

# CONSUMER FINANCIAL PROTECTION IN HEALTH CARE

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## ABSTRACT

*There are inadequate consumer protections from harmful medical billing practices that result in unavoidable, unexpected, and often financially devastating medical bills. The problem stems from the increasing costs shifting to patients in American health care and the inordinate complexity that makes health care transactions nearly impossible for consumers to navigate. A particularly outrageous example is the phenomenon of surprise medical bills, which refers to unanticipated and involuntary out-of-network bills in emergencies or from out-of-network providers at in-network facilities. Other damaging medical billing practices include the opaque and à la carte nature of medical bills, epitomized by added “facility fees,” as well as harsh medical debt collection and credit reporting practices. The impetus of this article was driven by the simple questions: Are these harmful health care billing practices legal? And if so, what can be done to protect patients as consumers? The questions are simple but the answers are not. This article canvasses a growing body of financial protections under federal and state law for health care consumers and concludes that, notwithstanding these significant efforts, consumer financial protections are inadequate for most health care consumers in the United States. This article sets forth a model set of policy reforms that build upon state reforms to protect health care consumers. The biggest gaps in protection, however, are structural—the federal Employee Retirement Income Security Act of 1974 (ERISA) preempts many state efforts to protect the large and growing number of health care consumers who are insured by self-funded employer health plans. Despite salutary state innovation in the area of patient financial protection, ERISA’s growing preemptive sweep means a federal solution is necessary to protect all health care consumers from medical-billing abuses.*

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## INTRODUCTION

Public school teacher and father of three, John Elfrank-Dana, slipped on the steps of the subway and hit his head, ending up with a serious injury requiring emergency cranial surgery.<sup>1</sup> Although Elfrank-Dana went to an emergency room that was within his insurance network, some of the physicians who treated him were out-of-network, which meant that he faced \$106,000 in medical bills for inadvertent out-of-network care that was not covered by his insurance. His insurance covered a portion of the bill, but there was nothing to prevent the out-of-network physicians from billing Elfrank-Dana for the difference between the amount his insurance plan paid and their full charges.<sup>2</sup> Such surprise medical bills are not limited to emergencies—Peter Drier underwent a planned surgery to repair herniated disks from his orthopedist, who was in-network, at an in-network hospital.<sup>3</sup> Nevertheless, Drier received a \$117,000 bill from a surgeon he had never met who stepped in to assist with his operation. The surgeon was out-of-network, which meant Drier was on the hook for the six-figure difference between the surgeon's full charges and what his insurance covered.<sup>4</sup>

Surprise medical bills are not the only problems health care consumers face. Another frustration stems from the opaque and à la carte nature of medical bills, such as the unanticipated facility fees that may be added to a physician's fees for outpatient care. David Hubbard had a heart condition and required periodic echocardiograms.<sup>5</sup> When he went to receive his routine echocardiogram at his cardiologist's office, he was shocked that the fee had jumped to \$1605 from \$373 just six months earlier.<sup>6</sup> Nothing about the service had changed, except that his cardiologist's practice was purchased by a local hospital system and was able to bill an added facility

1. Haley Sweetland Edwards, *How You Could Get Hit with a Surprise Medical Bill*, TIME, Mar. 7, 2016, available at <http://time.com/4246845/health-care-insurance-surprise-medical-bill/>.

2. *Id.* "Charges" are health care providers' list prices, from which health plan discounts are negotiated. Full charges are often two to three times, and as much as ten times greater than negotiated prices. See Ge Bai & Gerard Anderson, *Extreme Markup: The Fifty US Hospitals with the Highest Charge-to-Cost Ratios*, 34 HEALTH AFF. 922, 927 (2015); Uwe E. Reinhardt, *The Pricing of US Hospital Services: Chaos Behind the Veil of Secrecy*, 25 HEALTH AFF. 57, 58–59 (2006).

3. Elisabeth Rosenthal, *After Surgery, Surprise \$117,000 Medical Bill from Doctor He Didn't Know*, N.Y. TIMES, Sept. 20, 2014, available at [https://www.nytimes.com/2014/09/21/us/drive-by-doctoring-surprise-medical-bills.html?\\_r=1](https://www.nytimes.com/2014/09/21/us/drive-by-doctoring-surprise-medical-bills.html?_r=1).

4. *Id.*

5. Anna Wilde Mathews, *Same Doctor Visit, Double the Cost*, WALL ST. J. (Aug. 27, 2012, 10:19 AM), <https://www.wsj.com/articles/SB10000872396390443713704577601113671007448>.

6. *Id.*

fee as an outpatient department of the hospital.<sup>7</sup>

Even consumers who try to protect themselves cannot always avoid unexpected medical bills. When Rod's wife, Debbie, developed chest pains, Rod tried to shop around.<sup>8</sup> He used an app provided by their insurer, Aetna, to compare prices of emergency rooms nearby. At First Choice, the freestanding ER they selected, they tried to get a sense of how much the visit would cost, but no one at First Choice would give them a cost estimate. First Choice's staff assured them, however, they would not be charged a facility fee. Their \$4605 bill for the visit ended up including a \$2258 facility fee. The bill was sent to a collection agency, which can occur even while the patients are in the process of disputing or verifying their charges and coordinating with their insurer over how much they owe.<sup>9</sup> Although Rod and Debbie resolved their billing dispute, other patients are not so lucky, with some discovering that their medical bills have harmed their creditworthiness or worse, that they are being sued by a debt collector for their unpaid bills.<sup>10</sup>

These stories paint a fairly common picture of a health care consumer's financial experience with the health care system. Prior to their health care encounter, patients face inscrutable price opacity as they try to anticipate the financial ramifications of touching the health care system. The financial distress mounts after the service has been rendered, with the arrival of involuntarily triggered, surprise out-of-network medical bills or added facility fees. The ordeal continues as the patient tries to sort out the confusing pile of medical bills and insurance statements while unpaid amounts are sold to debt collectors and reported to credit reporting agencies, where the medical bill can become a lawsuit, a damaged credit score, a home foreclosure, or worse.

The United States is the only economically developed country where a slip and fall and a trip to the emergency room could spell financial ruin or bankruptcy.<sup>11</sup> With the implementation of the Affordable Care Act (ACA),

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7. *Id.*

8. Olga Khazan, *The Agony of Medical Bills*, ATLANTIC, May 21, 2015, available at <https://www.theatlantic.com/health/archive/2015/05/the-agony-of-surprise-medical-bills/393785/>.

9. See, e.g., Elisabeth Rosenthal, *When Health Costs Harm Your Credit*, N.Y. TIMES, Mar. 8, 2014, available at <https://www.nytimes.com/2014/03/09/sunday-review/when-health-costs-harm-your-credit.html>.

10. See, e.g., Paul Kiel & Chris Arnold, *From the E.R. to the Courtroom: How Nonprofit Hospitals Are Seizing Patients' Wages*, PROPUBLICA (Dec. 19, 2014, 6:00 AM), <http://www.propublica.org/article/how-nonprofit-hospitals-are-seizing-patients-wages>.

11. See DAVID SQUIRES & CHLOE ANDERSON, THE COMMONWEALTH FUND, U.S. HEALTH CARE FROM A GLOBAL PERSPECTIVE: SPENDING, USE OF SERVICES, PRICES, AND HEALTH IN 13 COUNTRIES 2-5 (2015), <http://www.commonwealthfund.org/~media/files/publications/issue-brief/201>

many more people have gained insurance coverage and the financial protection that comes with it.<sup>12</sup> Increasingly, however, insurance coverage does not ensure financial protection for patients.<sup>13</sup> With the election of Donald Trump as president, the future of the coverage gains under the ACA is uncertain at best.<sup>14</sup>

There is a great cost shift underway in American health care.<sup>15</sup> The costs of health care are rising, and the patient is picking up a larger portion through out-of-pocket cost-sharing.<sup>16</sup> The financial protection afforded by insurance coverage, even the historically robust coverage provided by employers, is eroding. Although premium growth has moderated, deductibles, which are the amounts patients must pay out-of-pocket before

5/oct/1819\_squires\_us\_hlt\_care\_global\_perspective\_oecd\_intl\_brief\_v3.pdf; Daniel A. Austin, *Medical Debt as a Cause of Consumer Bankruptcy*, 67 ME. L. REV. 1, 7–13 (2014); Melissa B. Jacoby & Mirya Holman, *Managing Medical Bills on the Brink of Bankruptcy*, 10 YALE J. HEALTH POL'Y L. & ETHICS 239, 245–248 (2010). See also, Max Blau, *In the State with the Highest Medical Debt, It's the Middle Class Who Carries the Burden*, STATNEWS.COM (Mar. 24, 2017), <https://www.statnews.com/2017/03/24/mississippi-medical-debt-middle-class/>.

12. Rachel Garfield & Katherine Young, *How Does Gaining Coverage Affect People's Lives? Access, Utilization, and Financial Security Among Newly Insured Adults*, 1–2, 14–16 KAISER FAM. FOUND. (June 19, 2015), <http://kff.org/health-reform/issue-brief/how-does-gaining-coverage-affect-peoples-lives-access-utilization-and-financial-security-among-newly-insured-adults/>.

13. See, e.g., Margot Sanger-Katz, *Why Insurance Doesn't Always Prevent Giant Medical Bills*, N.Y. TIMES: THE UPSHOT (May 20, 2015), <https://www.nytimes.com/2015/05/20/upshot/why-insurance-doesnt-always-prevent-giant-medical-bills.html>.

14. See, e.g., Ariana Eunjung Cha & Amy Goldstein, *The Ultimate Q&A About Health Care Under a Trump Presidency*, WASH. POST, Nov. 17, 2016, available at [https://www.washingtonpost.com/news/to-your-health/wp/2016/11/17/the-ultimate-qa-about-health-care-under-president-trump/?utm\\_term=.f8573b70d011](https://www.washingtonpost.com/news/to-your-health/wp/2016/11/17/the-ultimate-qa-about-health-care-under-president-trump/?utm_term=.f8573b70d011); Timothy Jost, *Day One and Beyond: What Trump's Election Means for the ACA*, HEALTH AFF. BLOG (Nov. 9, 2016), <http://healthaffairs.org/blog/2016/11/09/day-one-and-beyond-what-trumps-election-means-for-the-aca/>.

15. Topher Spiro, Maura Calsyn & Meghan O'Toole, *The Great Cost Shift: Why Middle-Class Workers Do Not Feel the Health Care Spending Slowdown*, CTR. FOR AM. PROGRESS (Mar. 3, 2015, 12:01 AM), <https://www.americanprogress.org/issues/healthcare/reports/2015/03/03/105777/the-great-cost-shift/>.

16. For example, the average hospitalization costs a patient with insurance \$1013 out-of-pocket, up 37% from \$738 in 2009. Emily R. Adrion et al., *Out-of-Pocket Spending for Hospitalizations Among Nonelderly Adults*, 176 JAMA INTERNAL MED. 1325, 1327 (2016). It is worth noting that out-of-pocket spending has steadied or declined based on the ACA's coverage expansion, but it can still be true that many see their out-of-pocket costs rising. This may be because now more people have relatively high out-of-pocket costs, but fewer have astronomical costs. See SHERRY GLIED ET AL., THE COMMONWEALTH FUND, REALIZING HEALTH REFORM'S POTENTIAL: HOW THE ACA'S HEALTH INSURANCE EXPANSIONS HAVE AFFECTED OUT-OF-POCKET COST-SHARING AND SPENDING ON PREMIUMS (2016), [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2016/sep/1899\\_glied\\_aca\\_hlt\\_ins\\_expansions\\_oop\\_spending\\_rb\\_v2.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2016/sep/1899_glied_aca_hlt_ins_expansions_oop_spending_rb_v2.pdf).

insurance kicks in, have been rising much faster than wages or inflation.<sup>17</sup> Deductibles have more than tripled in the past decade from \$303 on average in 2006 to \$1221 in 2016.<sup>18</sup> A growing proportion of workers have high deductible health plans, increasing from just 4% in 2006 to 29% in 2016.<sup>19</sup> Nearly 99% of individuals with coverage from an ACA exchange had a high deductible plan.<sup>20</sup>

Although some may blame the ACA for rising out-of-pocket costs, these trends were under way before 2010 and will likely persist regardless of the ACA's future,<sup>21</sup> particularly under Republican proposals to repeal and replace the ACA.<sup>22</sup> This cost shift to individuals is particularly burdensome for lower-income consumers who are unable to afford their health care costs and are finding themselves increasingly underinsured.<sup>23</sup>

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17. *Employer Family Health Premiums Rise 4 Percent to \$17,545 in 2015, Extending a Decade-Long Trend of Relatively Moderate Increases*, KAISER FAM. FOUND. (Sept. 22, 2015), <http://kff.org/health-costs/press-release/employer-family-health-premiums-rise-4-percent-to-17545-in-2015-extending-a-decade-long-trend-of-relatively-moderate-increases/>.

18. GARY CLAXTON ET AL., KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TR., *EMPLOYER HEALTH BENEFITS: 2016 ANNUAL SURVEY* 129 exhibit 7.9 (2016), <http://files.kff.org/attachment/Report-Employer-Health-Benefits-2016-Annual-Survey>.

19. *Id.* at 160 exhibit 8.5.

20. *Health Policy Brief: High Deductible Health Plans*, HEALTH AFF. 1 (Feb. 4, 2016), [http://healthaffairs.org/healthpolicybriefs/brief\\_pdfs/healthpolicybrief\\_152.pdf](http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_152.pdf). High-deductible health plans are defined as plans with an annual individual deductible of \$1300 or a family deductible of \$2600 in 2017. Rev. Proc. 2016-28, 2016-20 I.R.B. 852.

21. See Rachel Dolan, *From the Archives: Deductibles and Out-of-Pocket Costs*, HEALTH AFF. BLOG (Sept. 29, 2015), <http://healthaffairs.org/blog/2015/09/29/from-the-archives-deductibles-and-out-of-pocket-costs/>.

22. As passed by the House of Representatives on May 4, 2017, the Republicans' 2017 bill to repeal and replace the ACA, titled the "American Health Care Act" (AHCA) would substantially increase out-of-pockets health care costs. CONG. BUDGET OFF., *COST ESTIMATE: H.R. 1628 AMERICAN HEALTH CARE ACT* 7, 20 (May 24, 2017). Economists have estimated that an earlier version of the AHCA would increase cost-sharing significantly, raising total annual costs (including premiums and cost-sharing) for individuals by \$1542 immediately and \$2409 by 2020. For families, the cost increases would have been \$2243 immediately and \$4274 by 2020. David Cutler et al., *Analysis: GOP Plan to Cost Obamacare Enrollees \$1,542 More a Year*, VOX (Mar. 7, 2017, 1:00 PM), <http://www.vox.com/the-big-idea/2017/3/7/14843632/aca-republican-health-care-plan-premiums-cost-price>. A separate analysis estimated that the AHCA would increase Americans' out-of-pocket costs (deductibles, copays, and co-insurance) by \$33 billion by 2026. JOSH BIVENS, ECON. POLICY INST., *THE \$33 BILLION HIDDEN TAX IN THE AMERICAN HEALTH CARE ACT—HIGHER DEDUCTIBLES AND COPAYS 1–2* (2017), <http://www.epi.org/files/pdf/124460.pdf>.

23. Under the Commonwealth Fund's three-part definition of underinsurance, a person is underinsured if: "[1] out-of-pocket costs, excluding premiums, over the prior 12 months are equal to 10 percent or more of household income; [2] out-of-pocket costs, excluding premiums, are equal to 5 percent or more of household income if income is under 200 percent of the federal poverty level (\$22,980 for an individual and \$47,100 for a family of four); or [3] the deductible is 5 percent or more of household income." In 2014, 23% of all adults aged nineteen to sixty-four in the United States, or about thirty-one million people, were underinsured. SARA R. COLLINS ET AL., *THE COMMONWEALTH*

Medical bill-related financial distress was improved but not entirely solved by the expansion of coverage under the ACA due to rising out-of-pocket expenses.<sup>24</sup>

The increasing out-of-pocket burden on patients is exacerbated by a related trend of narrowing networks of providers participating in the patient's health insurance plan.<sup>25</sup> The ACA prohibits health plans from using traditional insurance underwriting practices to reduce health care spending through risk selection (e.g., avoiding bad risks and cherry-picking good risks).<sup>26</sup> As such, narrow networks have become the primary strategy for health insurers to keep health care premiums from ballooning, by contracting with a limited network of providers who agree to lower fees in exchange for a higher volume of patients.<sup>27</sup>

Narrow networks are correlated with lower health plan premiums,<sup>28</sup> but the increasing use of narrow networks means the patient is more likely to inadvertently find herself out-of-network. Health plan design typically gives patients significant financial incentives to receive health care within the network and, if it is covered at all, financial penalties for straying outside the network in the form of higher co-payments, co-insurance, and a separate, higher out-of-network deductible.<sup>29</sup>

This article's objective is to evaluate the existence and strength of financial protections for health care consumers. Despite consumers' sense that there are few legal protections against medical bill-related financial

FUND, THE PROBLEM OF UNDERINSURANCE AND HOW RISING DEDUCTIBLES WILL MAKE IT WORSE: FINDINGS FROM THE COMMONWEALTH FUND BIENNIAL HEALTH INSURANCE SURVEY, 2014 (2015), [blem\\_of\\_underinsurance\\_ib.pdf](#).

24. See Reed Abelson, *More Insured, but the Choices Are Narrowing*, N.Y. TIMES, May 12, 2014, available at <https://www.nytimes.com/2014/05/13/business/more-insured-but-the-choices-are-narrowing.html>.

25. See MARK A. HALL ET AL., THE SCHAEFFER INITIATIVE FOR INNOVATION IN HEALTH POLICY, SOLVING SURPRISE MEDICAL BILLS 12 (2016), <https://www.brookings.edu/wpcontent/uploads/2016/10/sbb1.pdf>; DAN POLSKY & JANET WEINER, LEONARD DAVIS INST. OF HEALTH ECON., THE SKINNY ON NARROW NETWORKS IN HEALTH INSURANCE MARKETPLACE PLANS 3 (2015), [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2015/rwjf421027](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf421027).

26. Patient Protection and Affordable Care Act (PPACA) § 1201, 42 U.S.C. § 300gg (2012) (establishing limits on health plan underwriting on the basis of health status); PPACA § 1302, 42 U.S.C. § 18022 (2012) (establishing requirements for health plans to cover the essential health benefits).

27. See David Cusano & Amy Thomas, *Narrow Networks Under the ACA: Financial Drivers and Implementation Strategies*, HEALTH AFF. BLOG (Feb. 17, 2014), <http://healthaffairs.org/blog/2014/02/17/narrow-networks-under-the-aca-financial-drivers-and-implementation-strategies/>.

28. Daniel Polsky et al., *Marketplace Plans with Narrow Physician Networks Feature Lower Monthly Premiums Than Plans with Larger Networks*, 35 HEALTH AFF. 1842, 1845 (2016).

29. HALL ET AL., *supra* note 25, at 7–8.

distress, there is a growing body of financial protections under federal and state law for health care consumers. The ACA contains a handful of consumer financial protections, including limits on cost-sharing and Internal Revenue Service (IRS) rules limiting the worst billing and collection practices of tax-exempt hospitals.<sup>30</sup> Some of these rules will likely remain in place even if the GOP passes a bill to repeal and replace the ACA.<sup>31</sup> The ACA's annual limit on consumers' out-of-pocket spending, however, is threatened.<sup>32</sup> Other federal efforts to make Medicare payments "site-neutral" and the work of the Consumer Financial Protection Bureau (CFPB) on credit reporting of medical debts have created significant protections for health care consumers across the country.<sup>33</sup> It is the states, however, that have led the way with an array of legal innovations to address consumer protections in health care—particularly in the area of surprise medical bills but also in limits to medical debt collection practices.<sup>34</sup> Thus, the optimistic view contends that there are significant policy efforts at the state and federal levels to give consumers meaningful protections from medical bill-related financial

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30. See 42 U.S.C. § 300gg-19a(b) (2012) (limiting cost-sharing for out-of-network emergency services); see also 29 C.F.R. § 2590.715-2719A(b) (2016) (implementing § 300gg-19a for Employee Retirement Income Security Act (ERISA) group health plans); 45 C.F.R. § 147.138(b) (2016) (implementing the same for group and individual health insurance markets); 42 U.S.C. § 18022(c)(1) (2012); 45 C.F.R. § 156.130 (2016) (capping annual out-of-pocket costs); 26 U.S.C. § 501(r) (2012) (imposing limits on tax-exempt hospitals' billing and collection practices). For a discussion of the ACA's limits on cost-sharing, see *infra* Part I.A.1. For a discussion of these rules for tax-exempt hospitals, see *infra* Part I.C.1.

31. The technical reason is that the GOP is trying to pass its ACA repeal bill through budget reconciliation to avoid the possibility of a Senate filibuster. According to Senate rules, reconciliation bills can only contain provisions that directly affect the federal budget (e.g., taxing and spending provisions), and thus many of the ACA consumer protections discussed in this article are not directly altered through the ACA repeal bill. See Timothy Jost, *Examining the House Republican ACA Repeal and Replace Legislation*, HEALTH AFF. BLOG (Mar. 7, 2017), <http://healthaffairs.org/blog/2017/03/07/examining-the-house-republican-aca-repeal-and-replace-legislation/>. Nevertheless, the AHCA would significantly increase out-of-pocket costs, increase cost-sharing, and substantially increase premiums for older and sicker individuals. See CONG. BUDGET OFF., *supra* note 22.

32. The version of the AHCA that passed the House on May 4, 2017, contains changes that could erode the ACA's caps on annual out-of-pocket costs for many, including those covered by employer-sponsored plans. See Stephanie Armour & Michelle Hackman, *GOP Health Bill Jeopardizes Out-of-Pocket Caps in Employer Plans*, WALL ST. J. (May 4, 2017, 2:54 PM), <https://www.wsj.com/articles/little-noted-provision-of-gop-health-bill-could-alter-employer-plans-1493890203>; Matthew Fiedler, *New Changes to Essential Benefits in GOP Health Bill Could Jeopardize Protections against Catastrophic Costs, Even for People with Job-Based Coverage*, BROOKINGS (May 4, 2017), <https://www.brookings.edu/blog/up-front/2017/03/24/new-changes-to-essential-benefits-in-gop-health-bill-could-jeopardize-protections-against-catastrophic-costs-even-for-people-with-job-based-coverage/>.

33. See *infra* Part I.C.3.

34. See *infra* Parts I.A.3 and I.C.2.



distress.

The dimmer view is that the significant state innovation in this area is insufficient, in part because of substantive gaps in these policies' protections and also because of structural limits of state regulation.<sup>35</sup> For the substantive gaps, this article sets forth a model set of policy reforms that build upon recent state legislation to protect health care consumers, including presumptively binding health care price estimates, regulatory caps on out-of-network rates, elimination of unwarranted facility fees for state and private payers, and private remedies under state unfair trade practice laws.<sup>36</sup>

More nettlesome are the structural limits of state consumer financial protections—even the most comprehensive state innovations cannot reach the growing number of privately insured individuals with employer-based coverage because of the sweeping preemptive effect of ERISA.<sup>37</sup> Despite beneficial state innovation and leadership in the area of patient financial protection, a growing ERISA black hole means a federal solution is necessary to extend protections to all health care consumers. The federal solution could include amending ERISA to exempt state health care consumer protections from preemption or regulatory actions to establish federal standards that protect all health care consumers.<sup>38</sup>

This article analyzes and proposes concrete policy approaches to address the range of harmful financial practices targeting health care consumers. Part I describes three types of harmful medical-billing practices: (1) surprise medical bills from involuntary out-of-network care, (2) price opacity and added facility fees for outpatient services, and (3) the medical debt collection and credit reporting actions that follow from unpaid medical bills. Part I goes on to catalogue the range of federal and state policy responses to each of these forms of health care consumer distress. Part II identifies the substantive gaps in existing law and imagines which model policies could provide the types of consumer financial protections needed to fill these gaps. Part III explains how ERISA creates a significant structural barrier limiting the reach of state-led policies for health care consumer protection, underscoring the need for a federal response and suggesting a few forms such a federal solution could take.

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35. For a discussion of the substantive gaps, *see infra* Parts I.A.4, I.B.3, and I.C.4.

36. *See infra* Part II.

37. *See infra* Part III.

38. *See infra* Part III.B.

## I. TYPES OF HEALTH CARE CONSUMER FINANCIAL DISTRESS AND POLICY RESPONSES

Health care consumers' financial distress is driven by an inability to pay for needed health care.<sup>39</sup> The purpose of health insurance is to shield the consumer from the financial risks of health care consumption,<sup>40</sup> which tends to be both unpredictable and extremely expensive. Notwithstanding rising rates of insurance coverage, several medical billing practices are leading to higher, unavoidable, and unanticipated out-of-pocket costs for patients. First is the phenomenon of surprise medical bills for involuntary and unanticipated out-of-network services. Second is the peculiar way we shop and pay for medical care—blind, à la carte, and confusingly complicated, which allows for billing practices such as added facility fees that are often the byproduct of increasing corporate consolidation in health care. And finally, there are the consumer's financial ramifications from unpaid medical bills ranging from damaged credit to aggressive debt collection practices.

Federal and state policymakers have begun to respond to the array of medical billing and collection practices that financially harm patients. For each type of harmful medical billing practice, this Part analyzes the policy responses to protect patients as consumers initiated by the federal government and by states. Although these policies are numerous, when taken together, most consumers in the country remain largely unprotected.

### A. Surprise Medical Bills

One of the most prominent examples of health care consumer harm is the surprise medical bill. A surprise medical bill is defined as charges that arise when an insured patient inadvertently receives care from an out-of-network provider.<sup>41</sup> Surprise medical bills typically occur in two situations. First, a patient may receive emergency care from an out-of-network provider (whether a hospital, an emergency physician, or emergency medical transportation) because the patient cannot choose an

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39. In a feedback loop mechanism, health-related financial distress itself can have negative effects on a person's physical health, which has been documented in particular for those with expensive, long-term cancer diagnoses. Isaac D. Buck, *The Cost of High Prices: Embedding an Ethic of Expense into the Standard of Care*, 58 B.C. L. REV. 101, 136–38 (2017).

40. Allison K. Hoffman, *Health Care Spending and Financial Security After the Affordable Care Act*, 92 N.C. L. REV. 1481, 1482 (2014).

41. Karen Pollitz, *Surprise Medical Bills*, KAISER FAM. FOUND. (Mar. 17, 2016), <http://kff.org/private-insurance/issue-brief/surprise-medical-bills/> (using this definition of surprise medical bill).

in-network provider due to the emergency.<sup>42</sup> Second, a patient may inadvertently receive care from an out-of-network provider at an in-network facility (e.g., the hospital is in-network, but the anesthesiologist or radiologist is out-of-network).<sup>43</sup> Thus, the three common characteristics of a surprise medical bill are that it is unanticipated, involuntary, and out-of-network.

Although precise calculations of the magnitude of surprise medical billing are lacking, a national survey by Kelly Kyanko, Leslie Curry, and Susan Busch reported that about 40% of individuals who used out-of-network services did so involuntarily, amounting to approximately three million people annually.<sup>44</sup> Federal Trade Commission (FTC) economists Christopher Garmon and Benjamin Chartock calculated that in 2014, among patients with employer-sponsored insurance, “20% of hospital inpatient admissions that originated in the emergency department (ED), 14% of outpatient visits to the ED, and 9% of elective inpatient admissions likely led to a surprise medical bill.”<sup>45</sup> A 2016 New York Times and Kaiser Family Foundation survey found that about 22% of insured adults between eighteen and sixty-four who had problems paying their medical bills had received a surprise bill in the previous year.<sup>46</sup> In just the emergency context, Zack Cooper and Fiona Scott Morton similarly found 22% of visits to in-network emergency departments involved out-of-

42. See Olga Khazan, *Don't Pay That Medical Bill*, ATLANTIC, Aug. 20, 2015, available at <https://www.theatlantic.com/health/archive/2015/08/dont-pay-that-medical-bill/401726/> (quoting Susan Rosalsky, who received a \$32,845 balance bill after her husband underwent emergency heart surgery: “Mike's life was in jeopardy . . . There was little time to think rationally. It would never have occurred to us to ask every individual, ‘Are you in my network?’”).

43. Kelly A. Kyanko et al., *Out-of-Network Physicians: How Prevalent Are Involuntary Use and Cost Transparency?*, 48 HEALTH SERVS. RES. 1154, 1154 (2013).

44. *Id.* at 1160, 1166 (estimating that 8% of privately insured individuals used out-of-network care in 2011, and 40% of those claims were involuntary, resulting in surprise medical bills).

45. Christopher Garmon & Benjamin Chartock, *One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills*, 36 HEALTH AFF. 177, 177, 179 (2017). Because narrow networks are more common in exchange plans than in employer-sponsored plans, the numbers may underestimate the actual prevalence of surprise bills across the entire insured population. *Id.* at 180.

46. LIZ HAMEL ET AL., KAISER FAMILY FOUND., THE BURDEN OF MEDICAL DEBT: RESULTS FROM THE KAISER FAMILY FOUNDATION/NEW YORK TIMES MEDICAL BILLS SURVEY 12 (2016), <http://kff.org/report-section/the-burden-of-medical-debt-introduction/>. The survey calculated that 32% of insured adults aged eighteen to sixty-four who reported having problems paying medical bills received care out-of-network, and 69% of them were unaware that the provider was out-of-network when they received the care. Thus, the percentage of responders who reported receiving out-of-network care that was a surprise is 22% (32% \* 69% = 22%). *Id.*

network physicians over a twenty-month period.<sup>47</sup>

The financial impact of surprise medical bills goes beyond the fact that the bill was unanticipated. Out-of-network charges are often substantially higher than in-network rates, and the patient bears much more of the cost because of higher cost-sharing obligations for out-of-network care and balance-billing.<sup>48</sup> When a patient receives care from an out-of-network provider, there are no negotiated rates with her insurance plan, so the provider typically charges full, undiscounted charges.<sup>49</sup> Even when a health plan covers a portion of an out-of-network charge, the patient is generally required to pay higher cost-sharing amounts for out-of-network care<sup>50</sup> and then receives a bill for the difference between provider's full charge and the amount paid by the plan, a practice called balance-billing.<sup>51</sup> Balance-billing obligations are uncapped, because they typically do not count toward the patient's deductible or the out-of-pocket limits under the plan.<sup>52</sup>

The individual financial impact becomes apparent through concrete examples. Aetna's website calculates the difference between a consumer's in-network versus out-of-network bill for an \$825 physician's charge. If the physician is in-network, the patient would pay only \$140, but if the physician was out-of-network, the patient would pay \$645 due to additional co-insurance, higher out-of-network deductible, and balance-billing.<sup>53</sup> A study of larger balance bills by New York's Department of

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47. Zack Cooper & Fiona Scott Morton, *Out-of-Network Emergency-Physician Bills—An Unwelcome Surprise*, 375 N. ENG. J. MED. 1915, 1916 (2016).

48. *Id.* at 1917 (estimating that out-of-network emergency physicians charged an average of 798% of the Medicare rate versus 297% of Medicare rates charged by in-network physicians, and that the average balance bill was \$622.55).

49. See Gerard Anderson, *From 'Soak the Rich' To 'Soak the Poor': Recent Trends in Hospital Pricing*, 26 HEALTH AFF. 780, 781 (2007).

50. HALL ET AL., *supra* note 25, at 7–8.

51. See Carol K. Lucas & Michelle A. Williams, *The Rights of Nonparticipating Providers in a Managed Care World: Navigating the Minefields of Balance Billing and Reasonable and Customary Payments*, 3 J. HEALTH & LIFE SCI. L. 132, 147 (2009) (“The term ‘balance billing’ refers to the practice of out-of-network medical providers billing a patient the difference between the reimbursement made by an enrollee’s health plan and the amount the provider contends it is owed for the services rendered.”). Hospitals are usually prohibited (by contract or state law) from balance-billing patients whose insurance plans have a contract with the hospital and must accept the insurance plan’s payment as payment in full. *Id.* at 147–48.

52. See 42 U.S.C. § 18022(c)(3)(B) (2012) (excluding “balance billing amounts” from cost-sharing); see also *Network and Out of Network Care*, AETNA.COM, <http://www.aetna.com/individuals-families/member-rights-resources/claims-coverage/out-of-network-doctor-costs.html> (last visited April 10, 2017) (“What you pay when you are balance billed does not count toward your deductible. And it is not part of any cap your plan has on how much you have to pay for covered services.”).

53. *Network and Out of Network Care*, *supra* note 52.

Financial Services found that in 2011 the average out-of-network emergency bill was \$7006, with the consumer paying \$3778, or 54% of the bill.<sup>54</sup>

The rise of surprise medical billing is driven in part by the increasing use by health insurance plans of narrow networks as a strategy to keep premiums affordable.<sup>55</sup> Narrow networks make it more likely that a patient will find herself inadvertently receiving care from an out-of-network provider in an emergency or even at an in-network facility.<sup>56</sup> In addition, the lack of disclosure or network transparency makes it difficult or impossible for a patient to avoid out-of-network providers even if the patient assiduously chooses an in-network facility.<sup>57</sup> In Texas, for example, the share of in-network hospitals with no in-network emergency physicians ranged from twenty-one to 56% for the three largest health insurers.<sup>58</sup> Having no in-network emergency physicians all but guarantees that a patient will receive a surprise medical bill from an out-of-network emergency physician even if she goes to an in-network emergency room.<sup>59</sup> The problem is not limited to Texas or emergency departments. A study of health plans offered on federal exchanges across thirty-four states found

54. 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 18, 19 (2012), <http://www.governor.ny.gov/sites/governor.ny.gov/files/archive/assets/documents/DFS%20Report.pdf> (defining "larger" balance bills as bills for emergency services exceeding \$2500 and more than 200% of Medicare's rate for emergency services in 2010). Similarly, average out-of-network charges for radiology were \$5406 (thirty-three times what Medicare would pay) for which the average patient's share of the bill was \$2910. The average out-of-network charges for assistant surgeons was \$13,914, or twenty-one times what Medicare would pay. *Id.*

55. See *supra* notes 27–28 and accompanying text. See Abelson, *supra* note 24.

56. According to a Kaiser Family Foundation survey, nearly 60% of individuals did not know that doctors at in-network hospitals are not always in-network as well. Mira Norton et al., *Assessing Americans' Familiarity with Health Insurance Terms and Concepts*, KAISER FAM. FOUND. (Nov. 11, 2014), <http://kff.org/health-reform/poll-finding/assessing-americans-familiarity-with-health-insurance-terms-and-concepts/>.

57. See, e.g., N.Y. STATE DEP'T OF FIN. SERVS., *supra* note 54, at 13 (reporting many consumer complaints due to lack of disclosure over the out-of-network status of health care providers); see also Cooper & Scott Morton, *supra* note 47, at 1916 (calculating that 99.35% of all emergency room visits occurred at in-network facilities).

58. STACEY POGUE & MEGAN RANDALL, SURPRISE MEDICAL BILLS TAKE ADVANTAGE OF TEXANS: LITTLE-KNOWN PRACTICE CREATES A "SECOND EMERGENCY" FOR ER PATIENTS, CTR. FOR PUB. POL'Y PRIORITIES 3 (Sept. 15, 2014), [http://forabettertexas.org/images/HC\\_2014\\_09\\_PP\\_BalanceBilling.pdf](http://forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf). The reported percentage of in-network hospital emergency rooms with no in-network emergency physicians are 21% for Blue Cross Blue Shield, 45% for United Healthcare, and 56% for Humana. *Id.* 8% of hospitals in Texas (twenty-three of 276) that contract with all three of the largest insurers have no in-network emergency physicians. *Id.* at 4.

59. *Id.* at 4.

that nearly 15% of plans had no in-network physicians in at least one specialty.<sup>60</sup>

Public outcry against surprise medical bills has started to drive legislation and policies to prevent or limit their occurrence. Moreover, existing tools of insurance regulation—limiting patients’ cost-sharing obligations and ensuring adequate access to in-network providers—provide additional protections against excess financial burdens from out-of-network care. Three main policies are explored below: (1) federal protections limiting patient’s out-of-pocket cost-sharing in the ACA, (2) regulation of network adequacy and provider network accuracy, and (3) laws limiting surprise medical bills.

### *1. ACA Limits on Cost-Sharing*

Specific provisions in the ACA aim to protect patients against uncapped financial exposure due to out-of-pocket spending, including limits on patients’ cost-sharing for out-of-network emergency care and caps on out-of-pocket spending. The ACA as a whole, including these particular provisions, continues to govern while the Republican-controlled Congress and President Trump advance efforts to “repeal and replace” the ACA.<sup>61</sup> Even if the insurance and coverage landscape changes dramatically in coming months or years, the ACA’s requirements and the effects of these rules on individuals’ out-of-pocket exposure provide an important baseline from which changes and trends can be measured, illustrating tangibly how changes in policy can affect individuals’ welfare.

The drafters of the ACA understood that in an emergency, a patient may be unable to choose an in-network provider, which can be extremely costly to patients if their health plans do not cover out-of-network emergency services. The ACA thus requires that all non-grandfathered health plans cover out-of-network emergency care and limit patients’ cost-sharing amount to the amount they would owe if they received the emergency care in-network.<sup>62</sup> Health plans must pay for out-of-network

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60. Stephen C. Dorner et al., *Adequacy of Outpatient Specialty Care Access in Marketplace Plans Under the Affordable Care Act*, 314 JAMA 1749, 1749–50 (2015).

61. For purposes of this discussion, one notable change in the bill that passed the House of Representatives would potentially eliminate annual limits on consumers’ out-of-pocket costs. See Armour & Hackman, *supra* note 32; *infra* notes 73–75 and accompanying text.

62. See 42 U.S.C. § 300gg-19a(b) (2012); see also 29 C.F.R. § 2590.715-2719A(b) (2016) (implementing § 300gg-19a for ERISA group health plans); Patient Protections 45 C.F.R. § 147.138(b) (2016) (implementing the same for group and individual health insurance markets).

emergency services according to one of three formulations.<sup>63</sup> In practice, this means that health plans typically pay an amount known as the “usual, customary, and reasonable” (UCR) charges for the service, which is an amount that is typically higher than the provider’s in-network rates, but lower than full charges.<sup>64</sup> But patients may still face higher costs for out-of-network emergency care because: (1) the cost-sharing limits only apply to co-payments and co-insurance, so out-of-network emergency services may be charged to a separate, higher out-of-network deductible<sup>65</sup> and (2) the requirements do not prevent the out-of-network provider from balance-billing the patient for the difference between the amount paid by the plan and the provider’s full charges.<sup>66</sup> If a state prohibits balance-billing, then health plans do not need to comply with the minimum payment requirement at all.<sup>67</sup>

Thus, the ACA’s requirements for out-of-network emergency care fail to protect patients from the largest out-of-network expense—balance-billing. And ironically, the requirement that health plans must pay for out-of-network emergency services may also increase providers’ incentives to

63. 29 C.F.R. § 2590.715-2719A(b)(3) (2016); 45 C.F.R. § 147.138(b)(3) (2016) (providing that non-grandfathered health plans shall pay for out-of-network emergency services in an amount equal to the greatest of: (1) the amount negotiated with in-network providers for the emergency service furnished; (2) the amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable charges), but substituting the in-network cost-sharing provisions for the out-of-network cost-sharing provisions; or (3) the amount that would be paid under Medicare for the emergency service).

64. See Lucas & Williams, *supra* note 51, at 138 (describing UCR as “a concept that generally embodies payment of an amount that a health plan determines is usual for a particular procedure, charged by a majority of physicians with similar training and experience within the same geographic area”).

65. See 29 C.F.R. § 2590.715-2719A(b)(3) (2016); 45 C.F.R. § 147.138(b)(3)(ii) (2016) (“Any cost-sharing requirement other than a copayment or coinsurance requirement (such as a deductible or out-of-pocket maximum) may be imposed with respect to emergency services provided out-of-network if the cost-sharing requirement generally applies to out-of-network benefits. A deductible may be imposed with respect to out-of-network emergency services only as part of a deductible that generally applies to out-of-network benefits. If an out-of-pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum must apply to out-of-network emergency services.”); see also 45 C.F.R. § 147.138(b)(3)(iv) ex. 6 (2016).

66. 29 C.F.R. § 2590.715-2719A(b)(3)(i) (2016); 45 C.F.R. § 147.138(b)(3)(i) (2016) (providing “a participant, beneficiary, or enrollee may be required to pay, in addition to the in-network cost-sharing, the excess of the amount the out-of-network provider charges over the amount the plan or issuer is required to pay under this paragraph (b)(3)(i)”).

67. 45 C.F.R. § 147.138(b)(3)(iii) (2016); *Affordable Care Act Implementation FAQs – Set 1*, CTRS. FOR MEDICARE & MEDICAID SERVS., [https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca\\_implementation\\_faqs.html](https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html) (“If a State law prohibits balance billing, plans and issuers are not required to satisfy the payment minimums set forth in the regulations.”).

remain out-of-network, because health plans must pay for the services, usually at a higher rate than they would receive if they agreed to be in-network.<sup>68</sup>

A separate provision of the ACA extends additional protection to patients by capping the amount of cost-sharing patients and families can be expected to pay. The ACA limits the amount of annual out-of-pocket spending on co-insurance, co-payments, and deductibles to \$7150 for individuals and \$14,300 for families in 2017.<sup>69</sup> After an individual or family reaches the limit, the health plan must cover 100% of additional covered health care costs for the rest of the year.<sup>70</sup> Significantly, however, these limits do not apply to premiums or to out-of-network services, including cost-sharing or balance bills for out-of-network services.<sup>71</sup> Because the ACA expressly excludes out-of-network balance bills from the definition of “cost-sharing,” HHS cannot, by regulatory interpretation, extend the limits on cost-sharing to surprise medical bills without additional legislation from (an unwilling) Congress.<sup>72</sup>

The House-approved ACA-repeal bill threatens to obviate the ACA’s annual limits on out-of-pocket caps. The AHCA would allow states to obtain waivers from the ACA’s insurance requirements, including how to define the “essential health benefits” that must be covered by all plans.<sup>73</sup>

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68. HALL ET AL., *supra* note 25, at 18.

69. 42 U.S.C. § 18022(c)(1) (2012); 45 C.F.R. §156.130 (2016). See *Out-of-Pocket Maximum/Limit*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/> (last visited May 19, 2017). The cost-sharing limit is adjusted annually according to a statutory formula. 42 U.S.C. § 18022(c)(1) (2012). This out-of-pocket maximum applies to all non-grandfathered health plans, including plans sold on the exchanges, individual plans, group plans, and self-insured plans. See *FAQs About Affordable Care Act Implementation (Part XXVII)*, DEP’T OF LAB. (May 26, 2015), <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xxvii.pdf>.

70. See HEALTHCARE.GOV, *supra* note 69.

71. 42 U.S.C. § 18022(c)(3) (2012) (“[C]ost-sharing” excludes “premiums, balance billing amounts for non-network providers, or spending for non-covered services.”); 45 C.F.R. § 156.130(c) (“In the case of a plan using a network of providers, cost sharing paid by, or on behalf of, an enrollee for benefits provided outside of such network is not required to count toward the annual limitation on cost sharing”). The Department of Health and Human Services (HHS) clarified that health plans may, at their option, count out-of-network cost-sharing toward the annual limit on cost-sharing, but they are not required to do so. Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10750, 10824 (Dep’t of Health & Human Servs. Feb. 27, 2015) (codified at 45 C.F.R. § 156.130(c) (2016)).

72. 42 U.S.C. § 18022(c)(3) (2012). See *infra* notes 133–37 and accompanying text for a discussion of a federal rule that counts surprise out-of-network cost-sharing (but not balance-billing) toward in-network cost-sharing limits for “qualified health plans” sold on ACA exchanges.

73. American Health Care Act, H.R. 1628, § 136(b) 115th Cong. (2017). This provision of the AHCA allowing redefinition of essential health benefits is known as the “MacArthur Amendment” after proponent Representative Tom MacArthur (R-NJ). See Timothy Jost, *The MacArthur Amendment Language, Race in the Federal Exchange, and Risk Adjustment Coefficients*, HEALTH AFF. BLOG



The ACA's annual cap on out-of-pocket costs is required of nearly all plans, including employer-sponsored plans, but the cap only applies to spending on "essential health benefits."<sup>74</sup> Thus, if states dramatically pare back the essential health benefits (for example, by eliminating prescription drug coverage or maternity coverage), it would dramatically limit how much of a patient's health care costs would be subject to an annual limit on out-of-pocket spending.<sup>75</sup>

Although these provisions were in the version of the ACA repeal bill that passed the House, it is likely the bill will change significantly in the Senate. It is also possible that Senate rules for budget reconciliation, under which the ACA repeal effort proceeds, will not permit alteration of these provisions (i.e., limiting out-of-pocket caps via changes to the essential health benefits) because they do not produce a change to budget outlays or revenues.<sup>76</sup> If provisions do not directly affect the federal budget, they must be addressed in separate legislation requiring bipartisan support due to the legislative filibuster.<sup>77</sup>

In sum, the ACA's out-of-pocket limits shield many people from catastrophic medical bills but only where all the treatment is received in-network. The ACA's cost-sharing limits are less helpful to those with recurring medical expenses or out-of-network bills.<sup>78</sup> The future of the ACA's protections against uncapped out-of-pocket expenses may be threatened by efforts to repeal and replace the ACA.

(April 25, 2017), <http://healthaffairs.org/blog/2017/04/25/the-macarthur-amendment-language-race-in-the-federal-exchange-and-risk-adjustment-coefficients/>.

74. Armour & Hackman, *supra* note 32; Fiedler, *supra* note 32.

75. Fiedler, *supra* note 32. Employer-sponsored plans may be free to choose which state's definition of "essential health benefits" it wants to use, which may lead them to choose the narrowest definition of required benefits to reduce costs. *Id.*

76. American Health Care Act, H.R. 1628, 115th Cong. (2017). 2 U.S.C. §§ 641(d); 644(b). See BILL HENIFF JR., CONG. RESEARCH SERV. RL30862, THE BUDGET RECONCILIATION PROCESS: THE SENATE'S "BYRD RULE" 5 (2010); see also Jost, *supra* note 31.

77. See, e.g., Jim Newell, *Half Measures: Why Is the GOP Trying to Do Some of Its Favored Health Care Reform Changes and Not Others?*, SLATE (Mar. 13, 2017, 12:38 PM), [http://www.slate.com/articles/news\\_and\\_politics/politics/2017/03/the\\_most\\_confusing\\_part\\_of\\_the\\_trumpcare\\_bill.html](http://www.slate.com/articles/news_and_politics/politics/2017/03/the_most_confusing_part_of_the_trumpcare_bill.html). See also *supra* note 31 and accompanying text.

78. See, e.g., Jayne O'Donnell & Laura Ungar, *Obamacare Reduces Maximum Out-of-Pocket Costs, but Not Enough for Some*, USA TODAY (Aug. 3, 2015, 6:02 PM), <https://www.usatoday.com/story/money/personalfinance/2015/08/03/how-pay-high-out-pocket-costs/30696993/>.

## 2. Network Adequacy/Provider Directories

Surprise medical bills and out-of-network costs have risen as provider networks have narrowed.<sup>79</sup> One widespread policy response has been to use insurance regulation to strengthen network adequacy requirements. Network adequacy refers to a health plan's ability to provide enrollees with timely and reasonable access to a sufficient number of in-network primary care and specialty physicians and other health care services included under the terms of the contract.<sup>80</sup>

### a. Federal Network Adequacy Requirements

The ACA requires all qualified health plans participating in the exchanges to meet network adequacy standards.<sup>81</sup> The ACA's network adequacy standards provide that exchange plans must maintain "a network that is sufficient in number and types of providers" such that "all services will be accessible without unreasonable delay," and requires them to disclose their provider directories to the marketplace for online publication.<sup>82</sup>

### b. State Network Adequacy Requirements

Despite the ACA's federal network adequacy standard for exchange plans, states have traditionally assumed the task of defining network adequacy as part of their role as primary regulators of insurance.<sup>83</sup> According to the National Conference of State Legislatures, twenty-eight states and the District of Columbia have passed their own network

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79. See HALLET AL., *supra* note 25, at 12–13.

80. See, e.g., Ashley Noble, *Insurance Carriers and Access to Health Care Providers: Network Adequacy*, NAT'L CONF. ST. LEGISLATURES (Nov. 13, 2015), <http://www.ncsl.org/research/health/insurance-carriers-and-access-to-healthcare-providers-network-adequacy.aspx>.

81. 42 U.S.C. § 18031(c)(1)(B) (2012); 45 C.F.R. § 156.230(a) (2016).

82. 45 C.F.R. § 156.230(a)(2) (2016). In 2015, CMS had proposed a rule to require quantitative time and distance standards for network adequacy requirements for exchange plans. HHS Notice of Benefit and Payment Parameters for 2017, 80 Fed. Reg. 75488, 75549–75552 (Dep't of Health & Human Servs. proposed Dec. 2, 2015). In the final rule, however, CMS declined to promulgate these specific federal network adequacy requirements to give states time to adopt the National Association of Insurance Commissioners (NAIC) Model Act (discussed *infra* notes 88–93 accompanying text). 81 Fed. Reg. 12204, 12301–12307 (Mar. 8, 2016).

83. See JUSTIN GIOVANELLI ET AL., THE COMMONWEALTH FUND, IMPLEMENTING THE AFFORDABLE CARE ACT: STATE REGULATION OF MARKETPLACE PLAN PROVIDER NETWORKS 1 (2015), [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/may/1814\\_giovanelli\\_implementing\\_aca\\_state\\_reg\\_provider\\_networks\\_rb\\_v2.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/may/1814_giovanelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf).

adequacy standards.<sup>84</sup> These vary in terms of specificity—some impose quantitative requirements such as providing sufficient numbers of in-network providers that an enrollee can access within a certain driving distance or time (e.g., thirty miles or thirty minutes’ drive), while others use minimum waiting times to see a provider or minimum ratios of providers to enrollees.<sup>85</sup> Others states’ requirements are worded more generally, similar to the ACA’s network adequacy standards.<sup>86</sup> The scope of the state laws vary—some apply to all plans with provider networks but others just apply to subsets of the insurance market, such as health maintenance organizations or individual market plans.<sup>87</sup>

*c. NAIC Model Act on Network Adequacy*

In 2015, the National Association of Insurance Commissioners (NAIC) released an updated Network Adequacy Model Act.<sup>88</sup> The Model Act is not binding upon any state, but serves as a model to guide state legislation. Unlike the ACA’s network adequacy standards, the Model Act extends

84. See Noble, *supra* note 80.

85. See, e.g., 325 ILL. COMP. STAT. 20/13.20 (2015) (requiring “the family . . . not have to travel more than an additional 15 miles or an additional 30 minutes to the network provider than it would have to travel to a non-network provider who is available to provide the same service”); KY. REV. STAT. ANN. § 304.17A-515 (West, Westlaw through 2017 Reg. Sess.) (requiring “[f]or urban areas, a provider network that is available to all persons enrolled in the plan within thirty (30) miles or thirty (30) minutes of each person’s place of residence or work, to the extent that services are available.”); MINN. STAT. § 62K.10 (2016) (limiting the travel time to the nearest “*primary care services, mental health services, and general hospital services*” to thirty miles or thirty minutes, sixty miles or sixty minutes for the nearest “provider of specialty physician services, ancillary services, specialized hospital services, and . . . other health services,” and requiring that networks “include a sufficient number and type of providers.”) (emphasis added); TEX. INS. CODE ANN. § 1305.302 (2015) (“Each network shall provide that network services are sufficiently accessible and available as necessary to ensure that the distance from any point in the network’s service area to a point of service by a treating doctor or general hospital is not greater than 30 miles in non-rural areas and 60 miles in rural areas and that the distance from any point in the network’s service area to a point of service by a specialist or specialty hospital is not greater than 75 miles in non-rural areas and 75 miles in rural areas.”).

86. See, e.g., TENN. CODE ANN. § 56-7-2356 (LEXIS through 2016 Reg. Sess.) (“Each managed health insurance issuer that offers a plan that limits its enrollees’ choice of providers shall maintain a network that is sufficient in numbers and types of providers to assure that all covered benefits to covered persons will be accessible without unreasonable delay.”); N.H. REV. STAT. ANN. § 420-J:7 (2017) (“A health carrier shall maintain a network that is sufficient in numbers, types, and geographic location of providers to ensure that all services to covered persons will be accessible without unreasonable delay.”).

87. See GIOVANELLI ET AL., *supra* note 83, at 3 fig.1.

88. HEALTH BENEFIT PLAN NETWORK ACCESS & ADEQUACY MODEL ACT (NAT’L ASS’N OF INS. COMM’RS 2015) [hereinafter NAIC MODEL ACT], <http://www.naic.org/store/free/MDL-74.pdf>.

beyond exchange plans to all health plans in a state that use provider networks.<sup>89</sup>

The Model Act requires all network plans to “maintain a network that is sufficient in numbers and appropriate types of providers, including those that serve predominantly low-income and medically underserved individuals, to assure that all covered services to covered persons, including children and adults, will be accessible without unreasonable travel or delay.”<sup>90</sup> The Model Act requires all provider networks obtain a determination from the state insurance commissioner that those networks are adequate.<sup>91</sup> Although the Model Act does not prescribe quantifiable standards for distance or time traveled, it provides a range of factors that the commissioner can consider when determining network adequacy.<sup>92</sup> When an enrollee cannot access an in-network provider without unreasonable travel or delay, the Model Act would require the plan to provide the enrollee access to an out-of-network provider at an in-network level of benefits, including cost-sharing.<sup>93</sup>

Related to network adequacy are requirements for updating provider directories to make timely and accurate lists of in-network providers available to those who are shopping for health insurance or covered services. Updated and accurate provider directories are necessary for consumers to be able to select in-network providers and plans, and for regulators to assess network adequacy.<sup>94</sup> Several states have implemented

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89. NAIC MODEL ACT § 4 (applying the Act to “network plans”); NAIC Model Act § 3.S. (defining “network plans” as plans that either require or incentivize (financially or otherwise) enrollees to use providers that are managed, owned, under contract with, or employed by an enrollee’s insurer).

90. NAIC MODEL ACT § 5.A(1).

91. NAIC MODEL ACT § 5.B. This marks a change from the prior NAIC Model Act on network adequacy, which left it to the insurance carriers themselves to determine whether their provider networks were adequate. See FAMILIES USA, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) NETWORK ADEQUACY MODEL ACT: SUMMARY OF KEY PROVISIONS 2, <http://familiesusa.org/sites/default/files/documents/Families-USA-NAIC-Network-Adequacy-Summary.pdf>.

92. NAIC MODEL ACT § 5.A. Insurance commissioners may establish network sufficiency by “any reasonable criteria, which may include, but are not limited to:” ratios of providers to covered persons; geographic accessibility of providers; wait times; hours of operation; ability to meet needs of low-income persons, those with serious, chronic, or complex conditions, physical or mental disabilities, or limited English proficiency; the availability of tele-health, mobile clinics, and other delivery options; and the volume of specialty care services available. *Id.*

93. NAIC MODEL ACT § 5.C.

94. See Simon F. Haeder et al., *Secret Shoppers Find Access to Providers and Network Adequacy for Those in Marketplace and Commercial Plans*, 35 HEALTH AFF. 1160, 1165 (2016) (“Network listing accuracy issues are distinct but inherently related to network adequacy issues. Inaccurate provider directories are challenging for patients attempting to access providers, and they make it difficult for regulators to assess network adequacy.”).

requirements for more frequent updating of provider directories, such as quarterly or monthly.<sup>95</sup>

Regulation of network adequacy and provider directories are best understood as building blocks for patient protection, but are not effective bulwarks, standing alone, against surprise medical bills and other financial distress from out-of-network services. For example, network adequacy requirements simply establish a floor of minimal sufficiency, but even if adopted, they do not eliminate narrow networks. In emergencies, under anesthesia, or at an in-network facility, none of these laws prevent patients from receiving care from an out-of-network provider or the surprise bill that follows. As such, the Model Act pairs network adequacy requirements with more explicit protections against surprise medical bills, described below.<sup>96</sup>

### 3. *Surprise Medical Bills and Balance-Billing Laws*

A number of states have begun to pass legislation targeting surprise bills and balance-billing directly. Surprise medical bills can be considered a subset of balance bills for out-of-network service. The difference is that surprise bills are also involuntary and unanticipated, whereas balance bills may be voluntary or expected if a person knowingly obtains out-of-network care.

#### a. *State Laws on Surprise Medical Bills*

Prior to the recent efforts by states to address surprise medical bills, several states already provided insured patients with some degree of protection from balance-billing by out-of-network providers,<sup>97</sup> including California, Delaware, Florida, Maryland, Minnesota, New Jersey, Pennsylvania, Rhode Island, Utah, and West Virginia.<sup>98</sup> Many of these

95. See GIOVANELLI ET AL., *supra* note 83, at 4–6; see, e.g., S.B. 302, 153rd Gen. Assemb. (Ga. 2016) (signed into law Apr. 26, 2016, to be codified at GA. CODE ANN. § 33-20C-1); H.B. 131, 436th Gen. Assemb. (Md. 2016) (signed into law Apr. 26, 2016).

96. See *infra* text accompanying notes 127–32.

97. Surprise bills often include balance bills but also include out-of-network cost-sharing. Balance bills also can be non-surprises if they are intentionally triggered by a patient who knowingly chooses to receive out-of-network care. Nearly every state prohibits balance-billing by *in-network* providers to managed care enrollees. Pollitz, *supra* note 41.

98. *Prospect Med. Grp., Inc. v. Northridge Emergency Med. Grp.*, 198 P.3d 86, 92 (Cal. 2009) (ruling that health maintenance organization (HMO) members may not be balanced-billed for emergency services in California); DEL. CODE ANN. tit. 18, § 3565 (2011) (protecting members of “individual and group health insurance policies” from balance-billing); DEL. CODE ANN. tit. 19 § 2322F (2009)

laws only prevent balance-bills for out-of-network emergency services, while others cover a broader range of covered benefits.<sup>99</sup> As noted above, surprise bills and balance bills can arise outside the emergency context, such as when the hospital is in-network, but the surgeon or anesthesiologist is out-of-network.<sup>100</sup> State laws prohibiting balance-billing may not eliminate the financial burden of a surprise medical bill because a patient who inadvertently receives out-of-network care may still owe more than if the care were in-network because of higher cost-sharing rates, separate or higher deductibles, and the lack of an out-of-pocket spending cap.<sup>101</sup> At the federal level, Medicare prohibits participating providers from balance-billing Medicare beneficiaries and limits non-participating providers from balance-billing more than 15% of the Medicare rate for the service.<sup>102</sup>

More recently, states have begun passing legislation to more specifically address the phenomenon of surprise medical bills. These state surprise medical billing laws generally take one or more of the following approaches: (1) require providers to disclose out-of-network status to patients and to obtain informed consent from patients (disclosure/informed

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(protecting those covered by workers compensation from balance-billing); FLA. STAT. § 641.3154 (2010) (protecting HMO members from balance-billing for non-network emergency care); IND. CODE § 32-33-4-3.5 (2013) (prohibiting hospital lienholders from balance-billing patients); MD. CODE ANN., HEALTH-GEN. § 19-710(i) (West 2013) (holding HMO subscribers harmless for covered services in- and out-of-network and mandating HMO payment to noncontractual providers); N.J. ADMIN. CODE § 11:3-29.6 (Lexis Advance through 2017) (protecting “any person” from balance-billing by health care providers); 35 PA. CONS. STAT. § 449.34 (1990) (prohibiting any primary health care practitioner, or any primary health center, corporation, facility, institution, or other entity that employs a health care practitioner from balance billing); R.I. GEN. LAWS § 27-41-26 (Lexis Advance through 2016) (protects enrollees of an HMO from balance-billing by “any provider” for charges for covered health services); UTAH CODE § 31A-8-501(5) (prohibits out-of-network providers from balance billing when an HMO or preferred provider organization enrollee lives or resides within 30 miles of a federally qualified health center or independent hospital or is in closer proximity to these providers than another contracting hospital); W. VA CODE § 33-25A-7a (1996) (protecting HMO members from balance billing if the provider is aware patient is HMO subscriber). In addition, Colorado requires managed care companies to hold members harmless for out-of-network balance bills, but it does not prevent the provider from balance-billing. COLO. REV. STAT. § 10-16-704(2)(a) (2006).

99. See Pollitz, *supra* note 41.

100. See, e.g., Roni Caryn Rabin, *Out-of-Network Bills for In-Network Health Care*, N.Y. TIMES: WELL BLOG (Nov. 19, 2012, 4:23 PM), <http://well.blogs.nytimes.com/2012/11/19/out-of-network-bills-for-in-network-health-care/>; Tara Siegel Bernard, *Out of Network, Not by Choice, and Facing Huge Health Bills*, N.Y. TIMES, Oct. 18, 2013, available at <http://www.nytimes.com/2013/10/19/your-money/out-of-network-not-by-choice-and-facing-huge-health-bills.html>.

101. See HALL ET AL., *supra* note 25, at 6–7.

102. 42 U.S.C. § 1395cc(a)(1)(A) (2012) (prohibiting participating providers from charging individuals for items or services for which such individual is entitled to have payment made under Medicare); 42 C.F.R. § 414.48 (2017) (nonparticipating providers may charge a beneficiary an amount up to 115% of the Medicare fee schedule amount). See Pollitz, *supra* note 41.

consent); (2) limit balance-billing and amounts that out-of-network providers may collect from patients, usually to in-network payment levels (limit charges/balance-billing); or (3) provide for dispute resolution mechanisms to determine payment amounts for out-of-network services among providers, patients, and payers (dispute resolution).<sup>103</sup> Thus far, New York, Connecticut, California, Florida, and Texas have passed laws curtailing surprise medical billing.

New York pioneered such legislation in its “Emergency Medical Services and Surprise Bills” law.<sup>104</sup> New York’s law adopts all three requirements of disclosure and informed consent, refraining from balance-billing, and requiring dispute resolution. Out-of-network providers that accept assignment of the patient’s benefits (i.e., agree to accept payment from the patient’s health plan) may not bill the patient more than in-network amounts, including balance-billing and/or out-of-network cost-sharing, unless the patient consents after full disclosure.<sup>105</sup> If an out-of-network provider does not accept assignment of benefits or if the patient is uninsured, then the patient may submit any surprise bill amounts to independent dispute resolution.<sup>106</sup> For out-of-network emergency services, physicians may not balance-bill or charge the patient more than in-network cost-sharing amounts.<sup>107</sup> The New York law generally tries to remove the patient from any dispute over surprise bills, leaving it to providers and payers to work out how much the out-of-network rate will be, using binding, independent dispute resolution to determine the rate if the parties cannot come to an agreement.<sup>108</sup> New York uses “baseball style” arbitration, where the provider and health plan each submit their best and final offer to the arbitrator, who then must select the offer that best

103. See Seth Bills & Wendy Rogaliner, *Lawmakers Weigh in as Battle over Surprise Billing Continues*, A.B.A. HEALTH ESOURCE (May 2016), [http://www.americanbar.org/publications/aba\\_health\\_esource/2015-2016/may/lawmakers-weigh-in-as-battle-over-surprise-billing-continues-.html](http://www.americanbar.org/publications/aba_health_esource/2015-2016/may/lawmakers-weigh-in-as-battle-over-surprise-billing-continues-.html); CONSUMERS UNION, GETTING STARTED ON SURPRISE MEDICAL BILLS: AN ADVOCATE’S GUIDE 5 (2015), <http://consumersunion.org/wp-content/uploads/2015/11/SurprisebillsAdvocatesGuide.pdf>.

104. N.Y. INS. LAW § 3241(c) (McKinney 2016); N.Y. FIN. SERV. LAW art. 6 (McKinney 2016). This law went into effect on April 1, 2015.

105. N.Y. FIN. SERV. LAW §§ 603(h), 606, 607(a) (McKinney 2016).

106. N.Y. FIN. SERV. LAW § 607(b) (McKinney 2016).

107. N.Y. FIN. SERV. LAW § 605 (McKinney 2016). If the health plan and the out-of-network emergency physician cannot agree on fees or if the patient is uninsured, then the parties can submit the claim for independent dispute resolution to receive a binding determination of fees. *Id.*

108. N.Y. FIN. SERV. LAW § 607 (McKinney 2016). Uninsured patients may also submit a claim for dispute resolution regarding bills for emergency services and for physicians in hospitals and ambulatory surgery centers from whom they have not received timely disclosures, upon approval of the superintendent. *Id.* §§ 605(b), 607(b).

approximates UCR, without itself independently determining what rate will be paid.<sup>109</sup>

Connecticut adopted prohibitions against surprise medical bills similar to New York's, such that an insured patient would only owe the applicable in-network cost-sharing amount for out-of-network services that she did not knowingly elect over an available in-network provider.<sup>110</sup> Although the Connecticut law does not provide a dispute resolution mechanism, it does give the patient an important remedy—the statute allows a patient who receives a surprise bill from an out-of-network provider in excess of what the patient would owe under her plan's in-network rate to seek actual damages, punitive damages, and injunctive relief under the Connecticut Unfair Trade Practices Act.<sup>111</sup> Connecticut imposes requirements on health insurance carriers as well: (1) they may not require greater cost-sharing of the enrollee for surprise out-of-network services than would be required for in-network care,<sup>112</sup> (2) they are required to reimburse the out-of-network provider for surprise bills at the in-network rate as payment in full (unless they agree otherwise with the provider),<sup>113</sup> (3) plans must include in their description of coverage an explanation of surprise bills, and (4) they must inform the enrollee of the network status of providers and an estimate of how much the insurer will pay for the service.<sup>114</sup> For out-of-network emergency services, health plans must pay, at minimum, UCR, which is defined as the 80th percentile of all charges for the service by providers in the same geographic area as reported in a nonprofit, third-

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109. HALL ET AL., *supra* note 25, at 22; JACK HOADLEY ET AL., THE CTR. ON HEALTH INS. REFORMS, BALANCE BILLING: HOW ARE STATES PROTECTING CONSUMERS FROM UNEXPECTED CHARGES? 13 (2015) (noting that this baseball-style arbitration is considered more efficient because the arbitrator only has to choose one of the numbers, not figure out the precise rate that is UCR, and because the system encourages the parties to come up with real approximations of UCR because of the coin-toss nature of the outcome).

110. CONN. GEN. STAT. § 38a-477aa (2016). The definition of “surprise bill” excludes emergency services, but a similar provision prohibits out-of-network providers from billing a patient for out-of-network cost-sharing or balance-billing for emergency services. *Id.* § 38a-477aa(a)(6)(A).

111. CONN. GEN. STAT. § 20-7f(b) (2016). The Connecticut Unfair Trade Practices Act is set forth at CONN. GEN. STAT. ch. 735a. Relevant to the discussion on credit reporting practices *infra* Part II.C., it is also an unfair trade practice under Connecticut's law for a health care provider to report a patient's unpaid surprise medical bill to a credit reporting agency. CONN. GEN. STAT. § 20-7f(c) (2016).

112. CONN. GEN. STAT. §§ 38a-477aa(c), (d).

113. *Id.* § 38a-477aa(c)(2). The health carrier and out-of-network provider may agree to a different rate, but essentially, the statute requires out-of-network providers at in-network facilities to accept the in-network rate as payment in full, with prohibitions on charging the patient higher cost-sharing or balance bills.

114. CONN. GEN. STAT. § 38a-591b.



party benchmarking database.<sup>115</sup>

California's surprise billing law protects patients who receive care at an in-network facility<sup>116</sup> from higher cost-sharing and balance-billing from out-of-network providers.<sup>117</sup> California's law incorporates disclosure and consent, limits on the amounts charged for surprise bills, and voluntary, binding dispute resolution. The law prohibits providers from charging patients more than the in-network cost-sharing amount that the patient would owe if the provider were in-network, unless the patient has consented in writing to pay the out-of-network charges at least twenty-four hours in advance.<sup>118</sup> Health plans are required to provide in their contracts that enrollees shall pay no more than in-network cost-sharing amounts to out-of-network providers at in-network facilities, which becomes significant for purposes of ERISA, as discussed below.<sup>119</sup> The law establishes a binding, independent dispute resolution process that health plans and non-contracted providers may elect to use to resolve appeals of the amount paid by the plan.<sup>120</sup>

The California law also includes certain innovations that extend protections beyond those of other states. First, and most significantly, California's law presumptively defines the amount the health plan owes the out-of-network provider as the greater of 125% of the Medicare rate or the plan's "average contracted rate" for similar services in the geographic area.<sup>121</sup> Second, the law provides that any cost-sharing paid by the patient

115. *Id.* § 38a-477aa(b)(3)(A). For out-of-network emergency services, the health insurance carrier must pay the greatest of (i) the in-network rate for the services; (ii) the UCR rate, calculated as the 80th percentile of all charges for the service in the geographic area, as reported to a nonprofit benchmarking database; or (iii) the Medicare rate. *Id.* In practice, the UCR rate will likely be the greatest amount. *See, e.g.,* FAIRHEALTH, UNDERSTANDING OUT-OF-NETWORK REIMBURSEMENT (2012), <http://www.fairhealth.org/servlet/servlet.FileDownload?file=%2001560000000YVRj>.

116. The law applies to providers at hospitals, ambulatory surgery centers, laboratories, and imaging centers. CAL. HEALTH & SAFETY CODE § 1371.9; CAL. INS. CODE § 10112.8.

117. CAL. HEALTH & SAFETY CODE § 1371.9; CAL. INS. CODE § 10112.8. California separately prohibits balance-billing by out-of-network providers in emergencies. *See* Prospect Med. Grp., Inc. v. Northridge Emergency Med. Grp., 198 P.3d 86 (Cal. 2009) (ruling that HMO members may not be balance-billed).

118. CAL. HEALTH & SAFETY CODE § 1371.9(a), (c); CAL. INS. CODE § 10112.8(a), (c).

119. CAL. HEALTH & SAFETY CODE § 1371.9(a), (c); CAL. INS. CODE § 10112.8(a), (c). For the discussion of ERISA, *see infra* Part IV.

120. CAL. HEALTH & SAFETY CODE § 1371.30; CAL. INS. CODE § 10112.81.

121. CAL. HEALTH & SAFETY CODE § 1371.31(a); CAL. INS. CODE § 10112.82(a) (“[U]nless otherwise agreed to by the noncontracting individual health professional and the plan, the plan shall reimburse the greater of the average contracted rate or 125% of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered.”). The law requires health plans to submit their average contracted rates to the

to the out-of-network provider at an in-network facility shall count toward the patient's annual limit on out-of-pocket expenses and *in-network* deductible.<sup>122</sup> Third, the exception for patients who voluntarily consent to receive services from an out-of-network provider requires the patient to be provided with a binding written estimate of their total out-of-pocket costs.<sup>123</sup> Fourth, the law limits out-of-network providers from initiating debt collection or credit reporting on more than the in-network cost-sharing amount, and prohibits the use of wage garnishment or liens on primary residences to collect unpaid bills.<sup>124</sup>

Florida's law relieves patients of any obligation to pay balance-billing or higher cost-sharing amounts to out-of-network providers at in-network facilities where the patient "does not have the ability and opportunity to choose a participating provider at the facility who is available to treat the insured."<sup>125</sup> Instead, the patient's health plan is solely responsible for paying the out-of-network provider, and if the amounts are disputed, they can be resolved by a court or through voluntary, binding dispute resolution.<sup>126</sup> The Florida law makes willful and frequent violations of the rules on surprise billing an unfair trade practice for health plans and grounds for disciplinary action and loss of licensure for providers.<sup>127</sup>

Texas does not prohibit balance bills, but it uses both disclosure and dispute resolution mechanisms to provide limited protection to consumers from surprise medical bills. A patient has the right to submit to mediation, which is nonbinding, any bills over \$500 from out-of-network facility-based providers at a facility that is in-network for the patient or from an emergency care provider.<sup>128</sup> A facility-based provider may not have to

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Department of Managed Health Care or the Commissioner of Insurance, but these rates will not be publicly available. CAL. HEALTH & SAFETY CODE § 1371.31(a); CAL. INS. CODE § 10112.82(a).

122. CAL. HEALTH & SAFETY CODE § 1371.9(b); CAL. INS. CODE § 10112.8(b).

123. CAL. HEALTH & SAFETY CODE § 1371.9(c)(3); CAL. INS. CODE § 10112.8(c)(3).

124. CAL. HEALTH & SAFETY CODE § 1371.9(e); CAL. INS. CODE § 10112.8(e).

125. FLA. STAT. § 627.64194(3)(b).

126. *Id.* § 627.64194(6). For out-of-network emergency services, the insurer is solely liable for payment except for the patient's applicable in-network cost-sharing amounts. *Id.* § 627.64194(2).

127. *Id.* §§ 456.072(1)(oo); 626.9541(1)(gg).

128. TEX. INS. CODE ANN. § 1467.051(a) (West 2016). This provision was amended in 2017 by S.B. 507 to (1) apply to a broader range of services, including emergency services; (2) mandate a notice in balance bills of the right to mediation for out-of-network medical bills, and (3) expand the protection to Texans who participate in the Teacher's Retirement System. *See* Press Release, Kelly Hancock, Senate of Texas, Texas Legislature Passes Balance Billing Mediation Expansion (May 11, 2017), <http://www.senate.texas.gov/members/d09/press/en/p20170511a.pdf>. The law was amended to define facility-based provider as "a physician, health care practitioner, or other health care provider who provides health care or medical services to patients of a facility." S.B. 507, 85th Leg. (Tex. 2017) (to be codified at TEX. INS. CODE ANN. § 1467.001(4)).

submit to mediation if she discloses to the patient her out-of-network status and an estimate of charges, the patient provides written acknowledgement of the disclosure, and the provider does not ultimately charge the patient more than estimated.<sup>129</sup> Unlike the other states' surprise billing laws, the patient is left to resolve disputes over surprise billing with the provider and plan, rather than letting providers and plans work out payment on their own.

Thus far, New York, Connecticut, California, Florida, and Texas, have enacted laws to curb surprise billing, and many other states are also considering legislation on surprise medical bills.<sup>130</sup>

*b. NAIC Model Act Provisions for Surprise Medical Bills*

As states consider surprise billing laws, a prominent model is provided by the NAIC Model Act, which contains a measure to curb surprise medical bills.<sup>131</sup> The Model Act's surprise billing provisions contain elements of disclosure, limits on out-of-network cost-sharing and balance-billing, and dispute resolution. Under the Model Act, health facilities must provide patients with prior written notice if the patient will be receiving non-emergency services from an out-of-network provider at an in-network facility, including a description of the associated charges.<sup>132</sup> Health plans would be required to apply in-network cost-sharing rates for surprise medical bills for both emergency and non-emergency services.<sup>133</sup> The Model Act would not require plans to hold patients harmless for surprise balance bills. Instead, out-of-network providers would be required to offer patients three choices regarding balance-billing amounts: (1) pay the balance bill, (2) for balance bill amounts greater than \$500, send the bill to the patient's health plan to be resolved with the provider through mediation, or (3) rely on any other rights and remedies that may be

129. TEX. INS. CODE ANN. §§ 1467.051(c), (d) (West 2016) (providing that the written estimate is not binding, but the facility based provider may not be required to mediate the bill with the patient if the amount is less than or equal to the estimate).

130. See, e.g., Surprise Billing & Consumer Prot. Act," S.B. 8, 2017-18 Reg. Sess. (Ga. 2017); Out-of-Network Consumer Prot., Transparency, Cost Containment & Accountability Act, Assemb. No. 1952, 217th Leg. (N.J. 2016); Emergency Med. & Health Care Servs. Surprise Billing Prevention Act, S.B. 1158, 2015 Sess. (Pa. 2015); S.B. 2107, 109th Gen. Assemb., Reg. Sess. (Tenn. 2016).

131. NAIC MODEL ACT § 7.

132. *Id.* § 7B.

133. This only applies to health plans subject to state insurance regulation (i.e., not self-funded ERISA plans). See *infra* Part III.A.

available in the state.<sup>134</sup> Similar to California or Connecticut, the Model Act would create a benchmark for what constitutes a reasonable out-of-network rate, defined as the higher of the plan's highest in-network rate or a set percentage of Medicare's applicable rate for the same services.<sup>135</sup> Although the Model Act contemplates administrative enforcement mechanisms, unlike Connecticut and Florida, it does not create a private cause of action under the state's unfair business or trade practices act.<sup>136</sup> Overall, the Model Act's consumer protections are weaker than most of the state laws on surprise billing because it does not prohibit balance-billing patients, it does not remove patients from disputes, and the dispute resolution mechanism of mediation is nonbinding.

In sum, although only a handful of states have passed surprise medical billing laws to date, state legislation has been comprehensive and somewhat varied in approach. When it comes to health care consumer protections, states are epitomizing their role as federalism laboratories.

### *c. Federal Action on Surprise Medical Bills*

The federal government, by contrast, appears to be taking a more incremental approach. In 2016, the Centers for Medicare and Medicaid Services (CMS) issued a very limited measure to address surprise medical bills for exchange plan enrollees in its 2017 Benefit Payment Parameters Rule.<sup>137</sup> Starting in 2018, enrollees in health plans sold on exchanges may count cost-sharing amounts for out-of-network ancillary providers at in-network facilities toward their annual *in-network* limit on cost-sharing, unless the plan provided notice to the enrollee forty-eight hours in advance or at the time of prior authorization.<sup>138</sup> The rule does not, however, apply

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134. NAIC MODEL ACT § 7D. Although the Model Act refers to "mediation," which is nonbinding, it is not clear whether the NAIC intended to exclude the possibility of a binding dispute resolution procedure. Background materials refer to "mandatory binding mediation," which may refer to something more akin to binding arbitration. HEALTH MGMT. ASSOCS., ENSURING CONSUMERS' ACCESS TO CARE: NETWORK ADEQUACY STATE INSURANCE SURVEY FINDINGS AND RECOMMENDATIONS FOR REGULATORY REFORMS IN A CHANGING INSURANCE MARKET 30 (2014), [http://www.naic.org/documents/committees\\_conliaison\\_network\\_adequacy\\_report.pdf](http://www.naic.org/documents/committees_conliaison_network_adequacy_report.pdf).

135. NAIC MODEL ACT § 7F.

136. NAIC MODEL ACT § 7.I. (providing that enforcement would be through the state consumer protection agencies, the attorney general, and the insurance department).

137. Notice of Benefit & Payment Parameters for 2017, 81 Fed. Reg. 12204, 12304-12306 (Dep't of Health & Human Servs. Mar. 8, 2016) (to be codified at 45 C.F.R. § 156.230(e)).

138. HHS Notice of Benefit & Payment Parameters for 2017, 81 Fed. Reg. at 12305. CMS describes an "ancillary provider" as a "provider of a service ancillary to what is being provided by the primary provider, such as anesthesiology or radiology[,] rather than the services supplied by the primary provider." *Id.*

to the balance-billing amounts owed by the enrollee, only cost-sharing such as deductibles, co-insurance, or co-pays.<sup>139</sup> Acknowledging that this provides very limited protection against surprise medical bills, CMS justified its approach by saying it was monitoring ongoing progress by states, the NAIC, and others, and noting that its rules do not preempt state laws prohibiting balance-billing.<sup>140</sup> Indeed, because the statutory definition of “cost-sharing” excludes balance-billing, CMS lacks the authority to address the balance-billing component of surprise bills.<sup>141</sup> Accordingly, the federal government lacks statutory authority and perhaps the inclination to comprehensively address surprise billing, so the states have taken the lead to address surprise bills in lieu of a federal solution.

President Obama’s 2017 budget included legislative measures to address surprise medical bills.<sup>142</sup> The Obama administration proposed limiting surprise out-of-network bills by requiring hospitals to take reasonable steps to match patients with in-network providers. If the hospital fails to match the patient with the in-network provider, the out-of-network provider would be required to accept the in-network fees as payment in full.<sup>143</sup> Congress did not take up the measure, but the issue of surprise medical bills has been the subject of at least one reform bill.<sup>144</sup> Nevertheless, it is unclear whether the Trump administration will be similarly inclined to address surprise medical bills.<sup>145</sup>

#### 4. Gaps in Policies for Surprise Medical Bills

The state law initiatives on surprise medical billing and balance-billing are starting to create fairly robust protections against surprise medical bills for consumers. Many of the substantive, as opposed to structural, limits of state surprise medical billing laws are amenable to state innovation. New

139. See Timothy Jost, *The 2017 Benefit and Payment Parameters Final Rule: Drilling Down (Part 2)*, HEALTH AFF. BLOG (Mar. 2, 2016), <http://healthaffairs.org/blog/2016/03/02/the-2017-benefit-and-payment-parameters-final-rule-drilling-down-part-2/>.

140. Notice of Benefit and Payment Parameters for 2017, 81 Fed. Reg. at 12305.

141. See *supra* text accompanying note 71.

142. OFFICE OF MGMT. & BUDGET, BUDGET OF THE U.S. GOVERNMENT: FISCAL YEAR 2017 137 tbl.S-9 (2016).

143. U.S. DEP’T OF HEALTH & HUMAN SERVS., FISCAL YEAR 2017 BUDGET IN BRIEF 116 (2016), <https://www.hhs.gov/sites/default/files/fy2017-budget-in-brief.pdf>.

144. End Surprise Billing Act of 2015, H.R. 3770, 114th Cong. (2015).

145. President Trump’s HHS Secretary, Tom Price, previously proposed legislation that would allow physicians to balance-bill Medicare patients for amounts above Medicare’s fees, which is currently prohibited. Medicare Patient Empowerment Act, H.R. 1700, 112th Cong. (introduced May 3, 2011).

York, Connecticut, and California, in particular, have passed surprise billing laws that contain substantive differences, but are fairly comprehensive in terms of protecting patients from surprise bills.<sup>146</sup> Part II contains further discussion about various combinations of policies and tradeoffs that could be recommended for a model state surprise billing law, building on these state innovations.<sup>147</sup> Standards for network adequacy, however, are quite difficult to enforce. The regulator must gather a daunting amount of information, including checking to see which physicians are accepting new patients, to meaningfully evaluate network adequacy.<sup>148</sup>

A significant limit of these surprise billing laws is geographic—only a handful of states have passed these laws. Consumers in the majority of states without such laws have little recourse or protection if they receive a surprise medical bill. However, many state legislatures are interested in pursuing measures to protect consumers from surprise bills.<sup>149</sup>

Another limit is legally constructed—to the extent they regulate health plans, state laws on network adequacy or surprise billing are subject to preemption by ERISA. An in-depth analysis of ERISA preemption of state health care consumer protections is set forth in Part III, below. But in practical terms, many of these emerging state consumer protections are simply inapplicable and unavailable if the consumer is one of the millions insured by an employer-based health plan, particularly a self-funded plan.

### *B. Opaque Prices and Facility Fees*

Though medical care ranks among the most expensive items or services a person can expect to buy in a lifetime, a consumer typically has no idea what it will cost until after she has consumed the service and receives the bill.<sup>150</sup> Two factors make the experience of “shopping” and being billed for health care uncommonly confusing and nearly impossible to navigate as a rational consumer would—a lack of transparency and up-front estimates of cost and à la carte billing such as added facility fees.

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146. See *supra* text accompanying notes 100–20.

147. See *infra* Part II.A.

148. See Haeder et al., *supra* note 94, at 1165.

149. See, e.g., S.B. 206, 71st Gen. Assemb., First Reg. Sess. (Colo. 2017); H.B. 71, 154th Gen. Assemb., Reg. Sess. (Ga. 2017); S.B. 7, 154th Gen. Assemb., Reg. Sess. (Ga. 2017); H.B. 2164, 190th Gen. Assemb., Reg. Sess. (Mass. 2017); H.B. 995, 99th Gen. Assemb., First Reg. Sess. (Mo. 2017); H.B. 313, 53rd Leg. Sess., First Sess. (N.M. 2017); H.B. 5012, 2017–2018 Reg. Sess. (R.I. 2017); S.B. 272, 2017–2018 Reg. Sess. (R.I. 2017); H.B. 2327, 83rd Leg. Sess., Reg. Sess. (W. Va. 2017).

150. See N.Y. STATE DEP'T OF FIN. SERVS., *supra* note 54, at 9–10 (noting the difficulty for consumers to comparison shop for care).

One of the most widely reported problems with medical bills is the inability of patients to access meaningful price or quality information about their health care before the service is rendered.<sup>151</sup> One journalist describes spending ten hours on the phone with various hospitals trying to get an estimate of how much it would cost for his pregnant wife's uncomplicated delivery, and found hospitals were both unwilling and unable to give him a price quote.<sup>152</sup> Despite a recent proliferation of price transparency tools, the accuracy and usability of this information remains poor.<sup>153</sup> Even if one can get a provider to give a cost estimate, these quotes are not binding on the provider,<sup>154</sup> so the patient cannot rely upon price quotes and has no recourse if the estimate turns out to be wrong.

Health care is also billed à la carte, with the patient receiving separate bills from each facility and physician who participated in the patient's care.<sup>155</sup> A troubling example is when facility fees are added to the physician's charge for outpatient care.<sup>156</sup> Although they are both

151. See Morgan A. Muir et al., *Clarifying Costs: Can Increased Price Transparency Reduce Healthcare Spending?*, 4 WM. & MARY POL'Y REV. 319 (2013); Jaime A. Rosenthal et al., *Availability of Consumer Prices from US Hospitals for a Common Surgical Procedure*, 173 JAMA INTERNAL MED. 427 (2013) (finding that only 16% of hospitals studied could provide a full price quote for a total hip replacement for a fictitious sixty-two year-old uninsured grandmother); Andrew Steinmetz & Ezekiel J. Emanuel, *What Does a Hip Replacement Cost? The Transparency Imperative in 2013*, 173 JAMA INTERNAL MED. 432 (2013); see also Betsy Q. Cliff, *Explainer: Why Can't Anyone Tell Me How Much This Surgery Will Cost?*, THE CONVERSATION (Jan. 12, 2016, 6:14 AM), <http://theconversation.com/explainer-why-cant-anyone-tell-me-how-much-this-surgery-will-cost-51013>; Johnny Harris, *I Tried to Find Out How Much My Son's Birth Would Cost. No One Would Tell Me.*, VOX (May 5, 2016), <http://www.vox.com/2016/5/5/11591592/birth-cost-hospital-bills>.

152. See Harris, *supra* note 151.

153. See, e.g., Anna D. Sinaiko et al., *Cost-Sharing Obligations, High Deductible Health Plan Growth, and Shopping for Health Care: Enrollees with Skin in the Game*, 176 JAMA INTERNAL MED. 395 (2016); see also Reed Abelson, *Online Tools to Shop for Doctors Snag on Healthcare's Complexity*, N.Y. TIMES, June 16, 2016, available at <https://www.nytimes.com/2016/06/17/business/online-tools-to-shop-for-doctors-snap-on-health-cares-complexity.html>; Cliff, *supra* note 151 (describing using various consumer-oriented health care price comparison tools for spinal fusion surgery at a particular hospital and obtaining price estimates ranging from \$9,350–\$71,000); Elana Gordon, *Patients Want to Price-Shop for Care, but Online Tools Unreliable*, NPR (Nov. 30, 2015, 4:54 AM), <http://www.npr.org/sections/health-shots/2015/11/30/453087857/patients-want-to-price-shop-for-care-but-online-tools-unreliable>.

154. See Khazan, *supra* note 8.

155. See Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 657 (2008); Sandra G. Boodman, *Extra Health-Care Facility Fees Take Many Patients by Surprise*, WASH. POST (Oct. 6, 2009), <http://www.washingtonpost.com/wp-dyn/content/article/2009/10/05/AR2009100502910.html>.

156. Carol M. Ostrom, *Why You Might Pay Twice for One Visit to Doctor*, SEATTLE TIMES (Nov. 5, 2012, 10:52 AM), <http://www.seattletimes.com/seattle-news/why-you-might-pay-twice-for-one-visit-to-doctor/>.

unanticipated, these facility fees differ from surprise medical bills because they are not limited to out-of-network services. The lack of transparency of added outpatient facility fees is especially shocking when the patient previously paid only one, lesser charge for the same service.<sup>157</sup> It is akin to going to a restaurant where you have dined before, but receiving an additional bill for use of the restaurant's space, tables, plates, utensils, lighting, and furniture.

Facility fees stem from the fragmented way we pay for medical care. Medicare pays facilities and physician services using different methodologies, which vary based on the location or site of clinical care.<sup>158</sup> Hospital outpatient departments are paid more than physicians' offices for performing the same type of service, in large part because hospital outpatient settings can charge a facility fee in addition to the physician's professional service fee.<sup>159</sup> By contrast, fees for services at physicians' offices usually include both the professional and overhead costs of the service in a single charge.<sup>160</sup> This pricing difference based on location, also called the "site-of-service differential," is replicated by private payers.<sup>161</sup>

Corporate consolidation of hospitals and physicians may reduce the incidence of surprise billing because physicians employed by a hospital are more likely to be in the same health plan networks as the hospital.<sup>162</sup> Nevertheless, the consolidation of hospitals and physician practices may lead to higher total spending for outpatient services by exploiting the fact that hospital-based services are typically reimbursed at higher rates than

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157. Eric Boodman, *Visits to the Doctor Cost More as Hospitals Buy Practices*, BOS. GLOBE (Oct. 19, 2015), <https://www.bostonglobe.com/2015/10/19/when-hospitals-buy-doctors-practices-patients-pay/bsK3hRYyCNQFnqSD18WKK/story.html> (discussing the Neprash et al. study, which concluded that higher outpatient prices were not explained by patients getting more services when doctors were acquired by hospitals).

158. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO CONGRESS: MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM 27 (2013) [hereinafter MEDPAC 2013 REPORT TO CONGRESS], <http://www.medpac.gov/docs/default-source/reports/june-2016-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf>.

159. Amanda Cassidy, *Health Policy Brief: Site Neutral Payments*, HEALTH AFF. 3 (July 24, 2014), [http://healthaffairs.org/healthpolicybriefs/brief\\_pdfs/healthpolicybrief\\_121.pdf](http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_121.pdf).

160. MEDPAC 2013 REPORT TO CONGRESS, *supra* note 158, at 32; Cassidy, *supra* note 159, at 3.

161. James D. Reschovsky & Chapin White, *Location, Location, Location: Hospital Outpatient Prices Much Higher than Community Settings for Identical Services*, NAT'L INST. HEALTH CARE REFORM, 1, 1–2 (June 2014), <https://www.mathematica-mpr.com/our-publications-and-findings/publications/location-location-location-hospital-outpatient-prices-much-higher-than-community-settings-for-identical-services>.

162. See Garmon & Chartock, *supra* note 45, at 180.



identical services provided in physician-based locations.<sup>163</sup> The fact that hospitals can charge an additional facility fee for acquired physicians' services is one of the financial incentives driving hospital-physician integration.<sup>164</sup>

Hospitals argue that facility fees are necessary to compensate them for the expenses of maintaining standby capacity to service acute care needs that may present at any time.<sup>165</sup> A facility fee to cover the costs of maintaining a continuously open emergency room may be justified,<sup>166</sup> but in cases where the added facility fee is simply the result of the hospital's acquisition of the physician's practice there is no difference in standby capacity or overhead to justify the fee. Nothing has changed in terms of the location, supplies, technology, staffing, the duration, or intensity of the care.<sup>167</sup> The higher price is merely the result of a change in corporate ownership, which allows the hospital to charge a facility fee for the acquired physician's services as though it were rendered in an outpatient

163. See Cory Capps et al., *The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending*, 1, 6 (Inst. for Policy Research, Working Paper No. WP-15-02, 2015), <http://www.ipr.northwestern.edu/publications/docs/workingpapers/2015/IPR-WP-15-02.pdf>; ANN S. O'MALLEY ET AL., CTR. FOR STUDYING HEALTH SYS. CHANGE, ISSUE BRIEF NO. 136, RISING HOSPITAL EMPLOYMENT OF PHYSICIANS: BETTER QUALITY, HIGHER COSTS? 3 (2011).

164. See Hannah T. Neprash et al., *Association of Financial Integration Between Physicians and Hospitals with Commercial Health Care Prices*, 175 JAMA INTERNAL MED. 1932, 1937 (2015); see also Margot Sanger-Katz, *When Hospitals Buy Doctors' Offices, and Patient Fees Soar*, N.Y. TIMES: THE UPSHOT (Feb. 6, 2015), [https://www.nytimes.com/2015/02/07/upshot/medicare-proposal-would-even-out-doctors-pay.html?smid=tw-share&\\_r=0](https://www.nytimes.com/2015/02/07/upshot/medicare-proposal-would-even-out-doctors-pay.html?smid=tw-share&_r=0).

165. See MEDPAC 2013 REPORT TO CONGRESS, *supra* note 158, at 28; see also Richard Umbdenstock, Letter to the Editor, *The Case for Hospital Facility Fees*, WASH. POST (Dec. 30, 2012), [https://www.washingtonpost.com/opinions/the-case-for-hospital-facility-fees/2012/12/30/ce79ebb6-512b-11e2-835b-02f92c0daa43\\_story.html](https://www.washingtonpost.com/opinions/the-case-for-hospital-facility-fees/2012/12/30/ce79ebb6-512b-11e2-835b-02f92c0daa43_story.html). Umbdenstock was writing as the President of the American Hospital Association and advocated that hospitals' standby capacity costs "such as around-the-clock availability of emergency services; emergency back-up for other settings of care; disaster preparedness; a wide range of staff and equipment" justify higher reimbursements for hospitals compared with other types of providers.

166. See, e.g., Sarah Kliff, *The Case of the \$629 Band-Aid—And What It Reveals About American Health Care*, VOX (May 13, 2016, 8:10 AM), <http://www.vox.com/2016/5/13/11606760/emergency-facility-fees-american-health-care>.

167. See *Local Hospitals Buy Medical Practices; Patients Forced to Pay*, WSBTV.COM (Feb. 12, 2015, 10:19 AM), <http://www.wsbtv.com/news/local/local-hospitals-buy-medical-practices-patients-for/53837305> (describing how cancer patient, Mike Rosenberg, was suddenly charged an additional \$3000 facility fee for chemotherapy at Atlanta Cancer Care when it was acquired by Northside Hospital and quoting Rosenberg as saying, "the same doctors, the same chair, the same material, everything is exactly the same."); Mathews, *supra* note 5 (quoting cardiac patient Hubbard who was charged a facility fee when his cardiologist's practice was acquired by a hospital, "nothing had changed, it was the same equipment, the same room . . .").

department of the hospital.<sup>168</sup>

The price increases from facility fees are significant. In 2012, Medicare paid 141% more for a level II echocardiogram and 70% more for a fifteen-minute office visit in a hospital outpatient department than in a freestanding physician's office.<sup>169</sup> For private payers, the price difference between hospital outpatient departments and physicians' offices ranged from 21% higher for office visits to 258% higher for chest radiography.<sup>170</sup> From the consumer's perspective, receiving services in a "hospital outpatient department" (which may just be their physician's office, newly acquired by a hospital) resulted in an average increase of 206% to 394% in out-of-pocket spending compared with receiving the same services in a freestanding physician's office.<sup>171</sup> Because of the increasing prevalence of high deductibles, many patients must pay all or much of the price increase out-of-pocket.<sup>172</sup> Added facility fees are not fully explained by the differences in the sickness or acuity of patients receiving care at hospital outpatient departments versus freestanding community settings.<sup>173</sup> In these cases, the added facility fees increase the cost of care without providing additional services or value to the patient's health.<sup>174</sup>

The following discussion explores two policy approaches to address these medical billing problems of price opacity and added facility fees—price transparency efforts and site-neutral payments that eliminate facility fees.

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168. See MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 53 (2014) [hereinafter MEDPAC 2014 REPORT TO CONGRESS] ("This payment difference creates a financial incentive for hospitals to purchase freestanding physicians' offices and convert them to HOPDs without changing their location or patient mix.").

169. MEDPAC 2013 REPORT TO CONGRESS, *supra* note 158, at 31. In 2014, MedPAC reported that a level II echocardiogram would cost Medicare \$228.02 in a physician's office and \$492.22 in a hospital outpatient department due to higher hospital facility fees. MEDPAC 2014 REPORT TO CONGRESS, *supra* note 168, at 80 tbl.3-9.

170. Aparna Higgins et al., *National Estimates of Price Variation by Site of Care*, 22 AM. J. MANAGED CARE e116, e117 (2016).

171. *Id.* at e120.

172. See Mathews, *supra* note 5 (describing how Hubbard had to pay about \$1000 more out of pocket for his echocardiogram under his high-deductible plan when his cardiologist's practice was acquired by a hospital system).

173. Reschovsky & White, *supra* note 161, at 4.

174. See Ostrom, *supra* note 156 (quoting Group Health Cooperative CEO, Scott Armstrong, as saying, "Facility fees demonstrate how the fee-for-service system can inflate cost without in any way contributing to the health of patients.").

### 1. Price Transparency

State price transparency efforts attempt to penetrate the opacity and secrecy around health care prices and quality. Consumers of health care cannot comparison shop for health care without information about prices and quality, which are kept secret by contractual confidentiality clauses or by the sheer complexity of a system where each service has different prices and methods of calculating rates depending on the payer.<sup>175</sup> Although many states have passed some form of legislation to promote health care price transparency, only a handful of states provide consumers with meaningful tools for consumers to compare the prices they can expect to pay under their health plan for both inpatient and outpatient care.<sup>176</sup> According to the Catalyst for Payment Reform, the most robust and useful state price transparency tools are built upon data reported to state all-payer claims databases (APCDs) on the *amounts paid* for services (reflecting negotiated prices and patient cost-sharing), as opposed to the less helpful *amounts charged*.<sup>177</sup> The best state price transparency tools make APCD data available to consumers via a searchable, public website that allows price and quality comparisons among a wide range of providers.<sup>178</sup> Examples of states with consumer-friendly price transparency websites built on APCD data are Colorado, Maine, New Hampshire, and Oregon.<sup>179</sup>

Price transparency tools are a necessary component of a broader set of policies to protect consumers from medical bill-related financial distress. By itself, however, price transparency is inherently limited as a consumer protection device.<sup>180</sup> The first limit is that price transparency does not help

175. Muir et al. *supra* note 151, at 319; Reinhardt, *supra* note 2, at 59.

176. FRANCOIS DE BRANTES & SUZANNE DELBANCO, HEALTHCARE INCENTIVES IMPROVEMENT INST. & CATALYST FOR PAYMENT REFORM, REPORT CARD ON STATE PRICE TRANSPARENCY LAWS 6 (2016).

177. *Id.* at 5–6. Charge data are not useful because they do not reflect the prices that the majority of individuals with insurance would pay. David Dranove, *The Rest of the Story About Hospital Pricing*, THE HEALTH CARE BLOG (May 9, 2013), <http://thehealthcareblog.com/blog/2013/05/09/the-rest-of-the-story-about-hospital-pricing/#more-61521>; Muir et al., *supra* note 151, at 328.

178. DE BRANTES & DELBANCO, *supra* note 176, at 6.

179. See CO MEDICAL PRICE COMPARE, <https://www.comedprice.org/#/home>; COMPAREMAINE: HEALTH COSTS & QUALITY, <http://www.comparemaine.org/>; *Health Costs for Consumer*, N.H. HEALTHCOST, <http://nhhealthcost.nh.gov/health-costs-consumers>; OR. HOSP. GUIDE, <http://oregonhospitalguide.org/>.

180. See, e.g., Austin Frakt, *Price Transparency Is Nice. Just Don't Expect it to Cut Health Care Costs*, N.Y. TIMES: THE UPSHOT (Dec. 19, 2016), <https://www.nytimes.com/2016/12/19/upshot/price-transparency-is-nice-just-dont-expect-it-to-cut-health-costs.html>. A secondary and possibly more important benefit of price transparency efforts by states is the importance of gathering comprehensive price and claims data to inform state oversight of health care markets, consolidation, prices, and

a consumer who lacks choices among in-network providers either due to market consolidation or narrow networks.<sup>181</sup> Second, price transparency tools are only useful for “shoppable” services, which are non-urgent services that can be scheduled in advance for which there are several choices of provider.<sup>182</sup> Unfortunately, much of health care is not shoppable, and patient-consumers cannot be expected to shop around in an emergency or when they or a loved one is gravely ill with complex medical needs.<sup>183</sup>

A third limit of price transparency as a consumer protection is that recent broadening of ERISA preemption has significantly undercut the scope and breadth of data reported to state APCDs. As discussed in more depth in Part III, the Supreme Court held in *Gobeille v. Liberty Mutual Insurance* that ERISA preempts state APCD reporting laws with respect to self-funded employee health benefit plans,<sup>184</sup> meaning that data from more than 60% of all individuals who are covered by an employer plan are no longer included in state APCDs or their consumer-facing transparency tools.<sup>185</sup>

Finally, robust price transparency tools do not provide patients with firm price estimates, specific to their care and health coverage, that are binding or enforceable against the provider or plan.<sup>186</sup> Some states require

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consumer choice. See Erin C. Fuse Brown & Jaime S. King, *The Double-Edged Sword of Health Care Integration: Consolidation and Cost Control*, 92 IND. L.J. 55, 81 (2016).

181. See HA T. TU & JOHANNA R. LAUER, CTR. FOR STUDYING HEALTH SYS. CHANGE, ISSUE BRIEF NO. 128, IMPACT OF HEALTH CARE PRICE TRANSPARENCY ON PRICE VARIATION: THE NEW HAMPSHIRE EXPERIENCE 1 (2009) (describing how New Hampshire’s robust price transparency tool has not led to reductions in prices or price variation in regions of the state with little competition in the hospital market).

182. CHAPIN WHITE & MEGAN EGUCHI, NAT’L INST. FOR HEALTH CARE REFORM, RESEARCH BRIEF NO. 18, REFERENCE PRICING: A SMALL PIECE OF THE HEALTH CARE PRICES AND QUALITY PUZZLE 4 (2014) (“Using an inclusive definition, all shoppable services accounted for about a third of total spending if both inpatient and ambulatory services are included.”).

183. Hall & Schneider, *supra* note 155, at 658.

184. *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936 (2016).

185. See Erin Fuse Brown & Jaime King, *The Consequences of Gobeille v. Liberty Mutual for Health Care Cost Control*, HEALTH AFF. BLOG (Mar. 10, 2016), <http://healthaffairs.org/blog/2016/03/10/the-consequences-of-gobeille-v-liberty-mutual-for-health-care-cost-control/>.

186. Of course, actual costs may vary if the severity or nature of the service is different than expected. But other industries and other health care settings (e.g., self-pay prices, elective, or non-covered procedures) find ways to make price quotes both more reliable as well as flexible enough to deal with unexpected contingencies. See Wendy Netter Epstein, *Price Transparency & Consumer Contracts in Health Care*, at \*42 (2017) [prepublication draft on file with author] (citing the Illinois Automotive Repair Act, 815 ILL. COMP. STAT. 306, as an example of a state law requiring written estimates for auto repair where the final bill may not be more than 10% above the estimate). Even in health care, price quotes are often provided for services that are typically not covered by insurance, such as LASIK eye surgery or fertility treatment.

health plans to provide prior estimates of the bill if the member requests one.<sup>187</sup> In most cases, the estimates are nonbinding and, if they simply state the facility's charges (which are several times higher than negotiated prices), do not help the patient understand what she will pay under her plan.<sup>188</sup> For example, Texas health care facilities must provide upon request an estimate of total charges for nonemergency procedures, but the estimate also must state that actual charges may vary.<sup>189</sup>

## 2. *Site Neutral Payment*

Recommendations to reduce or eliminate facility fees and the site-of-service differential in Medicare have been championed by the Medicare Payment Advisory Commission (MedPAC), a nonpartisan legislative agency that advises Congress on Medicare payment policy.<sup>190</sup> In its 2013 and 2014 reports to Congress, MedPAC identified sixty-six Ambulatory Payment Classification (APC) groups of outpatient services<sup>191</sup> that would be eligible for site-neutral payment, eliminating the higher payments to hospital outpatient departments.<sup>192</sup> These services do not require emergency standby capacity, tend not to have higher patient complexity in hospital settings, and do not require additional overhead to provide in a hospital setting.<sup>193</sup> MedPAC's recommendation for site-neutral payments was based on its view that "if the same service can be safely provided in different settings, a prudent purchaser should not pay more for that service

187. See, e.g., N.Y. INS. LAW § 3217-a(b)(14) (McKinney 2016) ("Each insurer . . . upon request of an insured, or prospective insured shall . . . with respect to out-of-network coverage, disclose the approximate dollar amount that the insurer will pay for a specific out-of-network health care service. The insurer shall also inform the insured through such disclosure that such approximation is *not* binding on the insurer and that the approximate dollar amount that the insurer will pay for a specific out-of-network health care service may change.") (emphasis added).

188. See, e.g., CAL. HEALTH & SAFETY CODE § 1339.585 (West 2016); MASS. GEN. LAWS ch. 111, § 228 (2017); MINN. STAT. § 62J.81 (2016); NEB. REV. STAT. § 71-2075 (2016).

189. See, e.g., TEX. HEALTH & SAFETY CODE ANN. § 324.101(d) (2009).

190. See generally MEDPAC 2013 REPORT TO CONGRESS, *supra* note 158, at 27; MEDPAC 2014 REPORT TO CONGRESS, *supra* note 168, at 53.

191. APC groups are Medicare's unit of payment for outpatient services. The Centers for Medicare & Medicaid Services assign all outpatient services to an APC group based on similar clinical characteristics and costs. CTRS. FOR MEDICARE & MEDICAID SERVS., DEP'T OF HEALTH & HUM. SERVS., HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM 4 (2016), <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HospitalOutpaysysfctst.pdf>.

192. MEDPAC 2013 REPORT TO CONGRESS, *supra* note 158, at 28; MEDPAC 2014 REPORT TO CONGRESS, *supra* note 168, at 77.

193. MEDPAC 2014 REPORT TO CONGRESS, *supra* note 168, at 77.

in one setting than another.”<sup>194</sup> MedPAC estimated that shifting to site-neutral payments for these outpatient services would save the Medicare program \$1.1 billion and beneficiaries \$180 million in cost-sharing in one year.<sup>195</sup>

In November 2015, Congress included a provision in the Bipartisan Budget Act of 2015 to implement site-neutral Medicare payments for outpatient services (other than emergency department services) furnished at any new, off-campus hospital outpatient departments.<sup>196</sup> As of January 1, 2017, outpatient services provided at new, off-campus hospital outpatient departments will be reimbursed at the same, lower rates as freestanding physicians’ offices.<sup>197</sup> This site-neutral payment policy exempts: (1) grandfathered off-campus hospital outpatient departments that were billing as such prior to November 2, 2015,<sup>198</sup> (2) emergency services performed by hospital outpatient departments,<sup>199</sup> and (3) on-campus hospital outpatient departments that are located in or within 250 yards of a hospital or a remote location of the hospital.<sup>200</sup> The Congressional Budget Office estimated that the Medicare site-neutral payment policy in the Bipartisan Budget Act of 2015 will save \$9.3 billion over ten years.<sup>201</sup>

Supporters of site-neutral payment in Medicare included President Obama,<sup>202</sup> the Government Accountability Office (GAO),<sup>203</sup> congressional leaders from both parties,<sup>204</sup> and a coalition representing primary care

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194. MEDPAC 2014 REPORT TO CONGRESS, *supra* note 168, at 75. MedPAC further explained, “We believe that if patient severity is similar and a service can be provided in a lower cost setting without a reduction in quality or safety, Medicare should pay a rate based on the cost of the more efficient setting. If Medicare paid a higher rate to the less efficient setting, services would shift to being billed by the higher cost site of care, the cost of care could increase, and beneficiary costs would increase without any evidence that care would improve.” *Id.* at 77.

195. *Id.* at 78.

196. Bipartisan Budget Act of 2015, 42 U.S.C. § 1395l(t)(21) (2012).

197. *Id.* § 1395l(t)(1)(b)(v).

198. *Id.* § 1395l(t)(21)(B)(ii).

199. *Id.* § 1395l(t)(21)(A).

200. *Id.* § 1395l(t)(21)(B)(i); 42 C.F.R. § 413.65(a)(2) (2017).

201. CONG. BUDGET OFFICE, ESTIMATE OF THE BUDGETARY IMPACT OF H.R. 1314, THE BIPARTISAN BUDGET ACT OF 2015, AS REPORTED BY THE HOUSE COMMITTEE ON RULES ON OCTOBER 27, 2015, <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr1314.pdf>.

202. OFFICE OF MGMT. & BUDGET, FISCAL YEAR 2016 BUDGET OF THE U.S. GOVERNMENT (2016).

203. U.S. GOV’T ACCOUNTABILITY OFFICE, MEDICARE: INCREASING HOSPITAL-PHYSICIAN CONSOLIDATION HIGHLIGHTS NEED FOR PAYMENT REFORM (2015).

204. See Virgil Dickson, *Congress Wants CMR to be Flexible in Final Site-Neutral Payment Rule*, MOD. HEALTHCARE (Oct. 6, 2016), <http://www.modernhealthcare.com/article/20161006/NEWS/161009938>.

physicians, private health insurance carriers, and consumers.<sup>205</sup> The GAO studied the issue and recommended Congress implement site-neutral payments in Medicare, concluding that Medicare is overpaying for services due to the site-of-service differential, which is inconsistent with its role as an “efficient purchaser of health care services.”<sup>206</sup> The American Hospital Association, however, opposes site-neutral payment, which it says significantly affects hospitals’ future plans to form new hospital outpatient departments.<sup>207</sup> Hospitals stand to lose the additional revenue generated by facility fees for services provided by acquired physician practices.

Site-neutral payment in Medicare marks a significant step toward eliminating unwarranted payment differentials driving excess Medicare spending, but there remain limits on the extent to which it will prevent consumers from receiving bills for unwarranted facility fees. First, as noted above, the Balanced Budget Act’s site neutral payment policy does not apply to grandfathered hospital outpatient departments already in existence as of November 2015.<sup>208</sup> Second, House leaders are still studying how broadly to interpret the site-neutral payment reforms.<sup>209</sup> Third, Medicare payment reforms may not be translated into changes for privately insured patients absent bargaining power from health plans to demand site-neutral payment from powerful health care provider systems or changes to state law.<sup>210</sup>

At the state-level, Connecticut has passed a law prohibiting hospitals from collecting a facility fee for outpatient office visits at an off-campus,

205. See Letter from Alliance for Site Neutral Payment Reform to Senate Leadership (Jan. 16, 2015), [https://www.acponline.org/system/files/documents/advocacy/where\\_we\\_stand/assets/alliance\\_site\\_neutral\\_payment\\_reform\\_senate\\_2015.pdf](https://www.acponline.org/system/files/documents/advocacy/where_we_stand/assets/alliance_site_neutral_payment_reform_senate_2015.pdf) (advocating for site-neutral payment reform on behalf of the American College of Physicians, the Academy of Family Physicians, America’s Health Insurance Plans, and Blue Cross and Blue Shield Association, among others).

206. U.S. GOV’T ACCOUNTABILITY OFFICE, *supra* note 203, at 16.

207. Letter from Am. Hosp. Ass’n to Reps. Upton and Pitts (Feb. 12, 2016), [https://www.google.com/url?sa=t&rc=j&q=&esrc=s&source=web&cd=2&ved=0ahUKEwi02cuD9tzNAhVLVD4KHWZDLUQFgg1MAE&url=http%3A%2F%2Fwww.aha.org%2Fadvocacy-issues%2Fletter%2F2016%2F160212-let-sn.docx&usg=AFQjCNGD9GROqtD\\_5QTg20ek-iy46Fom-A&sig2=CT7eJLNfujWfJiY1FMSXAg](https://www.google.com/url?sa=t&rc=j&q=&esrc=s&source=web&cd=2&ved=0ahUKEwi02cuD9tzNAhVLVD4KHWZDLUQFgg1MAE&url=http%3A%2F%2Fwww.aha.org%2Fadvocacy-issues%2Fletter%2F2016%2F160212-let-sn.docx&usg=AFQjCNGD9GROqtD_5QTg20ek-iy46Fom-A&sig2=CT7eJLNfujWfJiY1FMSXAg).

208. See *supra* note 192–97 and accompanying text.

209. Letter from Fred Upton, Chairman, and Frank Pallone, Jr., Ranking Member, House Comm. on Energy & Commerce, to Member of the Health Care Community (Feb. 5, 2016), <https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/114/Letters/20160205SiteNeutralLetter%5B1%5D.pdf>.

210. See, e.g., John Carroll, *Medicare Coverage Rules Are Not Always Last Word*, MANAGED CARE (Oct. 2007), <https://www.managedcaremag.com/archives/2007/10/medicare-coverage-rules-are-not-always-last-word>.

hospital-based facility.<sup>211</sup> Although Connecticut's facility fee ban only applies to "evaluation and management" codes used for office visits, not the full range of outpatient services covered by Medicare's policy, Connecticut provides patients with more transparency and notice of facility fees for other types of outpatient services.<sup>212</sup> For uninsured patients, providers may not charge more than the applicable Medicare rate for outpatient services received at an off-campus, hospital based facility, thereby incorporating any Medicare site-neutral payment changes into the amounts charged to uninsured patients.<sup>213</sup> Connecticut also prohibits health plans from imposing a co-payment for a facility fee for outpatient office visits at an off-campus site of a hospital.<sup>214</sup> Significantly for consumers, the Connecticut law makes a provider's violation of these facility fee requirements an unfair trade practice, giving consumers a private remedy against providers in the event of noncompliance.<sup>215</sup> In addition, it is an unfair trade practice for a provider in Connecticut to report a patient's nonpayment of a prohibited surprise bill or facility fee to a credit reporting agency.<sup>216</sup>

### 3. *Gaps in Policies Addressing Opaque Prices and Facility Fees*

Even among states with the most robust price transparency requirements, none of the requirements rectify the fact that most health care is non-shoppable, that price estimates are non-binding, that quality is difficult to assess, and that consumers may lack choices of providers. Nor do the existing legal protections address the morass of confusion stemming from the complex interplay of multiple bills from multiple

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211. CONN. GEN. STAT. § 19a-508c(k) (Westlaw through May 16, 2017) ("Notwithstanding the provisions of this section, on and after January 1, 2017, no hospital, health system or hospital-based facility shall collect a facility fee for (1) outpatient health care services that use a current procedural terminology evaluation and management code and are provided at a hospital-based facility, other than a hospital emergency department, located off-site from a hospital campus, or (2) outpatient health care services, other than those provided in an emergency department located off-site from a hospital campus, received by a patient who is uninsured of more than the Medicare rate . . . . A violation of this subsection shall be considered an unfair trade practice pursuant to chapter 735a.").

212. *Id.* § 19a-508c(b)-(c), requiring hospitals to notify patients of facility fees, including an estimate of the amount of the fee, explanations on patient bills about facility fees. In addition, health facilities engaged in a transaction that will establish a hospital-based facility, such as the acquisition of a physician practice, must notify all patients served in the past three years about the transaction, likely resulting in added facility fees. *Id.* § 19a-508c(j).

213. *Id.* § 19a-508c(k).

214. *Id.* § 19a-508c(b).

215. *Id.* § 19a-508c(k).

216. *Id.* § 20-7f.



providers (à la carte billing), facility fees, and the complicating element of insurance with its attendant in-network/out-of-network/cost-sharing calculations. Patients need a unified, understandable, itemized bill that clearly states how much they owe, and they need to be able to rely upon reasonable price quotes among meaningful choices provided in advance of receiving the care. But because patients are not typically in a position to exercise consumer-type shopping or negotiation (whether due to medical duress, lack of choices, or complexity), patients need more than disclosure of prices or added facility fees—they need regulatory protection from extreme price variation or added facility fees.

### *C. Medical Debt Collection and Reporting*

Medical debts are widespread. The CFPB reported that 52% of all debts on credit reports were medical debts, by far the most common type of debt.<sup>217</sup> Medical debts are also different than other types of debt—consumers are often unaware of their medical debts or they are struggling to get the bills resolved with the providers and payer.<sup>218</sup>

The problem of confusing and unanticipated medical bills is exacerbated for consumers when unpaid medical bills are sold to debt collectors and reported to credit reporting agencies. When a patient fails to pay a medical bill, the providers often sell the debt to collectors within 90-120 days,<sup>219</sup> even if the reason the patient has not paid is because he is unaware of the bill or is in the process of disputing billing errors or verifying how much he owes.<sup>220</sup> This happened to Gene Cavallo, who was negotiating with the hospital over a \$110,000 surgery bill, when the hospital sold his unpaid bill to a collection agency, which damaged his credit and negatively affected his business.<sup>221</sup> In a 2014 survey, of adults aged nineteen to sixty-four who reported having trouble with medical bills or debt, 41% (or approximately fourteen million people) reported lower

217. CONSUMER FIN. PROT. BUREAU, CONSUMER CREDIT REPORTS: A STUDY OF MEDICAL AND NON-MEDICAL COLLECTIONS 4 (2014).

218. CONSUMER FIN. PROT. BUREAU, DATA POINT: MEDICAL DEBT & CREDIT SCORES 3 (2014).

219. *Self Pay Account Referrals*, THE RECEIVABLES REPORT FOR AMERICA'S HEALTH CARE FINANCIAL MANAGERS, Nov. 2013, at 11 (reporting that in 2013, 48% of hospitals turned over self-pay accounts to collection agencies between 91–120 days, and 40% of hospitals did so between 121–180 days).

220. Elisabeth Rosenthal, *When Health Costs Harm Your Credit*, N.Y. TIMES, Mar. 8, 2014, available at <https://www.nytimes.com/2014/03/09/sunday-review/when-health-costs-harm-your-credit.html>.

221. *Id.*

credit ratings as a result.<sup>222</sup> Lower credit scores have a tangible impact on an individual's financial well-being, affecting the ability to secure a mortgage or subjecting a person to higher interest rates for consumer credit.<sup>223</sup>

Beyond reporting debts to credit rating agencies, health care providers and their debt collectors may also pursue a range of extraordinary collection actions to recover the debts, including lawsuits to garnish a patient's wages or to foreclose upon or place a lien on the patient's home.<sup>224</sup> A 2015 study of nonprofit, tax-exempt hospitals reported that as recently as 2012, 20% of these hospitals were using extraordinary collection actions against patients.<sup>225</sup> Media accounts suggest that the use of debt collection tactics varies by hospital and by the collection agency to which the provider sells the debt.<sup>226</sup> A single hospital could be responsible for hundreds or even thousands of lawsuits against patients for unpaid medical bills.<sup>227</sup>

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222. SARA R. COLLINS ET AL., COMMONWEALTH FUND, TOO HIGH A PRICE: OUT-OF-POCKET HEALTH CARE COSTS IN THE UNITED STATES exhibit 5 (Nov. 13, 2014), <http://www.commonwealthfund.org/publications/issue-briefs/2014/nov/out-of-pocket-health-care-costs>.

223. Press Release, Consumer Fin. Prot. Bureau, CFPB Study Finds Medical Debt Overly Penalizes Consumer Credit Scores (May 20, 2014), <https://www.consumerfinance.gov/about-us/newsroom/cfpb-study-finds-medical-debt-overly-penalizes-consumer-credit-scores/>.

224. Other extraordinary collection actions include requiring up-front payment before providing additional care and even seeking arrest for failing to appear in court for a debt collection hearing. 26 C.F.R. § 1.501(r)-6(b)(2017) (defining what constitutes "extraordinary collection actions" by tax-exempt hospitals). See also Erin C. Fuse Brown, *Fair Hospital Prices Are Not Charity: Decoupling Hospital Pricing and Collection Rules from Tax Status*, 53 U. LOUISVILLE L. REV. 509, 519 (2016).

225. Sayeh S. Nikpay & John Z. Ayanian, *Hospital Charity Care—Effects of New Community-Benefit Requirements*, 373 N. ENGL. J. MED. 1687, 1689 (2015).

226. Chris Arnold & Paul Kiel, *When Nonprofit Hospitals Sue Their Poorest Patients*, NPR (Dec. 19, 2014) (reporting that in Missouri, Heartland hospital filed 2200 debt-collection lawsuits against patients in 2013, while BJC Healthcare filed only twenty-six); Thomas Gounley, *From Patient to Defendant: One of Springfield's Two Health Systems Sues Far More Over Debt*, SPRINGFIELD NEWS-LEADER (April 2, 2015), <http://www.news-leader.com/story/news/local/ozarks/2015/04/02/patient-defendant-one-springfields-two-health-systems-sues-far-debt/70830566/> (reporting that of the 750 medical debt collection suits against patients filed in Greene County, Missouri in 2013, 701 were by Cox Health or its debt collector, while forty were filed by Mercy or its collector).

227. Ames Alexander & David Raynor, *Charlotte Hospital System Sues Thousands of Patients*, CHARLOTTE OBSERVER (Apr. 24, 2012, 12:00 AM), <http://www.newsobserver.com/news/special-reports/prognosis-profits/article16924670.html> (reporting that North Carolina hospitals had filed 40,000 debt collection suits against patients over the prior five-year period, with 12,000 of these suits filed by Carolinas HealthCare System). Due to the unfavorable press coverage as well as increased compliance with the legal reforms, some of the hospitals identified in high-profile news stories have curtailed their debt collection lawsuit activities. See Ames Alexander & David Raynor, *Hospitals Curb Patient Lawsuits*, CHARLOTTE OBSERVER (Feb. 21, 2015, 1:52 PM), <http://www.charlotteobserver.com/news/local/article10885310.html>; Chris Arnold & Paul Kiel, *Nonprofit Hospital*

This section evaluates three types of legal reforms aimed at protecting patients from the financial ramifications of medical debt collection and reporting: (1) the IRS rules for tax-exempt hospitals, (2) state medical debt collection laws, and (3) reforms led by the federal CFPB on how medical debt is treated in consumer credit reports.

### 1. *IRS Rules for Tax-Exempt Hospitals*

The ACA set forth financial protections for patients who receive care at federally tax-exempt hospitals, implemented by the IRS.<sup>228</sup> Among other provisions, these requirements prescribe financial assistance as well as fair billing and collection requirements for federally tax-exempt hospitals.

First, such hospitals must maintain and widely publicize a written financial assistance policy that sets forth eligibility criteria for free or discounted care as well as how charges to patients are calculated.<sup>229</sup> The IRS rules, however, do not prescribe how hospitals must determine eligibility for financial assistance, leaving these determinations to the hospitals' discretion.<sup>230</sup>

Second, hospitals must limit the amounts charged to patients who are eligible for financial assistance to "amounts generally billed" (AGB) to insured patients for emergency or medically necessary care.<sup>231</sup> Hospitals may not charge such patients "gross charges," which are the hospitals' full, undiscounted rates.<sup>232</sup>

Third, the IRS rules limit nonprofit hospitals' ability to engage in aggressive debt-collection practices to recover unpaid bills from

*Forgives Debts and Stops Suing So Many Poor Patients*, NPR (June 2, 2016, 8:00 AM), <http://www.npr.org/2016/06/02/480192982/nonprofit-hospital-forgives-debts-and-stops-suing-so-many-poor-patients>.

228. 26 U.S.C. § 501(r). These requirements were not altered by the Republican bill to repeal and replace the ACA, which was proposed in March 2017. *See* American Health Care Act, H.R. 1628, 115th Cong. (2017).

229. 26 U.S.C. § 501(r)(4) (2012); 26 C.F.R. § 1.501(r)-4(b)(5) (2017).

230. *See* Fuse Brown, *supra* note 224, at 529–30.

231. 26 U.S.C. § 501(r)(5) (2012); 26 C.F.R. § 1.501(r)-5(b) (2017). There are three alternate methods of calculating AGB. First, AGB can be calculated as the amount that would be paid by Medicare, including Medicare beneficiary co-insurance. Second, AGB can be calculated by taking into account the amounts that are paid by both Medicare and private insurers. Third, AGB can be based on the amounts paid by Medicaid, either alone or in combination with the rates paid by Medicare and private insurers. *Id.* § 1.501(r)-5(b)(3)(ii).

232. 26 C.F.R. § 1.501(r)-1(16) (2017) (defining "gross charges" as the chargemaster rate, a hospital facility's full, established price for medical care that the hospital facility consistently and uniformly charges patients before applying any contractual allowances, discounts, or deductions).

patients.<sup>233</sup> Hospitals may not use “extraordinary collection actions” unless the hospital has made reasonable efforts to determine whether the patient is eligible for financial assistance.<sup>234</sup> “Extraordinary collection actions” include: placing a lien on an individual’s property, foreclosing on an individual’s real property, attaching or seizing an individual’s bank account or any other personal property, commencing a civil action against an individual; causing an individual’s arrest, causing an individual to be subject to a writ of body attachment; garnishing an individual’s wages, reporting an individual to a credit agency, selling an individual’s debt to another party, or requiring payment of a prior debt before providing medically necessary care.<sup>235</sup> To have made “reasonable efforts,” a hospital must determine whether an individual is eligible for financial assistance or provide notice about the availability of financial assistance within 120 days after the date of the first bill.<sup>236</sup> Notably, these rules do not prohibit hospitals from using extraordinary collection actions after determining eligibility for financial assistance or making the required notification.

The IRS rules for tax-exempt hospitals create important financial protections, particularly for low-income patients, by reducing the amount of their hospital bills and limiting the use of collection tactics to recover unpaid bills. There are, however, significant limits to the rules’ protections. The rules do not cover for-profit or government-run hospitals, which make up about 40% of all hospitals.<sup>237</sup> In addition, the rules leave a lot to the hospital’s discretion, particularly eligibility for financial assistance from which all the other protections flow.<sup>238</sup> Finally, the rules do not apply to physician practices or other types of providers that tend to be for-profit, so the rules do not prevent surprise billing or aggressive debt collection practices by these providers.<sup>239</sup>

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233. 26 U.S.C. § 501(r)(6) (2012); 26 C.F.R. § 1.501(r)-6(a) (2017).

234. 26 U.S.C. § 501(r)(6) (2012); 26 C.F.R. § 1.501(r)-6(a) (2017).

235. 26 C.F.R. § 1.501(r)-6(b)(1) (2017).

236. *Id.* § 1.501(r)-6(c). The final rules clarify that the 120-day clock starts on the date of the first bill post-discharge. In addition, the rules require the hospital to process any financial assistance application submitted within 240 days after the post-discharge bill. Additional Requirements for Charitable Hospitals, 79 Fed. Reg. 78,954, 78,986–87 (Internal Revenue Serv. Dec. 31, 2014).

237. *Hospitals by Ownership Type*, KAISER FAM. FOUND., <http://kff.org/other/state-indicator/hospitals-by-ownership/> (setting forth data for 2015 and before).

238. Erin C. Fuse Brown, *IRS Rules Will Not Stop Unfair Hospital Billing and Collection Practices*, 17 AMA J. ETHICS 763, 764 (2015).

239. See, e.g., Samantha Liss, *When a Nonprofit Health System Outsources its ER, Debt Collectors Follow*, ST. LOUIS POST-DISPATCH, Apr. 17, 2016, available at [http://www.stltoday.com/business/local/when-a-nonprofit-health-system-outsources-its-er-debt-collectors/article\\_826b26bf-0c85-5ae4-9af1-a1f9f9591539.html](http://www.stltoday.com/business/local/when-a-nonprofit-health-system-outsources-its-er-debt-collectors/article_826b26bf-0c85-5ae4-9af1-a1f9f9591539.html) (reporting over 1000 lawsuits filed by debt collector for a for-profit contractor operating at a nonprofit hospital’s ER).

## 2. State Medical Debt Collection Laws

In addition to the federal limits on medical debt collection by tax-exempt hospitals, several states have enacted limits on medical debt collection, many of which apply to both for-profit and nonprofit hospitals. At least sixteen states<sup>240</sup> have laws that restrict hospital debt collection practices, including: limitations on interest rates hospitals may charge on medical debt,<sup>241</sup> limits on hospitals' ability to foreclose or place a lien on a patient's home or other property,<sup>242</sup> limits on wage garnishment,<sup>243</sup> obligations to offer payment plans,<sup>244</sup> and requirements for the timing and

240. These states include California, Connecticut, Colorado, Illinois, Kansas, Louisiana, Massachusetts, Maryland, New Jersey, New York, Nevada, North Carolina, North Dakota, Ohio, Rhode Island, and Washington. See *Hospital Community Benefit Program: Community Benefit State Law Profiles Comparison*, HILLTOP INSTITUTE, [http://www.hilltopinstitute.org/HCBP\\_CBL\\_state\\_table.cfm](http://www.hilltopinstitute.org/HCBP_CBL_state_table.cfm) (last visited Sept. 30, 2016).

241. CAL. HEALTH & SAFETY CODE § 127425(g) (West 2012) (requiring hospitals' extended payment plans to be interest free); MD. CODE ANN. HEALTH-GEN. §19-214-1(b) (West 2017); MD. CODE REGS. 10.37.10.26A-2(2)(a) (2017) (prohibiting interest for self-pay patients absent court order); N.D. CENT. CODE § 13-01-14.1 (2017) (limiting interest rates to 1% per month, finance charges to twenty-five dollars per month). See Fuse Brown, *supra* note 224, at 546 n.192.

242. CAL. HEALTH & SAFETY CODE § 127425(f) (WEST 2012) (prohibiting liens upon or sale of patient's primary residence where patient is eligible for discounted or charity care); LA. STAT. ANN. § 20:1(A)(2) (2009) (exempting a patient's homestead from seizure and sale for debts due to "catastrophic or terminal illness or injury"); MD. CODE ANN. HEALTH-GEN. § 19-214.2 (West 2017); MD. CODE REGS. 10.37.10.26 (2017) (prohibiting hospitals from forcing the sale or foreclosure of patient's primary residence, but permitting liens on such residence); 114.6 MASS. CODE REGS. 12.08(1)(b) (2017) (prohibiting legal execution against patient's residence or motor vehicle without approval of hospital Board of Trustees); NEV. REV. STAT. § 21.095 (2017) (prohibiting legal execution of debtor's primary residence for medical debt while occupied); N.Y. PUB. HEALTH LAW §2807-k(9-a)(h) (2017) (prohibiting forced sale or foreclosure of a patient's primary residence to collect an outstanding medical debt if patient is eligible for financial aid); N.C. GEN. STAT. §131E-91(d)(5)-(6) (2013) (prohibiting liens upon or forced sale of the principal residence of the patient-debtor, or the custodial parent of a minor patient); OHIO REV. CODE ANN. § 2329.66(A)(1)(a) (West 2017) (exempting a person's residence from execution, garnishment, attachment, or sale to satisfy a medical debt until the property is sold or transferred); 31-4-9 R.I. CODE R. § 11.0 (allowing hospitals to attach but not foreclose upon a patient's primary residence for non-payment of debts). See Fuse Brown, *supra* note 224, at 546 n.193.

243. CAL. HEALTH & SAFETY CODE § 127425(f) (WEST 2012) (prohibiting wage garnishment by hospitals and collection agencies, except by court order); KAN. STAT. ANN. § 60-2310(c) (West 2017) (prohibiting wage garnishment until two months after recovery from an illness that prevented work for more than two weeks and limiting the amount of wages that can be garnished). See Fuse Brown, *supra* note 224, at 546 n.194.

244. CAL. HEALTH & SAFETY CODE § 127425(e) (WEST 2012) (prohibiting sending unpaid bills to collection agency while a patient is negotiating a payment plan or making regular payments of a reasonable amount, unless assignee agrees to comply with all fair collections requirements); COLO. REV. STAT. § 25-3-112(4)(a) (2013) (requiring hospitals to offer a reasonable payment plan before seeking collection); 210 ILL. COMP. STAT. 88/30 (2013) (requiring hospitals to offer a payment plan

procedure for assigning medical debt to a collection agency.<sup>245</sup> The scope of these limits on collection practices varies, with some states applying them broadly, and others limiting the protections by the patient's income or uninsured status.

### 3. CFPB Activity on Medical Debts

Additional federal oversight over the collection and reporting of medical debt comes from CFPB, an independent federal agency created by the Dodd-Frank Wall Street and Consumer Protection Act in 2010 (Dodd-Frank).<sup>246</sup> CFPB has statutory authority to regulate unfair, deceptive, or abusive acts or practices of any person or their affiliate who offers a "consumer financial product or service."<sup>247</sup> Additionally, Dodd-Frank authorizes CFPB to issue implementing rules and enforce a variety of federal financial protection statutes, including, among others, the Fair

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before pursuing collection); MD. CODE REGS. 10.37.10.26(A-2)(2)(a) (West 2017) (requiring hospitals to offer a payment plan to uninsured patients with incomes from 200–500% of the federal poverty level (FPL)); N.Y. PUB. HEALTH LAW §2807-k(9-a) (d) (2017) (requiring hospitals to offer monthly installment plans, where payments may not exceed 10% of patient's gross monthly income).

245. CAL. HEALTH & SAFETY CODE § 127425(d) (West 2012) (prohibiting hospitals or collection agencies from reporting to credit agencies or commencing civil action until after 150 days after initial bill); COLO. REV. STAT. § 25-3-112(4) (2013) (allowing a thirty-day grace period after due date for first scheduled payment before initiating collection); CONN. GEN. STAT. §§ 19a-673, 19a-673b (2013) (prohibiting collections until hospital determines that the patient's income exceeds 250% of FPL and patient is not eligible for Medicare or Medicaid); 210 ILL. COMP. STAT. 88/30, 88/35 (2013) (permitting hospital to seek collection against an uninsured patient only after allowing the patient to assess the accuracy of bill, apply for financial assistance, and avail themselves of payment plan, and prohibiting collection against uninsured patients who demonstrate they lack financial means to pay); MD. CODE ANN. HEALTH-GEN. § 19-214.2 (2017) (prohibiting sale of debt by hospitals); N.J. ADMIN. CODE §10:52-11.14 (2014) (prohibiting hospitals from billing or initiating collection procedures against persons determined to be eligible for charity care or reduced charge charity care); N.C. GEN. STAT. §131E-91(d) (2013) (prohibiting hospitals and ambulatory surgical facilities from referring unpaid bills to collections agency while patient is applying for financial assistance and requiring thirty days' prior written notice before referral for collection); WASH. REV. CODE §70.170.060(6) (1998); WASH. ADMIN. CODE 246-453-020(1) (1991) (prohibiting collection until hospital determines whether the patient has insurance or is eligible for free or discounted care). *See* Fuse Brown, *supra* note 224, at 547 n.195.

246. Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010, Pub. L. No. 111–203, tit.X (codified at 12 U.S.C. § 5301).

247. Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010, Pub. L. No. 111–203, §1002(5); 12 U.S.C. § 5481(5) (2012) ("Consumer financial products or service[s]" are defined to include financial products or services that are offered or provided for use by consumers primarily for personal, family, or household purposes. It is also defined to include certain financial products or services that are delivered, offered, or provided in connection with a consumer financial product—specifically, those related to extending credit and loan servicing, real estate settlement services, consumer reporting, and debt collection.).

Debt Collection Practices Act (FDCPA) and the Fair Credit Reporting Act (FCRA).<sup>248</sup> The Trump administration has been critical of Dodd-Frank and has pledged to work with Republicans in Congress to repeal the law, including those provisions that provide authority to CFPB.<sup>249</sup>

CFPB's regulatory authority over medical debt remains somewhat ambiguous. Medical debt may not constitute a "consumer financial product or service" under Dodd-Frank unless it arises from the extension of credit, such as a deferred payment plan.<sup>250</sup> This means that Dodd-Frank's restrictions on unfair or abusive financial practices may not cover health care providers who bill a patient for unpaid fees for the providers' own services if they have not granted the patient a right to defer payment. Until the passage of Dodd-Frank in 2010, the FDCPA did not cover first-party collectors (i.e., the creditor seeking payment of a debt for itself), but Dodd-Frank amended FDCPA to authorize CFPB to regulate first-party collectors in addition to third-party collectors.<sup>251</sup>

In a 2013 Advanced Notice of Proposed Rulemaking, CFPB requested information and comments on whether and how it should regulate first-party collectors and how it should treat medical debts.<sup>252</sup> CFPB has not issued final rules on whether and to what extent it will regulate medical billing and debt collection by providers as first-party collectors. CFPB asserted its authority to enforce the FDCPA against the debt collection agencies and credit reporting agencies that collect and report on medical debts on behalf of the provider—the third-party collectors.<sup>253</sup> In other

248. Fair Debt Collection Practices Act § 814(d) (codified at 15 U.S.C. § 1692l(d), as amended by Dodd-Frank Act § 1089).

249. See, e.g., Marilyn Geewax, *Trump Team Promises to 'Dismantle' Dodd-Frank Bank Regulations*, NPR (Nov. 10, 2016, 4:48 PM), <http://www.npr.org/sections/thetwo-way/2016/11/10/501610842/trump-team-promises-to-dismantle-dodd-frank-bank-regulations>.

250. Defining Larger Participants of the Consumer Debt Collection Market, 77 Fed. Reg. 65775, 65779 (Consumer Fin. Prot. Bureau Oct. 31, 2012).

251. Debt Collection, 78 Fed. Reg. 67848, 67853 (Consumer Fin. Prot. Bureau proposed Nov. 12, 2013) ("[T]he Bureau believes it is important to examine whether rules covering the conduct of creditors collecting in their own names on their own debts that arise out of consumer credit transactions are warranted. As discussed above, Congress excluded such creditors from the FDCPA in 1977, but it gave the Bureau authority under the Dodd-Frank Act in 2010 to prescribe rules applicable to creditors.").

252. 78 Fed. Reg. at 67854.

253. *Id.* CFPB stated:

Some debt collection that is subject to the FDCPA may not be subject to the Dodd-Frank Act's prohibition against unfair, deceptive, or abusive acts or practices and thus could be addressed in a proposed FDCPA rule but not a proposed Dodd-Frank Act rule. For example, in its Larger Participant Rule, the Bureau noted that some medical debt (i.e. that which did not arise from an extension of credit within the meaning of the Dodd-Frank Act), might not

words, once the medical debt is in the hands of the third-party debt collector, it enters CFPB's supervisory scope.

Despite ambiguity about the extent of CFPB's authority over first-party medical billing and collection efforts by providers, CFPB has been quite active in the areas of medical debt collection by third-party collectors. In June 2015, CFPB entered a consent order against Syndicated Office Systems, LLC, a medical collection firm, for violations of the FDCPA and FCRA.<sup>254</sup> Syndicated is an indirect subsidiary of Conifer Health Solutions, LLC, a health care billing services company owned by for-profit hospital giant, Tenet Healthcare Corporation.<sup>255</sup> Syndicated allegedly violated the FCRA by failing to respond to over 13,000 consumer credit reporting disputes and allegedly violated the FDCPA by failing to send required debt validation notices to over 10,000 consumers while it pursued collections from these consumers.<sup>256</sup> CFPB ordered the company to pay \$5.4 million in relief to affected consumers, rectify its collection and reporting practices, and to pay a \$500,000 penalty.<sup>257</sup> The order against Syndicated was the first enforcement action that the CFPB has taken against a medical debt collector under its authority to enforce the FDCPA and FCRA and confirms CFPB's assertion of authority over medical debt collection agencies.

In addition, CFPB has taken steps to address the treatment of medical debt on consumer credit reports. CFPB published two reports in 2014 detailing the results from its study of the treatment of medical debt on credit reports.<sup>258</sup> The 2014 reports highlighted several findings: medical

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involve a consumer financial product or service. *Id.*

*See* Defining Larger Participants of the Consumer Debt Collection Model, 77 Fed. Reg. at 65780 (“[I]n supervising a larger participant of the consumer debt collection market, the Bureau will examine the entity’s collection of medical debt along with other activities subject to the FDCPA and other Federal consumer financial law.”) In an accompanying footnote, CFPB noted it “has the authority to examine an entity’s compliance with Federal consumer financial law, beyond the activities that rendered the entity subject to supervision.” *Id.* at 65,780 n.47.

254. Consent Order, *In re* Syndicated Office Sys., LLC, File No. 2015-CFPB-0012 (Jun. 18, 2015), [http://files.consumerfinance.gov/f/201506\\_cfpb\\_order-syndicated.pdf](http://files.consumerfinance.gov/f/201506_cfpb_order-syndicated.pdf).

255. Press Release, Consumer Fin. Prot. Bureau, CFPB Takes Action Against Medical Debt Collector (June 18, 2015), <https://www.consumerfinance.gov/about-us/newsroom/cfpb-takes-action-against-medical-debt-collector/>.

256. *See* Consent Order, *In re* Syndicated Office Sys., LLC, File No.-2015-CFPB-0012, at 5–6.

257. *See* Press Release, Consumer Fin. Prot. Bureau, CFPB Takes Action Against Medical Debt Collector (June 18, 2015), <https://www.consumerfinance.gov/about-us/newsroom/cfpb-takes-action-against-medical-debt-collector/>.

258. KENNETH P. BREVOORT & MICHELLE KAMBARA, CONSUMER FIN. PROT. BUREAU, DATA POINT: MEDICAL DEBT & CREDIT SCORES (2014) [hereinafter CFPB MAY 2014 REPORT], <https://www.consumerfinance.gov/data-research/research-reports/data-point-medical-debt-and-credit-scores/>; CONSUMER FIN. PROT. BUREAU, CONSUMER CREDIT REPORTS: A STUDY OF MEDICAL AND



debt was the most common type of debt appearing on credit reports, making up over half of all collections on consumer credit reports,<sup>259</sup> medical debt is different than other types of debt in that consumers are often unaware of the debt or are in the process of disputing or verifying the amount they owe when the debts are reported;<sup>260</sup> and as a result, medical debts tend to be overly penalized in the calculation of credit scores by underestimating the creditworthiness of those consumers with medical debts as compared with other debts.<sup>261</sup>

Although the CFPB did not promulgate regulations on the issue, its 2014 reports paved the way to two important industry changes for the treatment of medical debt on consumer credit reports. The first was a voluntary move by FICO in 2014 to weigh medical debts less than nonmedical debts in calculating an individual's credit score and to disregard all paid medical collection accounts.<sup>262</sup> The second industry change stems from a 2015 settlement agreement between the three major credit reporting agencies with New York Attorney General Eric Schneiderman, effectuating nationwide changes in credit reporting practices.<sup>263</sup> Specifically, the credit reporting agencies agreed to refrain from reporting medical debts on credit reports until 180 days delinquent, in order to allow for insurance payment, resolutions of disputes, and determinations by the consumer of how much he owes.<sup>264</sup> Second, credit reporting agencies agreed to remove from credit reports all debts that were paid in full or are being paid by insurance.<sup>265</sup> The medical debt provisions of the settlement must be fully implemented by June 6, 2018,<sup>266</sup> and are

NON-MEDICAL COLLECTIONS (2014) [hereinafter CFPB DEC. 2014 REPORT], <https://www.consumerfinance.gov/data-research/research-reports/consumer-credit-reports-a-study-of-medical-and-non-medical-collections/>.

259. CFPB DEC. 2014 REPORT, *supra* note 258, at 19, 21 (noting that 52% of all collection "tradelines" on credit reports were medical debts and appeared on 19% of all consumers' credit reports).

260. CFPB MAY 2014 REPORT, *supra* note 258, at 3; CFPB DEC. 2014 REPORT, *supra* note 258, at 36, 40–41.

261. CFPB MAY 2014 REPORT, *supra* note 258, at 5–6.

262. CFPB Dec. 2014 Report, *supra* note 258, at 52; Ethan Dornhelm, *The Impact of Medical Debt on FICO® Scores*, FICO BLOG (July 13, 2015), <http://www.fico.com/en/blogs/risk-compliance/impact-medical-debt-fico-scores/>.

263. Settlement Agreement, In re Investigation of Experian Info. Sols., et al., (Mar. 8, 2015), <https://ag.ny.gov/pdfs/CRA%20Agreement%20Fully%20Executed%203.8.15.pdf> (settlement agreement).

264. *Id.* at 13–14.

265. *Id.*

266. The settlement must be implemented by the "Completion Date," which is three years and ninety days from March 8, 2015, the date the settlement went into effect. *Id.* at 9, 11, exhibit A.

generally consistent with FICO's changes to its scoring methodology. The practical effect of the new practice of removing paid medical debts from credit reports, according to one estimate, is that consumers whose only reported debt was medical debt will see their FICO score (which ranges from 300-800) increase by twenty-five points.<sup>267</sup>

The upshot of CFPB's efforts to date, as augmented by the New York Attorney General and FICO, is a nationwide change to the ways medical debts can be reported to consumer credit agencies and factored into credit score calculations. Consumers will be protected from reductions in their credit ratings as a result of medical bills that have been paid or are being disputed or clarified with insurance providers, and standalone medical debts will not damage an individual's credit score to the same extent as before the changes. Moreover, consumers are more likely to know about medical debt reported to credit reporting agencies and more able to rectify errors on credit reports relating to medical debts.

#### *4. Gaps in Policies Addressing Medical Debt Collection*

The gaps in protections addressing medical debt collection and reporting practices stem from limits in their scope and applicability. First, the IRS rules only apply to tax-exempt hospitals, not for-profit hospitals, physicians, or other types of providers.<sup>268</sup> Second, some states fill this gap to a limited extent by imposing restrictions on medical debt collection by all hospitals or other types of providers regardless of tax status, but this is not the majority of states, nor do most state laws reach the debt collection or reporting activities of physicians.<sup>269</sup>

On credit reporting, however, there has been a national reform to credit scoring practices stemming from the CFPB's studies, voluntary action by FICO in adjusting the weight of medical debt in credit score calculations, and the New York Attorney General's settlement with the three major credit reporting firms.<sup>270</sup> These reforms provide consumers across the country with significant protection from unwarranted damage to credit scores from medical debts.

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267. Gregory Karp, *Credit Bureaus to Offer Relief to Consumers with Medical Debt*, CHI. TRIB. (Mar. 9, 2015, 1:42 PM), <http://www.chicagotribune.com/business/ct-credit-reports-0310-biz-20150309-story.html>.

268. See *supra* note 237 and accompanying text. See also Fuse Brown, *supra* note 224, at 527–29.

269. See *supra* notes 240–45 and accompanying text.

270. See *supra* notes 258–67 and accompanying text.

## II. CONSUMER FINANCIAL PROTECTION IN HEALTH CARE

Given the strengths and limitations of existing laws described in Part I, this Part sets forth a menu of model policies for consumer financial protection in health care. Many of these policies are modeled upon and extend beyond recent state legislation to protect health care consumers, including presumptively binding health care price estimates, regulatory caps on out-of-network rates, elimination of unwarranted facility fees for state and private payers, and private remedies under state unfair trade practice laws.

### *A. Model Policy to Address Surprise Medical Bills*

To address the problem of surprise medical bills, a model policy would build off the strengths of the state innovations in this area. Similar to several states with surprise billing provisions and the NAIC Model Act, any comprehensive measure should prohibit surprise billing for covered emergency services (whether in- or out-of-network) and medically necessary services at in-network facilities where the patient was not provided a meaningful option to receive care from an in-network provider.<sup>271</sup> The requirement of notice is built into the prohibition on surprise billing because a patient would only be obligated to pay additional cost-sharing or balance bill amounts if the patient affirmatively chooses the out-of-network provider over meaningful in-network options, and when the patient is fully informed of the financial ramifications of choosing a particular out-of-network provider. To be meaningful, the patient would have to be notified that they will be receiving care from an out-of-network provider far enough ahead of time (e.g., twenty-four hours or more) to allow the patient to request a different provider and be alerted to whether any in-network provider alternatives exist, and such advance notice would only be possible in non-emergencies. If choosing an in-network alternative would delay the patient's receipt of care by more than twenty-four hours, such alternative would not be considered meaningful. If there is an exception for out-of-network charges to which the patient has voluntarily consented, such consent should be accompanied by a

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271. See, e.g., CAL. HEALTH & SAFETY CODE § 1371.9; CAL. INS. CODE § 10112.8 (2016); CONN. GEN. STAT. 38a-477aa; N.Y. INS. LAW § 3241(c) (2014); N.Y. FIN. SERV. LAW § 6 (McKinney 2016); FLA. STAT. § 627.64194.

presumptively binding estimate of what the patient should expect to pay.<sup>272</sup>

Second, a model surprise billing law should solve the problem of how much a non-participating or out-of-network provider ought to be paid by payers for the service. Leaving it indeterminate (i.e., the provider's "usual, customary, and reasonable rates" or whatever rate upon which the health plan and provider may agree) invites expensive litigation.<sup>273</sup> Two options include legislating a rate cap, as California has done, calculated as a percentage of Medicare or benchmarked rates,<sup>274</sup> or using binding, independent dispute resolution mechanism, like New York's law.<sup>275</sup> Whether rate caps or dispute resolution are used to determine rates, the policy must strike a balance—if health plans have unilateral control to determine out-of-network prices, the measure will be politically and financially intolerable for providers, but if providers are allowed to bill full or close-to-full charges, the higher prices may perpetuate providers' incentives to remain out-of-network and raise the costs of care for health plans, which in turn drives up premiums for consumers.<sup>276</sup> Thus, California's approach of statutorily defining or capping out-of-network rates may be simpler to administer, but the legislature (or regulatory agency) must take care to define the maximum rates at a level that is neither too low for providers nor too high for plans.

Third, patients should have a private remedy against providers for violations of the surprise billing prohibitions. The model for this is Connecticut's law, which designates providers' violations of the surprise billing prohibition an unfair trade practice.<sup>277</sup> Although administrative enforcement may provide a significant deterrent to most surprise billing practices, a private remedy with punitive damages and attorneys' fees provides patients with direct recourse for violations of the requirements that may be too small to be enforced otherwise. For example, a surprise bill of \$1500 may be financially significant to a patient, but without punitive or treble damages and attorneys' fees, the figure is too small for a legal aid attorney to take on the patient's case and perhaps too insignificant for the state attorney general's office to pursue.

Fourth, all out-of-pocket payments for involuntary out-of-network bills

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272. For a description of the types of situations that could overcome the presumption that the written cost estimate is binding, *see infra* Part II.B.

273. *See* Lucas & Williams, *supra* note 51, at 138.

274. CAL. HEALTH & SAFETY CODE § 1371.31; Cal. Ins. Code § 10112.82 (capping out-of-network rates at the greater of 125% of Medicare or the average in-network price paid by the plan for the service).

275. N.Y. FIN. SERV. LAW §§ 605, 607 (McKinney 2016).

276. HALL ET AL., *supra* note 25, at 20.

277. CONN. GEN. STAT. § 20-7f.

should count toward a patient's out-of-pocket limit and in-network deductible. Even if surprise balance-billing is prohibited and cost-sharing amounts are equivalent to in-network rates, patients will end up paying more for involuntary out-of-network cost-sharing if those amounts do not count toward the annual out-of-pocket limit or are credited against a higher out-of-network deductible rather than an in-network deductible. An example is California's law, which requires all cost-sharing for out-of-network providers in an emergency or at in-network facilities to be treated for all purposes as in-network cost-sharing.<sup>278</sup>

Finally, the provider should be prohibited from reporting or initiating collection on unpaid bills that exceed the patient's in-network cost-sharing amount.<sup>279</sup> To the extent that a patient erroneously receives a surprise medical bill, the patient should be assured that they will not suffer the negative financial consequences from having the bill reported to credit agencies or sold to a debt collector while the patient and/or the health plan disputes the bill.<sup>280</sup>

### *B. Model Policy to Address Opaque Prices and Facility Fees*

The model policy to address the opacity of medical bills is to establish a price and quality transparency tool and require providers to provide presumptively binding, written cost estimates to patients. To overcome the presumption that the estimate is binding, the provider would have to show, for example, that the nature or extent of the diagnosis and service required or the patient's health plan were materially different than those on which the cost-estimate was provided.

Examples of robust price and quality transparency tools for consumers are New Hampshire's HealthCost, Maine's CompareMaine, and Colorado's Medical Price Compare websites.<sup>281</sup> These websites use data from state all-payer claims databases to provide consumers with tools to compare the prices for specific services across providers. To be meaningful to consumers, the prices should be the amounts paid by payers, including the insurance reimbursement and the patient's cost-sharing, not

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278. CAL. HEALTH & SAFETY CODE § 1371.9(b) (2016); CAL. INS. CODE § 10112.8(b) (2016).

279. See, e.g., CAL. HEALTH & SAFETY CODE § 1371.9(c)(2)); CAL. INS. CODE § 10112.8(c)(2).

280. See, e.g., CAL. HEALTH & SAFETY CODE § 1371.9(e); CAL. INS. CODE § 10112.8(e); CONN. GEN. STAT. § 20-7f(c). For a description of the negative consequences of medical debt collection and reporting practices for patients, see *supra* notes 203–211 and accompanying text.

281. N.H. HEALTHCOST, *supra* note 179; COMPAREMAINE: HEALTH COSTS & QUALITY, *supra* note 179; CO MEDICAL PRICE COMPARE, *supra* note 179. At this time, CO Medical Price Compare is limited to information on childbirth, knee replacement, and hip replacement services. *Id.*

the provider's charges, which often are much higher than the negotiated discounted rates billed to health insurance companies.

The searchable consumer websites populated by a robust data source (an all payer claims database) are considered more helpful than bare legal requirements for providers to disclose prices upon request.<sup>282</sup> Because search costs are high, the ideal price transparency tool is the searchable state-wide comparison website, supplemented by a legal requirement that prices posted on such websites are presumptively binding on providers (hospitals, physicians, outpatient clinics, etc.).

The second model policy would establish site neutral payments for all payers, public and private, for all non-emergency outpatient services that do not require additional standby capacity.<sup>283</sup> Medicare is moving in this direction, but states can legislate to extend this payment policy to private payers and Medicaid.<sup>284</sup> The Connecticut law is a model, but an incomplete one because it only eliminates facility fees for office visits, not the broader range of outpatient services identified by MedPAC as eligible for site-neutral payment.<sup>285</sup> Eliminating unwarranted facility fees for all payers is a highly contentious and politically difficult policy. Connecticut legislators originally planned a broader implementation of site-neutral payment, but narrowed the requirement after facing stiff opposition from powerful hospital facilities and physician groups in the state.<sup>286</sup>

Connecticut's law on facility fees<sup>287</sup> also set forth a model for enforcement by making a provider's violations of the facility fee prohibitions an unfair trade practice under the state's law prohibiting "unfair and deceptive acts or practices" or UDAP statute.<sup>288</sup> This provides

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282. DE BRANTES & DELBANCO, *supra* note 176, at 10.

283. MedPAC identified sixty-six groups of services within the Medicare Ambulatory Payment Classification (APC) system that it recommended to move to site-neutral payment because they do not require additional standby capacity or have other features that would justify added facility fees. MEDPAC 2013 REPORT TO CONGRESS, *supra* note 158, at 28.

284. *See generally* 42 U.S.C. § 1396a(a)(13)(A) (2012), which gives states the authority to determine Medicaid rates and methodologies for determining the rates in their Medicaid state plans for approval by the federal government.

285. *See supra* note 208 and accompanying text for a discussion of this part of the Connecticut law.

286. *See, e.g.,* Arielle Levin Becker, *House Nearing Deal on Massive Health Care Bill*, CONN. MIRROR (May 29, 2015), <https://ctmirror.org/2015/05/29/house-nearing-deal-on-massive-health-care-bill/>; E-mail from Jennifer Macierowski, Chief Counsel and Dir. of Research, Conn. Senate Minority Office, to author (Oct. 22, 2015) (on file with author).

287. Conn. Acts No. 15-146 § 13 (Reg. Sess.) (to be codified at CONN. GEN. STAT. § 19a-508c).

288. State Unfair and Deceptive Practices (UDAP) statutes generally mimic section 5 of the Federal Trade Commission Act (FTCA) which prohibits "unfair or deceptive acts or practices in or affecting commerce." Unlike the FTCA, which may only be enforced by the FTC, however, state UDAP statutes generally permit private causes of action. Bob Cohen, Annotation, *Right to Private*

individual patients who have been charged unlawful facility fees or who have not received mandated notices about such fees a private right of action against providers. By contrast, Medicare patients do not have a private right of action if they are improperly charged cost-sharing payments for facility fees.

### *C. Model Policy to Address Medical Debt Collection Practices*

A model policy would expand the fair debt collection requirements of the IRS' rules for tax-exempt hospitals and fill its two main gaps: (1) the rules do not apply to for-profit or government-run hospitals, which make up over 40% of all hospitals in the U.S., or other types of providers, such as physicians<sup>289</sup> and (2) the rules give hospitals complete discretion to determine eligibility for financial assistance, which is the trigger for the rules' protections.<sup>290</sup>

California's Hospital Fair Pricing Act provides a model for a better approach—it limits the charges and collection activities of all California hospitals for uninsured patients who earn less than 350% of the federal poverty level or insured patients whose medical bills exceed 10% of household income.<sup>291</sup> By defining the income and affordability thresholds, the policy would replace hospitals' discretion in determining eligibility for fair billing and collection with level and predictable standards across all hospitals. However, a model policy would also apply debt collection requirements to physicians, urgent care centers, free-standing emergency rooms, and other types of providers.

Connecticut provides a model for private enforcement of these requirements. It prohibits providers and their collection agents from suing to collect unpaid bills owing from out-of-network emergency care, surprise medical bills, or prohibited facility fees.<sup>292</sup> In addition, the Connecticut statute makes it an unfair trade practice for any provider to report debts to credit reporting agencies stemming from prohibited surprise medical bills, bills for out-of-network emergency services, or facility fees.<sup>293</sup>

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*Action Under State Consumer Protection Act—Preconditions to Action*, 117 A.L.R. 5th 155, § 2[a] (2004).

289. KAISER FAM. FOUND., *supra* note 237.

290. *See* Fuse Brown, *supra* note 224, at 529–30.

291. CAL. HEALTH & SAFETY CODE §§ 127400-127446.

292. CONN. GEN. STAT. § 38a-193(c).

293. CONN. GEN. STAT. § 20-7f(b)-(c).

The importance of designating medical billing practices as an unfair trade practice is twofold: first, it provides a valuable private remedy for those harmed by unfair and abusive consumer financial practices, and second, the availability of attorneys' fees and punitive or treble damages creates valuable incentives for attorneys to take these cases on behalf of consumers. Nearly every state has a UDAP statute, and legislatures can designate certain health care billing practices as unfair trade practices under their state UDAP statute.<sup>294</sup> Alternatively, the FTC could pursue enforcement or itself define certain medical billing practices as unfair and deceptive under the FTCA, which while not providing a private remedy, could have persuasive effects on states' UDAP interpretations.<sup>295</sup> The FTC has taken an interest in surprise medical bills, and pressure has been mounting from some in Congress for the FTC to investigate surprise medical billing.<sup>296</sup> The FTC has expressed an interest in the role such bills play in causing narrow networks, a proven cost-saving mechanism, to fall into disfavor.<sup>297</sup>

States can fill many of the substantive gaps in financial protections for health care consumers. Indeed, many of the best examples can be drawn from states themselves. Other examples come from the federal government (e.g., site-neutral payment) or a combination of federal, state, and private efforts (e.g., treatment of medical debts on credit reports). States can also go further than the federal government, typically through the creation of private remedies under consumer protection laws for medical billing

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294. For claims against health insurance carriers, the state could designate the practice a violation of the state's Unfair Insurance Practices Act. Margot Sanger-Katz & Reed Abelson, *Senator Calls for Inquiry into 'Surprise' Medical Bills*, NY TIMES: THE UPSHOT (Dec. 3, 2016), <https://www.nytimes.com/2016/12/03/upshot/senator-takes-up-issue-of-unexpected-medical-bills.html>.

295. Such a designation would apply to for-profit hospitals, physicians, and other facilities, but would potentially exclude nonprofit hospitals and those in the "business of insurance." 15 U.S.C. §§ 44, 45 (2012); Prepared Statement of the Federal Trade Commission: Hearing Before the S. Comm. on Commerce, Sci., & Transp., 110<sup>th</sup> Cong. 1 (2008), [https://www.ftc.gov/sites/default/files/documents/public\\_statements/ftc-testimony-reauthorization/p034101reauth.pdf](https://www.ftc.gov/sites/default/files/documents/public_statements/ftc-testimony-reauthorization/p034101reauth.pdf). Note, however, that because self-funded health plans are not deemed to be in the business of insurance under ERISA, the FTCA could be applied to such self-funded ERISA plans. *See infra* note 360.

296. Sanger-Katz & Abelson, *supra* note 294.

297. *See* Edith Ramirez, Chairwoman, Fed. Trade Comm'n, Keynote Address at the Antitrust in Health Law Conference (May 12, 2016), [https://www.ftc.gov/system/files/documents/public\\_statements/950143/160519antitrusthealthcarekeynote.pdf](https://www.ftc.gov/system/files/documents/public_statements/950143/160519antitrusthealthcarekeynote.pdf) ("Another ongoing study examines the frequency with which patients are treated by out-of-network providers when receiving care at in-network facilities, potentially exposing them to significantly higher costs. One concern we have is that an increase in unexpected out-of-network costs could lead to the disfavoring of narrow networks, even though narrow networks are a proven means of lowering provider costs."). One result of the FTC's examination of surprise billing is the publication of a study on the incidence of surprise billing by two FTC economists. *See* Garmon & Chartock, *supra* note 45.



practices that are designated as unfair or deceptive acts or practices. This optimistic view of state innovation in consumer financial protections in health care, however, encounters a substantial structural barrier in the form of ERISA preemption.

### III. ERISA AND THE NEED FOR A FEDERAL SOLUTION

The greatest shortfall in health care consumer financial protection is not substantive but structural. Even as more states are moving to adopt substantive patient financial protections, ERISA makes these laws inapplicable for a large proportion of consumers who get their health insurance from employer-based health plans. “ERISA” stands for the Employee Retirement Income Security Act of 1974, the primary federal law that regulates employee benefit plans, including employer-based health plans.<sup>298</sup> This structural gap in consumer financial protection in health care is more problematic than the substantive shortfalls because it cannot be overcome even by a willing state legislature. ERISA’s preemptive effects are extraordinarily broad and can result from express preemption under ERISA section 514<sup>299</sup> or complete preemption of state remedies under ERISA section 502.<sup>300</sup> This part demonstrates how both forms of ERISA preemption could render many state health care consumer protections inapplicable to consumers covered by employer based health care coverage and then suggests what a federal solution could look like.

#### *A. ERISA Preemption of State Consumer Financial Protections*

The Table in Appendix 1 summarizes which state health care consumer financial protection laws would be expressly preempted by ERISA with respect to self-funded plans under the deemer clause, saved from preemption with respect to fully insured employee health plans, or completely preempted by ERISA section 502. An analysis of ERISA preemption of states’ health care consumer protections is provided in more detail below.

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298. See ERISA, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. § 1001); see also *Health Plans & Benefits: ERISA*, U.S. DEP’T LAB., <https://www.dol.gov/general/topic/health-plans/erisa> (last visited May 20, 2017) (“The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans.”).

299. 29 U.S.C. § 1144 (2012).

300. 29 U.S.C. § 1132(a) (2012).

### 1. Express Preemption Under ERISA Section 514

ERISA expressly preempts any state law that “relates to an employee benefit plan.”<sup>301</sup> This provision has been construed extremely broadly to displace a swath of state laws, including many state laws that regulate provision of or payment for health care, because of their impermissible connection to employee health plans.<sup>302</sup>

Not all state laws that have *some* effect on ERISA plans “relate to an employee benefit plan.” The Court has noted that everything can be conceived of to relate to everything else, so if “relate(s) to” was taken literally, there would be no practical limits to ERISA’s express preemption.<sup>303</sup> Particularly relevant to the health care consumer protections explored in this article, state laws that are primarily directed at health care *providers* that have only an incidental effect on ERISA plans would not “relate to” an employee benefit plan, and would not trigger ERISA’s express preemption.<sup>304</sup>

Under this framework, state surprise medical billing laws that prohibit out-of-network *providers* from balance-billing patients in emergencies or for services at a facility that is in-network to the patient would not relate to an employee benefit plan.<sup>305</sup> Similarly, state laws that limit providers’ medical debt collection and credit reporting practices would also escape

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301. 29 U.S.C. § 1144(a) (“Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . .”).

302. For example, state laws relate to ERISA plans if they: (1) mandate ERISA plans to cover certain benefits, *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983) (noting “the Disability Benefits Law, which requires employers to pay employees specific benefits, clearly ‘relate to’ benefit plans.”); (2) interfere with nationally uniform plan administration, *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 946 (2016); or (3) intrude on the relationship between ERISA plans, beneficiaries, and administrators, *Self-Ins. Inst. of Am., Inc. v. Snyder*, 827 F.3d 549, 559 (6th Cir. 2016) (finding, in part, that the state law did not “relate to” ERISA because the state law did not intrude upon the relationships between ERISA-covered entities).

303. See *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995) (“If ‘relate to’ were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for ‘[r]eally, universally, relations stop nowhere . . . .’”) (quoting H. JAMES, RODERICK HUDSON xli (New York ed., *World's Classics* 1980) (1875)).

304. *Travelers*, 514 U.S. at 668 (holding a state law requiring hospital surcharges that “indirectly [affected] the relative prices of insurance policies” for ERISA plans was not preempted by ERISA); *De Buono v. NYSA–ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 816 (1997) (holding that a state tax on hospitals, including medical centers operated by ERISA funds, only had an indirect impact on a self-insured employee health plan did not relate to an ERISA plan); *Retail Indus. Leaders Ass’n v. Fielder*, 475 F.3d 180, 191 (4th Cir. 2007) (Citing *DeBuono* and *Travelers* to conclude, “States continue to enjoy wide latitude to regulate healthcare providers.”).

305. See *Travelers*, 514 U.S. at 668; *De Buono*, 520 U.S. at 816.

express preemption by ERISA.<sup>306</sup> Laws requiring providers to provide patients with presumptively binding cost estimates would not relate to ERISA plans and thus also escape ERISA preemption.<sup>307</sup> The key features of these laws are their requirements on providers instead of plans.<sup>308</sup> However, questions of ERISA preemption arise as soon as these laws regulate health plans—for example, state surprise billing laws typically include provisions for health plans, such as the requirement that plans hold patients harmless for surprise bills.<sup>309</sup>

*a. Savings Clause Analysis of Consumer Financial Protections*

A significant exception to ERISA’s express preemption provision derives from the “savings clause,” which saves from preemption state laws that regulate insurance.<sup>310</sup> Thus, if they regulate insurance, states’ health care consumer protections directed at health plans will not be preempted. These insurance laws will apply to what are known in industry parlance as “fully insured” employee health plans, where the employer contracts with an insurance company to assume the financial risk for employees’ health care costs in exchange for premiums.<sup>311</sup>

The Supreme Court articulated a two-part test to determine whether a state law regulates insurance in *Kentucky Association of Health Plans v. Miller*: first, the state law “must be specifically directed towards entities engaged in insurance,” and second, the state law “must substantially affect the risk pooling arrangement between the insurer and the insured.”<sup>312</sup> The second requirement will be met when the state statute “alter[s] the scope of permissible bargains between insurers and insureds.”<sup>313</sup>

Several of the states’ consumer protections that are directed at health insurers would likely be saved from preemption under the savings clause because they regulate insurance, and would thus apply to fully insured employee health plans. For state surprise medical billing laws, these

306. For a discussion of these laws, see *supra* notes 236–41 and accompanying text.

307. For a discussion of this proposal, see *supra* Part II.B.

308. See *supra* note 277–78 and accompanying text.

309. For a tabular depiction of the ERISA preemption analysis for surprise billing laws, see *infra* Appendix 1.

310. 29 U.S.C. § 1144(b)(2)(A) (2012) (“Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.”).

311. Approximately 39% of workers who are covered by employer-based plans are in fully insured plans. GARY CLAXTON ET AL., *supra* note 18, at 188.

312. *Ky. Ass’n of Health Plans v. Miller*, 538 U.S. 329, 342 (2003).

313. *Id.* at 338–39.

provisions include the requirement that plans ensure that enrollees only incur in-network cost-sharing for surprise bills,<sup>314</sup> requirements for plans to include clauses regarding surprise billing in enrollee plan terms,<sup>315</sup> and requirements for payments to out-of-network physicians to count toward insureds' out-of-pocket costs and deductibles.<sup>316</sup> These laws are directed at entities engaged in insurance, satisfying the first prong of the *Miller* test. For example, the Florida statute specifically states “[a]n insurer is solely liable for payment of fees to a nonparticipating provider . . . .”<sup>317</sup> On the second prong, the laws alter the scope of permissible bargains by controlling the terms of the contract between the insurer and the insured.<sup>318</sup> For example, surprise billing laws may require health plans to pay for members' bills from non-participating physicians. Consequently, the laws affect the insurers' calculations of how to set rates based on their pre-negotiated agreements with in-network providers as well as expected payments to out-of-network providers. These terms provide enrollees with substantive benefits and protections that, in essence, increase the level of coverage for out-of-network providers at in-network facilities.

State network adequacy and provider directory laws would also likely constitute insurance regulation for the same reason that the state's “any-willing-provider” law was saved in *Miller*.<sup>319</sup> Any-willing-provider laws require health plans to accept any provider who meets certain qualifications (such as licensure or willingness to accept the plan's rates) into the plan's network.<sup>320</sup> Like any-willing-provider laws, network adequacy laws regulate and alter the number of in-network providers for

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314. See, e.g., N.Y. FIN. SERV. LAW § 602(b)(2) (McKinney 2016) (“The health care plan shall ensure that an insured shall not incur any greater out-of-pocket costs for emergency services billed under a CPT code as set forth in this subsection than the insured would have incurred if such emergency services were provided by a participating physician.”).

315. See, e.g., CAL. HEALTH & SAFETY CODE § 1371.9(a)(1) (establishing that “a health care service plan contract issued, amended, or renewed on or after July 1, 2017, shall provide that if an enrollee receives covered services from a contracting health facility at which, or as a result of which, the enrollee receives services provided by a noncontracting individual health professional, the enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from a contracting individual health professional. This amount shall be referred to as the ‘in-network cost-sharing amount.’”).

316. *Id.*

317. FLA. STAT. § 627.64194(2) (2016) (emphasis added).

318. See *Ky. Ass’n of Health Plans v. Miller*, 538 U.S. 329, 338 (2003).

319. *Id.* at 338–39 (“By expanding the number of providers from whom an insured may receive health services, AWP laws alter the scope of permissible bargains between insurers and insureds . . . .”).

320. Ashley Noble, *Any Willing or Authorized Providers*, NAT’L CONF. ST. LEGISLATURES (Nov. 5, 2014), <http://www.ncsl.org/research/health/any-willing-or-authorized-providers.aspx>.

enrollees of the plans.<sup>321</sup> If there are inadequate participating providers, these laws may require the plans to cover out-of-network providers at in-network rates and levels of benefits, which expands the network of providers like Kentucky's any-willing-provider law in *Miller*.<sup>322</sup>

State price transparency laws requiring the participation of health insurers would also be saved from preemption. The most robust state price transparency laws rely upon the collection of health care claims data by state-run APCDs. In *Gobeille v. Liberty Mutual Insurance Company*, the Supreme Court held that state APCD reporting requirements are preempted by ERISA.<sup>323</sup> The Court did not discuss the applicability of the savings clause in its analysis, but the question was not before the Court in *Gobeille* because respondent Liberty Mutual was a self-funded ERISA plan.<sup>324</sup> For fully insured employee benefit plans, the question is whether state APCD reporting requirements would be saved as insurance regulation. Such reporting laws provide the raw data that permit states to operate consumer price transparency tools and regulate insurance company premiums through rate review, among other functions.<sup>325</sup> APCDs thus alter the scope of permissible bargains between insurers and insureds by providing enrollees with certain benefits, such as price comparison tools; by regulating premiums; and by helping plans steer enrollees to high-value providers through cost-sharing incentives.

In sum, to the extent state surprise billing, network adequacy, or price transparency laws require compliance by health plans, many of these laws could be saved from ERISA preemption and thus extend to consumers who are covered by fully insured employee health plans. The analysis is reversed for those covered by self-funded employee health plans.

#### *b. Deemer Clause Analysis of Consumer Financial Protections*

Although ERISA's savings clause saves state insurance regulation from preemption, the "deemer clause" creates an exception from the

321. *Miller*, 538 U.S. at 339 ("No longer may Kentucky insureds seek insurance from a closed network of health-care providers in exchange for a lower premium. The AWP prohibition substantially affects the type of risk pooling arrangements that insurers may offer.")

322. *See, e.g.*, NAIC MODEL ACT § 5.C.

323. *See generally* 136 S. Ct. 936 (2016).

324. Brief for Petitioner at 8, *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936 (2016) (No. 14-181).

325. *See, e.g.*, Letter from Senator Ron Wyden & Senator Patty Murray to Sylvia Mathews Burwell, Secretary of Health & Human Servs., & Thomas E. Perez, Secretary of Labor (May 18, 2016), [https://www.finance.senate.gov/imo/media/doc/apcd%20letter\\_final\\_RWPM.pdf](https://www.finance.senate.gov/imo/media/doc/apcd%20letter_final_RWPM.pdf).

savings clause, preempting all state laws that relate to *self-funded* group health plans, which are not deemed to be in the business of insurance.<sup>326</sup> Thus, even state insurance laws that would be saved by the savings clause with respect to *fully insured* plans are preempted by ERISA insofar as they apply to *self-funded* employee health plans. The net effect is that ERISA preempts state laws that relate to employee benefit plans if they either do not qualify as insurance regulation or relate to self-funded employee health plans.

Self-funded plans, also referred to as self-insured plans, are employee health plans where the employer pays for the health benefits with its own funds, retaining financial or insurance risk.<sup>327</sup> Approximately 61% of all individuals who receive health insurance from an employer are insured by self-funded health plans.<sup>328</sup> Typically, self-insured employers contract with third party administrators, entities that may also operate health insurance companies, to administer the benefits. To employees, it is far from clear whether their health plan is self-funded or fully insured—it may look as though Anthem or Cigna is their health insurer because the administrator issues insurance cards, manages the provider network, and handles the claims.

Thus, even if all states were to adopt the model patient financial protection policies described in Part II, a large number of consumers, about a third of the nonelderly U.S. population,<sup>329</sup> would be excluded from protection because of the sweeping preemptive effect of ERISA with respect to self-funded employee health plans.<sup>330</sup>

## 2. Preemption of State Remedies by ERISA Section 502

ERISA's express preemption of state laws is but one way ERISA can block application of state laws to employee health plans. ERISA also

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326. 29 U.S.C. § 1144(b)(2)(B) (2012).

327. See e.g., *Self-Funded Plans*, BLUE CROSS BLUE SHIELD, <http://www.bcbsm.com/employers/products-services/health-insurance-plans/self-funded-plans.html> (last visited Oct. 10, 2016); *Advantages and Myths of Self-Funding for Employers with Fewer than 250 Employees*, CIGNA HEALTH & LIFE INS. CO. (Feb. 2014), [http://www.cigna.com/assets/docs/business/small-employers/841956\\_b\\_self\\_funding\\_whitepaper\\_v8.pdf](http://www.cigna.com/assets/docs/business/small-employers/841956_b_self_funding_whitepaper_v8.pdf) (“Traditional self-funding is defined as when an employer pays for their own medical claims directly, while a third-party administrator administers the health plan by processing the claims, issuing ID cards, handling customer questions and performing other tasks.”).

328. GARY CLAXTON ET AL., *supra* note 18, at 188.

329. *Id.* at 188–200. In 2015, 56% of the nonelderly population was enrolled in employer-sponsored coverage. Of those, 61% were enrolled in self-funded plans. So (56% \* 61% = 34%).

330. For a tabular depiction of the ways ERISA's deemer clause alters the preemption analysis for self-funded plans, see *infra* Appendix 1.

broadly preempts state laws that provide additional remedies against employee health plans outside the limited remedies available in ERISA section 502.<sup>331</sup> Known as complete or field preemption, ERISA's extraordinary preemptive powers over state law *remedies* that duplicate, supplement, or supplant the ERISA remedies derive from courts' interpretations that Congress intended ERISA to occupy the field and prevent the application of state-specific remedies to ERISA plans.<sup>332</sup> Although it only applies to state law remedies, section 502 preemption is broader than ERISA's express preemption insofar as it applies to all ERISA plans, whether self-funded or fully insured.<sup>333</sup> The question is whether the state law gives beneficiaries additional remedies beyond ERISA's exclusive list.

The two remedies among all the state laws discussed in this article that may be subject to complete preemption under ERISA are the dispute resolution provisions in state surprise billing laws and the UDAP causes of action against health plans for violations of surprise billing requirements. Although it is not clear that every state's dispute resolution requirements would be preempted under ERISA section 502, a UDAP remedy against an ERISA plan would almost certainly be preempted.<sup>334</sup>

#### *a. Dispute Resolution Provisions*

In *Rush Prudential v. Moran*, the Supreme Court suggested that "common arbitration" would constitute a state law remedy that would be preempted by ERISA section 502, but a state requirement for independent medical review of coverage denials would not.<sup>335</sup> The key question for state surprise billing laws is whether their dispute resolution mechanisms more closely resemble common arbitration or independent review procedures.

331. 29 U.S.C. § 1132 (2012).

332. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208–09 (2004). Any claim against an ERISA plan that falls within the scope of an ERISA claim under section 502 is converted to a federal ERISA claim and is removable to federal court. *Id.* at 209.

333. *See Davila*, 542 U.S. at 216–17 ("Respondents also argue . . . that the [state law] is a law that regulates insurance, and hence that ERISA § 514(b)(2)(A) saves their causes of action from pre-emption (and thereby from complete pre-emption). This argument is unavailing. The existence of a comprehensive remedial scheme can demonstrate an overpowering federal policy that determines the interpretation of a statutory provision designed to save state law from being pre-empted.") (internal quotes and citations omitted).

334. For a summary of how ERISA § 502 may preempt state consumer financial protection laws providing for dispute resolution or UDAP remedies, *see infra* Appendix 1.

335. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 381–82 (2002).

In *Moran*, the Court noted key features of arbitration, including a binding decision on the merits, a decision based on evidence submitted by the parties and subject to cross-examination at a hearing, and the breadth of power of the arbitrator such as the power to subpoena witnesses or administer oaths.<sup>336</sup> The Court conceded that the independent review bore some resemblance to arbitration because the independent reviewer deliberates disputes about the meaning of the HMO contract and receives “evidence” in the form of medical records and statements from physicians.<sup>337</sup> But, the state independent review law did not create an additional remedy like adjudication but was more akin to a second medical opinion because the independent reviewer lacked “free-ranging power to construe contract terms,”<sup>338</sup> was confined to a narrow determination of medical necessity, did not hold an evidentiary hearing, and was required to be a physician and to exercise independent medical judgment.<sup>339</sup> The majority rejected the dissenters’ argument that because the independent reviewer’s decision was binding, the process was akin to arbitration.<sup>340</sup>

The binding dispute resolution provisions of New York and California’s surprise billing statutes share some similarities with the independent review mechanism in *Moran*. First, the independent dispute resolution inquiry is confined to one narrow issue—deciding which rate most closely resembles UCR.<sup>341</sup> Second, the decision-maker does not have free-ranging power to construe plan terms or to independently determine what UCR should be, but is limited instead to selecting between two choices of fees.<sup>342</sup> Semantically, however, the laws call these decision-makers “independent dispute resolution entities,”<sup>343</sup> and the power to determine payment rates (even if through baseball-style arbitration) is a task typically handled by courts or arbitrators, which does not seem analogous to what the court in *Moran* characterized as an independent physician giving a second medical opinion.

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336. *Id.* at 382–83 (internal quotes omitted) (citing 1 I. MACNEIL, R. SPEIDEL & T. STIPANOWICH, FEDERAL ARBITRATION LAW § 2.1.1 (1995)).

337. *Id.* at 382.

338. *Id.* at 383.

339. *Id.*

340. *Id.* at 394–95 (noting because the statute stated that “[i]n the event that the reviewing physician determines the covered service to be medically necessary, the [HMO] shall provide the covered service,” the review decision was a binding determination) (emphasis in original).

341. N.Y. FIN. SERV. LAW § 607(a)(6) (McKinney 2016); CAL. HEALTH & SAFETY CODE §§ 1371.30(c), 1371.31(a)(1).

342. N.Y. FIN. SERV. LAW § 607(a)(6) (McKinney 2016); CAL. HEALTH & SAFETY CODE §§ 1371.30(c), 1371.31(a)(1).

343. N.Y. FIN. SERV. LAW § 607(a)(4) (McKinney 2016); Assemb. B. 72 § 1, 2015–2016 Leg., Reg. Sess. (Cal. 2016) (to be codified at CAL. HEALTH & SAFETY CODE §§ 1371.30(c), 1371.31(a)(1)).



The Texas mediation framework includes some provisions that resemble adjudication. First, both the nonparticipating physician and the plan “may present information regarding the amount charged for the medical service or supply.”<sup>344</sup> Moreover, only individuals who have been trained in alternative dispute resolution techniques will qualify as mediator.<sup>345</sup> But, unlike New York or California, the mediation process in Texas is not binding, and like in *Moran*, the inquiry is limited to two narrow issues—the amount to be paid to the out-of-network physician and the enrollee’s cost-sharing amount.<sup>346</sup>

Florida’s law may come closest to providing a remedy that resembles traditional adjudication. In Florida, any dispute regarding payment amounts to out-of-network providers under its surprise medical billing law, “shall be resolved in a court of competent jurisdiction or through the voluntary dispute resolution process.”<sup>347</sup> This dispute resolution organization has authority to review a wide variety of unresolved claims between health plans and non-contracted providers under evidentiary and hearing procedures that resemble common arbitration.<sup>348</sup>

ERISA’s statutory remedies are available to enrollees of ERISA plans.<sup>349</sup> But the ERISA preemption analysis remains unchanged even if state dispute resolution mechanisms remove the beneficiary from the dispute, leaving the plan and physician to work out payment. For example, in New York, the insured “assigns benefits to [the] non-participating physician” who then resolves the balance bill with the health care plan.<sup>350</sup> Under ERISA, the term “beneficiary” is defined as a “person designated by a participant or by the terms of an employee benefit plan, who is *or may become entitled to* a benefit thereunder.”<sup>351</sup> Thus, when the insured

344. TEX. INS. CODE ANN. § 1467.056 (b) (West 2016).

345. TEX. INS. CODE ANN. § 1467.052 (West 2017).

346. TEX. INS. CODE ANN. § 1467.056 (a)(2) (West 2017).

347. FLA. STAT. ANN. § 627.64194(6) (West 2016).

348. FLA. STAT. ANN. § 408.7057 (West 2016).

349. 29 U.S.C. § 1132(a) (2012) (“A civil action may be brought . . . by a participant or beneficiary (A) for the relief provided for in subsection (c) of this section, or (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan”). A participant is a current or former employee who is eligible to participate in an employee benefit plan, and a beneficiary is someone designated by the participant (e.g., a family member) who is entitled to plan benefits. 29 U.S.C. § 1002(7), (8) (2012). ERISA § 502(a)(2) also allows the Secretary of Labor or a plan fiduciary (e.g., administrator) to bring other causes of action that are not relevant here.

350. N.Y. FIN. SERV. LAW § 607(a) (McKinney 2016).

351. 29 U.S.C. § 1002(8) (2012) (emphasis added). The ERISA definition of “participant” is “any employee or former employee of an employer, or any member or former member of an employee

assigns his or her benefits to the non-participating physician, the non-participating physician is designated to receive the benefits under the ERISA plan and steps into the shoes of the beneficiary.<sup>352</sup> Consequently, even though the beneficiary does not participate in the dispute resolution, the dispute resolution mechanism may still duplicate, supplement, or supplant ERISA's remedies for beneficiaries.

In sum, it remains unresolved whether courts will conclude that independent dispute resolution processes included in state surprise medical billing laws will be preempted by ERISA section 502. Relevant factors will include the extent to which the dispute resolution entity's authority is limited to a narrow determination of the amount to be paid to the non-participating provider, the evidentiary and hearing procedures used, and the degree to which the process resembles common arbitration or adjudication. ERISA plans will argue, perhaps successfully, that these alternative dispute resolution procedures are akin to arbitration, which run afoul of ERISA's exclusive civil enforcement scheme. It seems like a close call in New York, California, and Texas, where there are some features that weigh against section 502 preemption, similar to *Moran*. Florida's dispute resolution provision seems to tilt more clearly towards preemption. The Court's recent willingness to expand as opposed to contract ERISA preemption and courts' "reluctan[ce] to tamper with an enforcement scheme crafted with such evident care as the one in ERISA,"<sup>353</sup> could result in widespread preemption of alternative dispute resolution programs for surprise billing for all consumers with employer-based coverage.

*b. UDAP remedies for surprise billing violations*

ERISA's complete preemption under section 502(a) likely poses an insurmountable barrier to plaintiffs trying to bring an unfair trade practice claim under state law against an ERISA plan for surprise billing. For

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organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit." 29 U.S.C. § 1002(7) (2012).

352. See *City of Hope Nat'l Med. Ctr. v. HealthPlus, Inc.*, 156 F.3d 223, 227 (1st Cir. 1998) ("[A] health care provider, as the assignee of a beneficiary, acquires derivative standing and is able to sue as a 'beneficiary' by standing in the shoes of his assignor."). But see *DB Healthcare, LLC v. Blue Cross Blue Shield of Ariz. Inc.*, No. CV-13-01558-PHX-NVW, 2014 WL 3349920, at \*7 (D. Ariz. July 9, 2014), *aff'd*, No. 14-16518, 2017 WL 1075050 (9th Cir. Mar. 22, 2017) (finding that without valid assignments, the provider-plaintiffs were not "beneficiaries" and were unable to sue to enforce ERISA).

353. *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985).

example, Florida makes violations of the surprise billing prohibitions by health plans a violation of the state's UDAP statute.<sup>354</sup> As to whether the UDAP action supplements, supplants, or duplicates an ERISA remedy, state UDAP laws allow for a range of recoveries, including compensatory and punitive damages, attorney's fees, and other remedies not available under an ERISA remedy.<sup>355</sup> UDAP remedies against plans thus improperly supplement the ERISA remedies, triggering complete preemption.

In *Aetna Health Inc. v. Davila*, the Court supplied a test for determining whether a claim falls within the scope of and is therefore preempted by ERISA section 502(a)(1)(B):

if an individual brings suit complaining of a denial of coverage for medical care, where the individual is entitled to such coverage only because of the terms of an ERISA-regulated employee benefit plan, and where no legal duty (state or federal) independent of ERISA or the plan terms is violated, then the suit falls 'within the scope of' ERISA § 502(a)(1)(B).<sup>356</sup>

Applying the test articulated in *Davila*, the first question is whether the beneficiary bringing a UDAP claim against a plan for repeated violations of the surprise billing law is complaining of a denial of coverage of medical care, where the individual is only entitled to such coverage because of the terms of an ERISA plan.<sup>357</sup> The answer, at least when applying Florida's law, is yes because the health plan's failure to hold the enrollee harmless for a surprise bill means that the plan has not paid for the out-of-network care that was supposed to be covered. Moreover, an individual is only entitled to such coverage because of the terms of an ERISA plan. An enrollee's claim against a plan for nonpayment of any service is derived entirely from the particular rights and obligations established by the plan's terms.<sup>358</sup> In other words, if the enrollee's asserted right to coverage that was denied is based on her enrollment in an ERISA

354. FLA. STAT. §§ 456.072(1)(oo), 626.9541(1)(gg). Connecticut also makes surprise balance-billing an unfair trade practice, but only for providers. Thus, Connecticut's UDAP remedy would not implicate ERISA because it does not relate to employee benefit plans.

355. Although the remedies vary by state, the majority of UDAP laws allow plaintiffs to recover compensatory damages, punitive damages, and attorney fees, or compensatory damages and attorney fees. See Cohen, *supra* note 288.

356. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004).

357. *Id.* at 210.

358. *Id.* at 211 (noting that the only connection between the plaintiffs and the defendants Aetna and CIGNA were that the defendants administered the plaintiffs' employee benefit plan, and concluding that the first prong of the test was satisfied).

plan, this first question is satisfied. Finally, the state law does not create an “independent legal duty” of the plan under the second question, because the plan has no independent duty to pay for services for an enrollee outside of the plan terms.<sup>359</sup>

Thus, to the extent state laws extend UDAP remedies to health plans that violate surprise medical billing requirements, such laws would likely be completely preempted by ERISA section 502(a) for all ERISA employee health plans.

### *B. Escaping ERISA’s Black Hole*

ERISA has grown far beyond the framers’ intent from a federal law that focused on regulating employee pension and retirement plans to a preemptive black hole that is increasingly consuming the field of state health and safety regulation.<sup>360</sup> In the context of consumer financial protection, ERISA preemption excludes from protection a large and growing number of consumers whose are insured by self-funded employer health plans. Despite meaningful state innovation and leadership in the area of patient financial protection, the ERISA black hole means a federal solution is needed to protect all health care consumers from medical-bill related financial harms.

Such a federal solution could take a few different forms: (1) pursue federal rulemaking by the Department of Labor to apply particular substantive requirements (e.g., surprise billing provisions, network adequacy, cost-sharing limits, price transparency reporting) to self-funded ERISA plans, (2) legislation to amend ERISA to allow state flexibility in terms of health care consumer protections that can be applied to self-funded ERISA plans without preemption, or (3) pursue federal standards on surprise billing from the FTC that would apply to providers and all health plans.

#### *1. Regulation by the Department of Labor*

The Department of Labor (DOL) has authority over employee health plans under ERISA,<sup>361</sup> so one option would be for DOL to issue rules

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359. *Id.* at 212–13 (concluding that there is no independent legal duty created by a state law that imposes liability or legal obligations on an ERISA health plan because plaintiffs’ state law claim “derives entirely from the particular rights and obligations established by the benefit plan”).

360. *See, e.g.,* Michael S. Sirkin, *The 20 Year History of ERISA*, 68 ST. JOHN’S L. REV. 321, 322–23 (1994).

361. NAT’L ACAD. FOR STATE HEALTH POLICY, *ERISA PREEMPTION PRIMER* 3 (2009), <http://www.nashp.org/erisa-preemption-primer/> (“The U.S. Department of Labor is responsible for

applicable to self-funded health plans on surprise medical bills and price transparency. For example, DOL could interpret its network adequacy standards to prohibit ERISA plans from counting surprise bills toward annual out-of-pocket maximums.<sup>362</sup> DOL could require ERISA plans to make it transparent to enrollees when they receive care from an out-of-network provider and what it may cost the enrollee to see the out-of-network provider.<sup>363</sup> However, it is unclear whether DOL has the existing statutory authority to *require* ERISA plans to hold patients harmless from surprise bills.<sup>364</sup> Mark Hall has suggested that where DOL lacks the authority to mandate protections by group health plans, DOL could incentivize voluntary protections by creating a safe harbor that would shield employers from claims that they breached their fiduciary duties to enrollees under ERISA if the employer complied with provisions protecting enrollees from surprise medical bills.<sup>365</sup> Such a safe harbor could establish a federal standard for protections against surprise bills, including requirements to hold enrollees harmless from surprise bills, participating in dispute resolution, or accede to out-of-network payment limits. Finally, DOL could clarify through guidance that states retain the authority to regulate *providers*, such as defining or capping providers' out-of-network rates, surprise billing prohibitions on providers, and providers'

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administering and enforcing the ERISA law and setting policy for the conduct of employee benefit plans.”).

362. Public Health Service Act (PHSA) § 2707(b), 42 U.S.C. § 300gg-6(b) (2012) (requiring group health plans to limit annual cost-sharing by enrollees as provided in PHSA § 1302(c), 42 U.S.C. § 13022(c) (2012)). See Mark Hall, *How the Department of Labor Can Help End Surprise Medical Bills*, BROOKINGS (Dec. 14, 2016), <https://www.brookings.edu/2016/12/14/how-the-department-of-labor-can-help-end-surprise-medical-bills/>; see also DEP'T OF LAB., *supra* note 69 (discussing limits and guidelines for ERISA plans' use of network designs, particularly reference pricing, to evade annual cost-sharing limits).

363. 42 U.S.C. § 18031 (2012) (setting forth cost-sharing transparency requirements for Exchange plans); 42 U.S.C. § 300gg-15a (2012) (requiring group health plans to provide the information required of Exchange plans in 42 U.S.C. § 18031); 29 U.S.C. § 1185d (2012) (incorporating the ACA's market reforms for exchange and other health insurance plans into ERISA with respect to group health plans).

364. To the extent DOL lacks authority under ERISA to promulgate any of these rules, it underscores the enormity of the black hole created by ERISA. ERISA preemption means that states' health care consumer financial protections cannot be enforced against self-funded ERISA plans, but ERISA itself may not provide the DOL (or any other agency) the authority to promulgate parallel federal requirements of self-funded plans. In other words, no one—neither the states nor the DOL—has the authority to regulate self-funded health plans on these matters.

365. See HALL ET AL., *supra* note 25.

collection practices.<sup>366</sup>

On price transparency, DOL could use its authority under the ACA and ERISA to require self-funded health plans to report a standardized set of health care claims data to state APCDs and DOL.<sup>367</sup> The statutory authority for DOL to require ERISA plans to submit health care claims data is derived from Public Health Service Act (PHSA) section 2715A, which authorizes collection of data on health care costs and payments, and section 2717, which authorizes collection of data on health care quality. Both provisions were among those health insurance reforms created by the ACA and applied to group health plans by ERISA section 715. In addition, DOL has authority to collect data under the provisions of ERISA sections 104 and 505, which authorize DOL to promulgate regulations and require any information or data from plans as necessary to carry out the purposes of the statute.<sup>368</sup>

The problem, politically and technically, is that federal rulemaking or legislation will be required on an issue-by-issue basis.<sup>369</sup> ERISA requires that self-funded plans be subject to nationally uniform standards, and so federal standards would need to be crafted in each area of consumer protection, absent significant change to ERISA's scope. Where substantive consumer protections are beyond DOL's statutory authority under ERISA, additional legislation by Congress would be required.<sup>370</sup> A second challenge is that much of DOL's substantive statutory authority to regulate group health plans' networks, transparency, or consumer protections were established by the ACA's health insurance reforms, and many of these provisions may be rolled back or altered in an ACA replacement.<sup>371</sup> Thus, the administrative solution through DOL rulemaking may depend heavily

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366. See Nicholas Bagley, *A Small Step Forward on Surprise Billing*, THE INCIDENTAL ECONOMIST (Dec. 20, 2016, 7:00 AM), <http://theincidentaleconomist.com/wordpress/a-small-step-forward-on-surprise-billing/>.

367. See National Academy for State Health Policy, Comment on Proposed Changes to Annual Reporting Requirements for Employee Benefits Plan (Sept. 20, 2016), <https://www.regulations.gov/contentStreamer?documentId=EBSA-2016-0010-0033&attachmentNumber=1&disposition=attachment&contentType=pdf> (providing a legal analysis for DOL's authority to collect health care claims data and to partner with state APCDs to through cooperative agreements to collect health care claim data from self-funded ERISA plans and report such data to DOL).

368. *Id.*

369. President Trump has expressed hostility to federal regulation, for example, by issuing an executive order that purports to require two rules be eliminated for every new rule. Reducing Regulation and Controlling Regulatory Costs, Exec. Order No. 13,771, 82 Fed. Reg. 9339 (Feb. 3, 2017).

370. HALL ET AL., *supra* note 25, at 24.

371. See *supra* notes 360–61, 365–66 and accompanying text.

on Congress.

## 2. Amend ERISA

The second approach would be to seek legislation to carve out certain state consumer protection laws that require participation of health plans (e.g., surprise medical billing requirements or transparency and reporting to state APCDs) from ERISA's preemptive scheme, replacing it with ordinary conflict preemption.<sup>372</sup> Under conflict preemption, state laws are only preempted if they conflict with federal law, as opposed to ERISA's express preemption scheme which preempts all state laws if they relate to employee benefit plans, whether or not they conflict with ERISA.<sup>373</sup> This change would permit states to experiment with additional or different consumer protections, but allow federal standards to be established where desired. The challenge here is largely political.<sup>374</sup> Even though ERISA has strayed far beyond its original scope in 1974, the current political climate is generally deregulatory and may favor business interests—the self-funded plan sponsors—over the interests of individual consumers.<sup>375</sup> The effect of ERISA preemption is not just national uniformity of standards for employers sponsoring benefit plans, but also light-touch regulation (compared to regulation by states) to entice multi-state employers to continue to offer employee benefits. Nevertheless, to the extent that states are being asked to assume more responsibility for their health care systems, and Republican plans to replace the ACA all depend on consumerism and high levels of cost-sharing, there could be some support for limited carve-outs to ERISA to open the door for state health consumer protections and transparency efforts.

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372. See Elizabeth Y. McCuskey, *Body of Preemption: Health Law Traditions and the Presumption Against Preemption*, 89 TEMP. L. REV. 95, 103 (2016).

373. *Id.*

374. See Nicholas Bagley, *Federalism and the End of Obamacare*, 127 YALE L.J. FORUM 1, 12 (2017) (“[B]ecause of the intensity of the business lobby's resistance to limiting ERISA's preemptive scope, Congress is very unlikely to amend the law to address the concern”).

375. See, e.g., Michael Corkery, *Trump Expected to Seek Deep Cuts in Business Regulations*, N.Y. TIMES, Nov. 9, 2016, available at <https://www.nytimes.com/2016/11/10/business/dealbook/trump-expected-to-see-deep-cuts-in-business-regulations.html>; Nick Timiraos & Andrew Tangel, *Donald Trump's Cabinet Selection Signals Deregulation Moves Are Coming*, WALL ST. J. (Dec. 8, 2016), <https://www.wsj.com/articles/donald-trump-cabinet-picks-signal-deregulation-moves-are-coming-1481243006>.

### 3. *FTC Designation of Surprise Billing as an Unfair Trade Practice*

Finally, the federal consumer protection standards could come from the FTC designating surprise medical billing as an unfair trade practice. Although an FTC rule would not apply to nonprofit hospitals or insurers, it would apply to self-funded plans, filling one of the major gaps created by ERISA preemption.<sup>376</sup>

One challenge of a federal designation of surprise billing as an unfair trade practice is determining whose conduct would be targeted by such a ruling. For example, if the FTC determined that it is an unfair trade practice for self-funded plans to charge members higher cost-sharing or refuse to hold members harmless for surprise bills, who would bear the risk of noncompliance, the employer that maintains the self-funded plan or the third-party administrator that handles the administrative functions of plan design, network participation, and claims processing? Perhaps both, where the employer plan sponsor can be deemed to engage in an unfair trade practice if its third-party administrator does not abide by these requirements, whether contractually or in practice. In addition, the FTC standard should apply to providers, such as out-of-network physicians, prohibiting balance-billing or imposing higher cost-sharing on the patient when the patient was not fully informed of provider's out-of-network status and given a meaningful opportunity to select an in-network provider.

A further question and potential drawback of this approach is whether it would cut short salutary state experimentation and replace it with a national standard. If states lose flexibility to layer additional protections above the federal standard, then the benefits of state innovation will be lost.<sup>377</sup>

Federal standards for consumer financial protection in health care are not unheard of—under the Obama administration, the ACA and other federal policies, such as site-neutral Medicare payments, have made several regulatory inroads.<sup>378</sup> These federal policies generally permit state flexibility to impose additional requirements above the federal floor or for

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376. The McCarran-Ferguson Act provides that FTCA “shall be applicable to the business of insurance to the extent that such business is not regulated by State law.” 15 U.S.C. § 1012(b) (2012). ERISA provides that self-funded plans are not deemed to be “engaged in the business of insurance . . . for the purposes of any law of any State . . .” 29 U.S.C. § 1144 (2012). Thus, self-funded plans, if not engaged in the business of insurance, should be subject to FTC jurisdiction.

377. See Bagley, *supra* note 374, at 2.

378. For a discussion of the ACA's limits on cost-sharing *see supra* Part I.A.1; on network adequacy *see supra* Part I.A.2; and on site-neutral payments in Medicare *see supra* Part I.B.2.



populations not covered by the federal standard. Nevertheless, the Trump administration has signaled hostility to expanding regulatory efforts to protect health care consumers.<sup>379</sup> The federal solution to expand state-based consumer financial protections in health care may be elusive until the political climate changes.

In the absence of a federal solution, states will continue to be the sources of innovation and legislative reform. The first strategy for states to limit the effect of ERISA preemption is to promulgate measures that limit the medical billing practices of *providers*, while continuing to include requirements of non-ERISA plans (fully insured, non-group plans, state employee plans, or Medicaid).<sup>380</sup> Second, states can encourage voluntary participation by self-funded ERISA plans by demonstrating to employers and plan sponsors the benefits of transparency for more value-based provision of health care for their members.<sup>381</sup> Finally, the actions of FICO, the three major credit agencies, in collaboration with federal (CFPB) and state authorities illustrate how meaningful consumer protection can emerge on a national scale through a combination of approaches—public and private, voluntary and mandated, and state and federal.<sup>382</sup>

#### CONCLUSION

Every generation has attempted to reform health care and protect patients from the worst perceived abuses of the time. The ACA focused on expanding coverage and reforming insurance practices. The assumption has always been that gaining health coverage protects people from the financial health risks. That is the classical model—the individual purchases insurance to shift the financial risk of health care consumption to the insurer. In the managed care revolution in the 1980s and 1990s insurers further shifted that financial risk to providers.<sup>383</sup> Recently, the

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379. HHS Secretary Tom Price has made statements in the past in favor of permitting balance-billing in Medicare, for example. President Trump also wants to repeal Dodd-Frank, which created and gives CFPB its authority. *See supra* notes 141, 242–43.

380. *See supra* notes 297–300 and accompanying text.

381. *See* Fuse Brown & King, *supra* note 185.

382. *See supra* notes 258–63 and accompanying text.

383. *See* Clark C. Havighurst, *How the Health Care Revolution Fell Short*, 65 L. & CONTEMP. PROBS. 55, 62 (2002) (discussing managed care plans' attempt to "ration financing . . . [and] control costs by inducing their provider-subcontractors to assume substantial financial risks for the care they undertake to provide"); 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, 6 (1993) ("Under managed care products, the risk of financial loss shifts from third-party payers to physicians.").

emphasis on consumerism has resulted in a shift of significant financial risk back to patients.

The importance of gaining health insurance coverage for a household's financial security and stability is undisputed. But the lesson here is that gaining coverage is not the end of the battle, especially as increased cost shifting is making that coverage less robust. The next frontier for patient financial protection is getting at harm to patients as consumers. States have been out front with innovative policies, but because of the expansive nature of ERISA preemption, these state innovations will never reach a large and growing segment of the population. Thus, unless ERISA changes, federal protections for health care consumers will be necessary.

The story of consumer financial protection in health care is a tale of regulatory pluralism across methods (caps, disclosure, private remedies, and incentives) and across institutions (state and federal, public and private, legislative, administrative, and judicial). On the one hand, the story tells of a dynamic interplay where each method and institution acts to create standards, reinforce protections, and fill gaps. But it also is a story of the perils of preemption and regulatory conflict that threatens the experimental and reinforcing benefits of regulatory pluralism. There is no one approach that will suffice—the strength of consumer financial protections in health care depend on the overlapping efforts of many regulatory tools and institutions.

## APPENDIX 1

**Table. ERISA Preemption Analysis for  
State Health Care Consumer Protection Laws**

ERISA Preemption Analysis	Relates to Employee Benefit Plan (Preempted by 514(a)?)	Saved by Savings Clause?	Deemer Clause: Preempted for self-funded plans?	Preempted by 502(a)?
<b>1. Surprise Medical Bills</b>				
a. ACA limits on cost-sharing	<b>No.</b> Federal law, not preempted.	--	--	--
b. Network adequacy/provider directories	<b>Yes.</b> Requirements relate to health plans.	<b>Yes.</b> Not preempted for fully insured plans.	<b>Yes.</b> Preempted for self-funded plans.	<b>No.</b> No additional remedies provided by state law.
c. Surprise balance-billing laws	<b>Yes.</b> Certain provisions relate to health plans.	<b>Yes.</b> Not preempted for fully insured plans.	<b>Yes.</b> Preempted for self-funded plans.	<b>Maybe.</b> For state dispute resolution requirements in surprise billing laws. <b>Yes.</b> For UDAP remedies against plans
<b>2. Transparency / facility fees</b>				
a. Site neutral payment	<b>No.</b> Medicare, federal law, not preempted. <b>Yes.</b> For state law provisions that relate to health plans (e.g., no copayment for facility fees)	--  <b>Yes.</b> Not preempted for fully insured plans	--  <b>Yes.</b> Preempted for self-funded plans.	--  <b>No.</b> No additional remedies provided by state law.
b. Price transparency tools (APCDs)	<b>Yes.</b> Requirements relate to health plans.	<b>Yes.</b> Not preempted for fully insured plans.	<b>Yes.</b> Preempted for self-funded plans ( <i>Gobeille</i> )	<b>No.</b> No additional remedies provided by state law.
<b>3. Medical debt collection /reporting</b>				
a. IRS 501(r) rules	<b>No.</b> Federal law, not preempted.	--	--	--
b. State medical debt collection laws	<b>No.</b> If directed only at providers.	--	--	--
c. CFPB action on medical debt	<b>No.</b> Directed at credit reporting agencies.	--	--	--