



Balance Billing: Current Legal Landscape and Proposed Federal Solutions

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As [several recent](#) reports have publicized, some patients covered by private health insurance continue to receive surprise—and often surprisingly high—medical bills resulting from treatment by out-of-network providers. Through a practice known as “balance billing,” an out-of-network provider bills the patient for charges that exceed her health insurance plan’s payment for a covered service. These bills are often surprising to the patients because they had received out-of-network care involuntarily or unknowingly—some were receiving emergency care and therefore had no choice in providers, while others unknowingly received care from such providers at an in-network facility. Several [states](#) have enacted legislation that would prohibit providers from balance billing the patients while also addressing the key underlying question—who should pay for the care provided and how much to pay. A [number of proposals introduced](#) in the 115th Congress aimed to address the issue at the federal level and additional proposals [may](#) be forthcoming in the 116th Congress. This Sidebar provides an overview of balance billing, the relevant state and federal laws that currently govern this practice, and relevant federal legislation that has been proposed so far. The Sidebar concludes by highlighting several legal issues for Congress’s consideration as it continues to study this issue.

Overview of Balance Billing

[Typically](#), a patient with private insurance receives care from in-network health care providers who have contracted with the health plan and accepted the plan’s negotiated payment rate. As part of the contract, the provider agrees not to charge the plan or the patient more than the negotiated rate. The plan, in turn, pays the negotiated rate with the patient contributing to a cost-sharing amount (usually in the form of coinsurance or a co-payment) for the specific health care services received. In contrast, an out-of-network provider has no contract with the health plan and thus no negotiated payment rate. When an out-of-network provider treats a patient, the health plan may pay only an amount it determines is fair or may not pay any charges if the plan does not offer out-of-network benefits. When this occurs, the out-of-network provider may “balance bill” the consumer by billing her for the difference between what her health plan paid and what the provider charged.

From the perspective of the patients, balance bills can be seen as unfair because, as noted above, they may have received out-of-network care involuntarily or unknowingly. From the perspective of the providers,

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balance bills may trace back to their decision not to contract with the relevant health plans in the first instance. There may be a variety of reasons for this decision, but it often comes down to the providers' economic determination that they may need to charge more for certain services than the rate offered by the health plans to maintain their practice. Some individual health providers and small medical groups, for instance, may have **chosen** not to contract with certain health plans because they lacked sufficient bargaining power to negotiate favorable rates and terms. To them, accepting the discounted rates the plan offers may result in the failure of their practice. As a result, they opt instead to provide care as out-of-network providers and issue balance bills to the patients for any balance owed. Until more recently, federal law and most state laws generally permitted this practice.

Relevant Legal Framework Governing Balance Billing

Balance billing is currently governed by a patchwork of federal and state laws that provide varying degrees of protection to the patients and guidance on the underlying payment question.

Relevant Federal Law

Federal law currently addresses balance billing only in the context of Medicaid, which is a cooperative federal-state program that provides health coverage to low-income individuals, and Medicare, which provides health coverage to qualified elderly and other individuals. Under Medicaid, providers generally **cannot** balance bill Medicaid beneficiaries if the providers have already **billed and accepted** payment from Medicaid. In contrast, under Medicare, a provider's ability to balance bill depends on whether he is a "participating" provider. A participating provider cannot balance bill Medicare beneficiaries because they have **accepted** the beneficiary's assignment of Medicare benefits and Medicare's approved payment amounts as full payment for the Medicare-covered services. Meanwhile, nonparticipating providers, who accept Medicare but have not agreed to accept assignment (i.e., they do not accept Medicare's approved amount for health care services as full payment), can generally balance bill a Medicare beneficiary, but the amount **cannot exceed** more than 15 percent of the Medicare-approved payment amount for nonparticipating physicians for the service. An exception to this rule involves Medicare beneficiaries with low income who are dual-eligible for Medicaid—Medicare participating *or* nonparticipating providers **cannot** balance bill these beneficiaries. A small number of providers completely opt out of Medicare and choose not to accept any payments from the program. Medicare beneficiaries who want to receive care from these providers must **agree** to a private contract and pay for all the charges.

No federal law currently addresses balance billing in the private insurance context. The Affordable Care Act (ACA, [P.L. 111-148](#)) took a step in that direction when it addressed a patient's payment responsibility vis-à-vis her health plan for out-of-network emergency care. Specifically, when a patient receives emergency care from an out-of-network provider, the ACA **limits** a patient's cost-sharing amount to the in-network rate of patient's health plan. However, the provision does not address a patient's payment responsibility vis-à-vis the emergency care provider, who is not prohibited from balance billing the patient for any remainder charges not paid by the health plan. In other words, the ACA limits what a patient's health plan can charge the patient, but does not regulate the out-of-network provider's billing practices. The provision also does not address payment issues related to nonemergency care.

Relevant State Law

About **half** of the states have adopted some form of legislation to address balance billing in the private insurance context, but the degree of patient protection and guidance on payment rate varies. The more comprehensive state laws **generally**:

- provide protections that apply to both **emergency care** by out-of-network providers and **nonemergency care** by out-of-network providers in in-network facilities;

- **affirmatively** prohibit providers from sending balance bills to patients and limit patient responsibility to their in-network cost-sharing amounts; and
- require providers to seek any additional payments from health plans and establish a **standard** for adequate payment for the provider and/or a **dispute resolution** process in the event of a payment dispute between the health plan and the provider.

Some state laws also require a provider to make certain affirmative **disclosures** about a provider's out-of-network status prior to providing care. Many enacted state laws on balance billing, however, only include **some** of these components.

The application of the relevant state laws may also be subject to a significant limitation. Under the Employee Retirement Income Security Act of 1974 (ERISA, P.L. 93-406), self-funded health plans (i.e., plans that pay claims out of their own funds instead of through an insurer) are **exempt** from state insurance regulation. Thus, to the extent a state law on balance billing encompasses elements that could be construed as **insurance regulation**—for instance, by imposing certain requirements on the plans' out-of-network benefits coverage—ERISA may preempt these requirements for self-funded private insurance plans. These plans cover about **60 percent** of workers who receive coverage through their jobs.

Proposed Federal Legislation

Efforts to address balance billing in the private insurance context at the federal level—which could fill the gaps in existing state laws—are ongoing in the 116th Congress. A number of proposals introduced in the 115th Congress, including one **reintroduced** in the 116th Congress, would have tackled the issue in a number of ways.

For example, one **draft** bill, the Protecting Patients from Surprise Medical Bills Act, would have, similar to more comprehensive state laws, applied in both emergency and nonemergency settings to **limit** patient responsibility to the in-network cost-sharing amounts and defined the health plans' payment responsibility. In the case of emergency care, the proposal would have also affirmatively **prohibited** the providers from balance billing the patients for amounts beyond their in-network cost-sharing amount. As to any remaining charges, the proposal would have established a set of **payment standards** that limit the amount of additional payments the provider can seek—for both emergency and nonemergency services—from the patient's health plan. Specifically, it would cap the additional amount to either (1) the amount determined by the applicable state law; or (2) in the absence of which, an amount based on a set of statutory formulas. For out-of-network providers who provided emergency care, the proposal would have also required them to make certain **disclosures** about their out-of-network status once the patients are stabilized and offer the patients the option to transfer to an in-network facility.

Another bill introduced in the 115th Congress, **Reducing Costs for Out-of-Network Services Act of 2018**, would have imposed requirements similar to that provided under existing Medicare law. Specifically, the bill would have **allowed** providers to bill patients beyond their in-network cost-sharing in both emergency and nonemergency settings, but would have limited the amount based on a set of specified statutory formulas. The applicable formula would be selected by the relevant state authority.

Two other proposals, **No More Surprise Medical Bills Act of 2018** and **End Surprise Billing Act of 2017** (which has been **reintroduced** in the 116th Congress), would have focused on imposing affirmative disclosure requirements. Specifically, the bills would have required out-of-network providers to **disclose**, at the time of the appointment, their out-of-network status and the estimated charges for the relevant services and to obtain the patients' consent at least 24 hours before the services are furnished. Where a provider either fails to or cannot comply with the disclosure and consent requirements (e.g., in the case of same-day emergency service), the proposals would have **limited** the patients' responsibility to the in-network cost-sharing amount. In those circumstances, one of the proposals would have further directed

the Secretary of Health and Human Services to [establish](#) a dispute resolution entity to resolve any disputes between the providers and health plans about the remaining charges.

Considerations for Congress

As Congress continues to study the balance billing issue, there are several legal points that Congress may consider, including from the experiences of existing state law.

First, a balance billing law that includes statutory payment standards for providers may implicate certain constitutional issues under some circumstances. In California, after the state legislature enacted a balance billing law in 2017 that imposes a statutory default payment rate, a professional association of physicians [sued](#) to enjoin the law, alleging that the law on its face violated several provisions of the U.S. Constitution. Among them, the association alleged that the default payment rates constitute confiscatory wage control that violates the Takings Clause of the Fifth Amendment, which prohibits private property from being “taken for a public use, without just compensation,” and procedural due process, which prohibits the government from depriving a person’s property interest without reasonable procedural protections. The district court [rejected](#) the association’s facial challenge, which required showing that no application of the statute would be constitutional. The court explained that because the statute requires the provider and insurer to first negotiate before imposing the statutory default, “it is entirely possible that reimbursement rates will actually be higher than the default rates.” The court, however, also noted that “it seems more likely that in practice [the statutory default] rates will end up acting as a ceiling rather than a floor,” and if that happens, “[p]laintiff may be able to successfully pursue an as applied challenge[.]” The court thus granted California’s motion to dismiss but with leave to amend. The association has since filed an amended [complaint](#) that added a plaintiff member provider, who alleges that the implementation of the law has resulted in a loss of 25 percent of her revenue in 2018. The state has moved to dismiss the amended complaint, and the [motion](#) is currently pending before the district court.

As this case illustrates, a government regulation that has the effect of reducing the use or value of a claimant’s property is generally not susceptible to a facial challenge. Whether such regulation effects a taking is generally subject to a multi-factor “[ad hoc, factual inquir\[y\]](#).” Moreover, in either a Takings Clause or a procedural due process claim, there would be a threshold question of whether the providers have a constitutionally protected property interest defined by a [source independent](#) from the Constitution, such as state law, ordinances, or express and implied contracts. Because the providers’ existing payment rate is, by definition, not set by statute or contracts, the providers may not have a protected property interest. On the other hand, the Supreme Court has, in a recent Takings Clause [case](#), highlighted the extent of economic impact on a claimant in finding that a regulation that required a raisin farmer to turn over in a single year 47 percent of his raisin crop to have effected a taking. Thus, a provider who can demonstrate a very significant economic impact resulting from the statutory payment standard—perhaps an impact so significant that it affects her ability to make use of her medical license, a protected property [interest](#)—may be able to mount an as-applied challenge.

Second, whenever Congress legislates in an area in which it shares regulatory responsibilities with the states, the doctrine of preemption is implicated. Under the doctrine, which is grounded in the Supremacy Clause of the Constitution, “[any](#) state law . . . however clearly within a State’s acknowledged power, which interferes with or is contrary to federal law, must yield.” Federal law can preempt state law [either expressly](#) (i.e., through a statutory clause that explicitly specifies the categories of state law that are displaced) or [impliedly](#) (i.e., when Congress’s command is implicitly contained in the relevant federal law’s text, structure, and purpose). The scope of preemption may implicate different [values](#) and policy preferences (e.g., the benefits of uniform national regulation versus policy experimentation at the state level). Thus, in drafting legislation relating to balance billing—a subject many state legislatures have addressed to varying degrees—Congress may consider whether to include an express preemption clause that clarifies the intended scope of preemption.

Finally, to the extent any federal legislation imposes any limits, prohibitions, or requirements on the relevant stakeholders (e.g., limitation on the providers' ability to balance bill patients or requirement to make certain disclosures), Congress may consider whether to include any enforcement mechanisms to address violations of the statute. The potential mechanisms may include a provision that authorizes the Secretary to bring [enforcement actions](#), a provision that authorizes a [private right of action](#), and/or a provision that specifies certain [statutory penalties](#) for instances of violation.

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