing patients for costs beyond in-network cost sharing for emergency services rendered at an in-network facility. This provision completely removes the patient from the medical billing dispute process from the very beginning. In emergency situations, this is especially important because patients almost never have control over the network status of their treating physicians or ambulance providers. Therefore, because of this lack of control, it is not fair to hold patients financially responsible for such services. Banning balance billing for emergency services eliminates the possibility of consumers simply paying surprise medical

bills received in the mail because they are unaware of any alternative option. Thus, the approach of this provision requires very little, if any, consumer education to be effective.

It is better to leave medical bill disputes to those who actually have a say in the network arrangement, namely providers and health plans. Through banning the balance billing of patients for emergency situations, the burden is placed on the out-of-network provider and health plan to negotiate a fair price for services rendered. If the health plan does not agree with the reasonableness of an out-of-network provider's asking price, or if an out-of-network provider does not agree with the reasonableness of a health plan's rate, either party can appeal to the independent dispute resolution process set out in Provision Five. The option for arbitration keeps the bargaining power between providers and health plans as equal as possible. Banning balance billing is the most consumer-protective strategy and is appropriate and necessary in emergency situations where consumers are most vulnerable.

2. Provision Two

Similarly, Provision Two holds patients harmless for out-of-pocket costs beyond in-network cost sharing for out-of-network non-emergency services rendered at an in-network facility, as long as the patient submits an assignment of benefits form. Like the New York law previously discussed, it is recommended that states mandate an assignment of benefits form to accompany any balance bill sent by an out-of-network provider to a consumer, thereby immediately informing the consumer of the option to either pay the bill or fill out the simple form to allow the provider to pursue payment. The form places the burden on the out-of-network provider and health plan to negotiate a fair price for services rendered and keeps the consumer removed from such negotiations. Assigning benefits to out-of-network providers makes it easier for such providers to collect payments because they are entitled to the benefits by law. Creating a legal entitlement to benefits for providers is a useful strategy to gain support from physician groups that may be otherwise disapproving of legislation that limits the ability of out-of-network physicians to balance bill patients. This provision essentially bans balance billing patients when an assignment of benefits is in place, protecting the consumer in a similar manner as Provision One, with an added attraction for out-of-network physicians through the legal entitlement to plan benefits.

3. Provision Three

Provision Three bans anti-assignment clauses from health plans in surprise medical billing contexts to ensure that patients can assign benefits to providers, who can accordingly negotiate a reimbursement rate with the health plan

directly.¹¹² This provision prevents health plans from strategically getting around the hold harmless protection of Provision Two by simply adding an anti-assignment clause to their contracts with consumers. Having a ban on anti-assignment clauses is vital because consumers may not understand the implications of all the terms in insurance contracts. Additionally, consumers virtually never have the option to negotiate an anti-assignment clause because insurance contracts are typically contracts of adhesion where each consumer has limited bargaining power compared to the insurance company.¹¹³ Accordingly, the legislative framework needs to include a ban on anti-assignment clauses in health insurance contracts to protect the consumer-protecting intention behind Provision Two.

4. Provision Four

In the event that a consumer chooses to pay for non-emergency services rendered by an out-of-network provider instead of assigning benefits to that provider, Provision Four counts the payment towards annual out-of-pocket limits. This provision is aimed at preventing consumers from being overburdened by medical bills with high out-of-network service charges should they choose to pay the bills. This provision would not apply to all balance billing but only to surprise medical billing circumstances—where a patient is unexpectedly billed for out-of-network services rendered at an in-network facility—so as to prevent very sick patients from strategically reaching their out-of-pocket limits quickly in order to have their health plans cover all remaining costs.

5. Provision Five

Provision Five establishes an independent, state-run arbitration process where health plans, out-of-network physicians, and patients can dispute reimbursement rates for out-of-network services rendered. This dispute resolution process is a better alternative to the NAIC Model Act's and Texas's mediation processes because it concludes with a final, binding decision made by an impartial arbitrator. Although arbitration tends to be more formal and expensive than mediation,¹¹⁴ arbitration is a better option in surprise medical

112. Modeled after Colorado law that requires insurers to permit the assigning of benefits to out-of-network providers. COLO. REV. STAT. § 10-16-106.7 (2016) (providing that “[a]ny carrier that provides health coverage to a covered person shall allow, but not require, such covered person under the policy to assign, in writing, payments due under the policy to a licensed hospital, other licensed health care provider, an occupational therapist . . . , or a massage therapist”).

113. See Clark C. Havighurst, *Prospective Self-Denial: Can Consumers Contract Today to Accept Health Care Rationing Tomorrow?*, 140 U. PA. L. REV. 1755, 1766 (1992).

114. See Jeanne M. Brett et al., *The Effectiveness of Mediation: An Independent Analysis of Cases Handled by Four Major Service Providers*, 12 NEGOTIATION J. 259, 259 (1996) (reviewing

billing scenarios because the end result is always a binding reimbursement rate, as opposed to an optional agreement subject to administrative appeal and then judicial appeal.

To address concerns regarding New York's baseball arbitration process, the recommended process would instead use an external standard, such as a percentage above Medicare rates (e.g., 150% the Medicare rate for a given service), as the baseline rate. The health plan and out-of-network provider could present evidence to the arbitrator explaining why the rate should be adjusted up or down due to various factors, like those considered by New York arbitrators, such as provider education and experience, case circumstances and complexity, individual characteristics of the patient, and usual and customary charges. This external standard would help to provide an environment to establish a truly fair payment that will likely be set somewhere between the health plan's offer price and the out-of-network provider's asking price. Thus, compromise in rate negotiation would be consistently established instead of one side necessarily "winning" and the other "losing" as in New York's baseball arbitration process. Health plans and providers alike will probably favor this method, especially after giving input as to what the external baseline rate should be, because it simplifies the negotiation process and ends in compromise instead of a one-sided outcome.

6. Recommended Disclosure and Transparency Requirements

In addition to the above framework, states should adopt legislation that increases disclosure and transparency to prevent surprise medical bill circumstances from arising in the first place when at all possible. As discussed previously, New York's disclosure and transparency framework is ideal because it sets standards for all those involved in health care delivery: insurers, providers, and health care facilities. Like the New York framework, health plans should be required to keep a current and accurate provider directory available online with a user-friendly interface, to provide a clear explanation of how out-of-network reimbursement rates are calculated, examples of anticipated out-of-pocket costs for out-of-network services that are often billed, and a written and online method where consumers can estimate their expected out-of-pocket costs for out-of-network care in a given location.

Furthermore, every health plan should be mandated to disclose the specific cost of an out-of-network service that the insurer will pay upon request. Out-of-network providers should also be required to give patients notice before a scheduled non-emergency service that, upon request, they can obtain an estimate of anticipated costs for out-of-network services or a fee schedule. Further, hospitals should be required to post the following information on their websites: (1) a list of plan networks in which the hospital participates, (2) an explanation

449 mediation cases and finding that mediation costs "far less than arbitration, took less time, and was judged a more satisfactory process than arbitration").

that physician services are not included in hospital charges and therefore physicians may not participate in the same networks, (3) a list of plan networks in which the hospital's employed physicians participate and their contact information, and (4) contact information of physician groups that the hospital has contracted with for emergency medicine, anesthesiology, pathology, radiology services, and other independent contractors so that consumers can determine their network status. This comprehensive approach to disclosure makes the consumer the priority and holds insurers, providers, and hospitals alike to a high standard of transparency.

The higher standard of transparency might encourage health care facilities to adopt internal corporate policies that require all providers, as a condition of practicing there, to participate in the same health plan networks in which the facility participates. Several facilities, such as Boca Raton Regional Hospital in South Florida and Jewish Hospital in Louisville, Kentucky, have taken this approach with a policy that requires its contracting anesthesiologists, emergency physicians, pathologists, and radiologists to contract with the health plans in which the hospital participates.¹¹⁵ As a result of such a policy, the facilities have processed fewer complaints regarding surprise medical billing, which is to be expected because nearly all providers at the in-network facility now also have in-network status.¹¹⁶ This incentive is perhaps the most straightforward strategy to eliminate scenarios in which surprise medical billing might occur, but it is challenging to get providers and health plans to reach an agreement about rates for services rendered. The AMA vehemently opposes the concept of facilities forcing out-of-network providers to enter negotiations with health plans, viewing this policy as “a methodology to coerce physicians through yet another way to not receive sufficient payment.”¹¹⁷ However, if such a policy becomes commonplace among health care facilities, negotiated rates between out-of-network providers and health plans may be more likely to reach a fair and reasonable price. Having the industry voluntarily come to this consensus in response to the transparency standards would likely receive more support than mandating the above policy, such as by making it a Medicare condition of participation, although this is another potential option.

It remains important to recognize that disclosure and transparency cannot always prevent surprise medical bill situations. Many consumers who fall victim to surprise medical billing were in an emergency condition or anesthetized at the time of service when an out-of-network provider unexpectedly participated in their care. Therefore, while these disclosure and transparency measures are essential to protect informed consumer choice, they cannot wholly eliminate surprise medical billing. Thus, the proposed framework is necessary to work in

115. Herman, *supra* note 17.

116. *See id.*

117. Meyer, *supra* note 21.

conjunction with disclosure and transparency measures to best protect consumers.

B. Implementation and Enforcement of the Recommended Legislation

To ensure successful enactment and implementation, states must first consider the political feasibility of the above comprehensive surprise medical bill legislation. In general, supporters of a comprehensive approach include consumer groups¹¹⁸ and state health plan associations.¹¹⁹ State medical associations have been inconsistent in terms of their support for such an approach.¹²⁰ Ancillary providers who are often out-of-network providers in billing situations, such as anesthesiologists and radiologists, tend to disapprove of the comprehensive approach.¹²¹ States must be prepared to navigate their particular stakeholders and to strategically emphasize the ultimate goal of this legislation: to protect consumers by removing them entirely from medical bill disputes, leaving only those best equipped to negotiate about rates (providers and health plans) at the table.

After the legislation is enacted, it is essential to inform consumers about their new options when they receive a surprise medical bill. Thus, as in New York's legislation, both health plans and providers will be required to disclose to consumers that they are not financially responsible for any amount above that

118. See Harris Meyer, *Florida Governor Signs Law Shielding Patients from Surprise Medical Bills*, MOD. HEALTHCARE (Apr. 14, 2016), www.modernhealthcare.com/article/20160414/NEWS/160419946 (last visited July 28, 2017); FLA. HOUSE OF REPS. STAFF ANALYSIS, CS/CS/HB 221 OUT-OF-NETWORK HEALTH INSURANCE COVERAGE, at 4 (2016), www.flsenate.gov/Session/Bill/2016/221/Analyses/h0221c.APC.PDF (outlining the Florida Insurance Consumer Advocate's recommendations for legislation that would "[h]old consumers harmless (prohibit 'balance billing') in emergency and 'surprise billing' situations[,] [e]stablish an alternative dispute resolution process to allow nonparticipating providers to challenge the amount of payment received from an insurer[,] . . . [r]equire insurers to update their provider directories on a timely basis[, and] [r]equire hospitals to make data available regarding hospital-based providers who are not in the network").

119. See, e.g., Meyer, *supra* note 118 (reporting that the CEO of the Florida Association of Health Plans declared, "This is the most comprehensive consumer protection legislation in the country on (this issue), and our association is proud to support it The stakeholders came together and agreed to remove patients from the middle of disputes between insurers and providers.").

120. *Id.* (reporting that while the Florida Medical Association supported Florida's comprehensive consumer protection legislation, the California Medical Association strongly opposed its similar law, "arguing that it would hinder consumers' ability to use their plans' out-of-network benefits and give plans too much negotiating leverage over physicians").

121. *Id.* (reporting that anesthesiology and radiology groups strongly opposed Florida's comprehensive law); see also Harris Meyer, *Passage of California Surprise-Bill Legislation Could Spur Other States to Act*, MOD. HEALTHCARE (Sept. 1, 2016), www.modernhealthcare.com/article/20160901/NEWS/160909980 (last visited July 28, 2017) (reporting that physician groups representing plastic surgeons, cardiologists, and anesthesiologists were strongly against California's comprehensive law).

which they would normally pay if they had received care from an in-network provider, along with information about the assignment of benefits form, the independent dispute resolution process, and where to file a complaint through the state. The simplest way to start enforcing the legislation is through monitoring consumer and provider complaint data collected through the state. Enforcement of the recommended legislation would involve a collaboration of agencies, such as the state insurance department that has jurisdiction over health plans and the state medical board that has jurisdiction over licensed providers. These agencies would jointly investigate illegal balance billing by either health plans or medical providers.

VI. CONCLUSION

Now is the time for state legislatures to act. As narrow provider networks continue to thrive as a premium-lowering mechanism, it is more important than ever to protect vulnerable consumers from surprise medical billing by enacting comprehensive legislation as recommended above. Consumers should not be stuck with outrageous balance bills in circumstances where they have no control over which providers participate in their care, despite playing by the rules and attempting to utilize only the services of in-network providers. Therefore, states should adopt the recommended statutory framework, based on a modified version of New York's comprehensive law, because it both insulates consumers from unfair financial responsibility and promotes informed consumer choice, which can prevent surprise medical bills from arising, through transparency and disclosure. It is time to aggressively address surprise medical bill sticker shock once and for all.

MERLOW M. DUNHAM*

* Bachelor of Arts in Biochemistry, Saint Louis University; Master of Health Administration, Saint Louis University College for Public Health & Social Justice (anticipated 2019); Juris Doctor, Saint Louis University School of Law (anticipated 2019). The author would like to thank Professor Tim Greaney for his thoughtful insight and guidance; Jeffrey, the rest of her family, and friends for their continuous support; and the Editorial Board of Volume 11 of the *Saint Louis University Journal of Health Law & Policy* for their dedication and hard work.

