Estimating Surprise Bills Among Members of Commercial Health Insurance

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CONTENTS

KEY HIGHLIGHTS

- Claims from out-of-network healthcare providers that could result in a surprise bill occurred for 1.8 percent of Elevance Health's affiliated commercial health plan members and 6.2 percent of episodes in 2018.
- Emergency care had a higher rate of episodes (11.1%) with out-of-network claims that could result in a surprise bill compared to non-emergency care (1.8%).
- There was variation across facility types in both the percentage of episodes that could potentially result in a surprise bill and the average estimated consumer liability—with episodes that include a hospital stay being the most costly.

Overview

Unexpected, and frequently unavoidable, bills to consumers for out-of-network healthcare services—commonly referred to as "surprise bills"—have drawn considerable attention from policymakers and the public.

Surprise medical bills can come from a **variety of healthcare provider types and care settings.**

Surprise medical bills can come from a variety of healthcare provider types (e.g., physicians, specialists, assistant surgeons) and settings of care (e.g., hospitals, ambulatory surgical centers). They often occur in episodes when a consumer is not able to select all of the providers from whom they receive care, such as in emergency situations (e.g., emergency physician or emergency department) or in the case of ancillary services delivered incident to the care of an in-network physician (e.g., labs or anesthesiology).[1]

Numerous legislative and regulatory approaches to eliminate or reduce surprise bills have been considered at the federal and state levels. More than half of states have enacted some form of protections that apply to fully insured commercial health plans. At the federal level, in December 2020, the No Surprises Act was signed into law providing protections to consumers with both fully and self-insured commercial health plans.[2]

Federal law notwithstanding, state policymakers continue to consider proposals to limit surprise bills that are subject to state oversight. Moreover, the federal government will need to develop regulations to operationalize the legal framework established in the No Surprises Act. Recent data on the prevalence and characteristics of potential surprise bills can help inform these public policy solutions moving forward.

Background

Health plans use benefit designs and provider networks to encourage the use of "in-network" healthcare providers that meet quality standards and are less costly for consumers.

Generally, when individuals with commercial health insurance receive care, in-network providers receive payment from the health plan at a negotiated rate agreed to by the plan and the provider, which are traditionally well below the list prices a provider charges. Further, in-network providers agree not to bill consumers for any amounts above what the plan paid, other than applicable patient cost sharing (e.g., deductible, co-pay, or co-insurance).

Many plans also offer out-of-network benefits that allow a consumer to choose to see a provider outside of the plan's network, typically at a higher cost for the consumer. In contrast to in-network providers, out-of-network providers have no contractual agreement with the health plan. Therefore, there is no agreed upon negotiated payment rate.

There is a patchwork of laws that aim to **shield consumers from surprise bills.**

Frequently, in the absence of a negotiated rate, health plans will set standard payment amounts for out-of-network care, in some cases in accordance with state mandates. Out-of-network providers are then free to charge the consumer the difference between their full list price and the out-of-network payment amount paid by the health plan. This is known as "balance billing."

Even individuals who knowingly choose to see providers outside of their plan's network may be surprised by bills from these out-of-network providers, if they aren't aware of providers' ability and intention to balance bill. These bills are not the focus of this analysis. Rather, this analysis focuses on surprise bills for out-of-network providers and services that consumers have little-to-no control over—whether due to an emergency or because after arranging to receive a procedure from an in-network provider/facility (e.g., surgeon/hospital) they also receive care from out-of-network providers they did not select (e.g., radiologist).

Today, there is a patchwork of laws that aim to shield consumers from these types of surprise bills. At the federal level, the Affordable Care Act offers some protection to consumers in emergency situations by requiring that their health plans pay the in-network rate and apply in-network cost sharing even if the provider is out-of-network. However, it does not prevent providers from billing consumers for the difference between what they receive from a health plan and what they charge as their list price (i.e., balance billing).[3]

Protections in state laws range from banning balance billing to approaches to resolve or settle the difference between a plan's typical rate and what the out-of-network provider seeks for reimbursement.[4] However, states' laws apply to fully insured commercial health plans, with some allowing for self-insured plans to opt-in. Self-insured plans—typically offered by larger employers—are regulated at the federal level. The majority (61%) of those who receive healthcare benefits from an employer have a self-insured plan.[5]

Beginning January 1, 2022, a new federal law protecting consumers from surprise bills, the No Surprises Act, will go into effect.[6] Healthcare providers will be banned from balance billing consumers for unexpected emergency expenses[7] or services that they could not select.

Instead, consumers will pay their plan's standard in-network cost sharing amount. While the law encourages providers and health plans to come to resolution on a payment rate, disputes will be resolved using a "baseball style" arbitration process in which the arbiter must select either the amount the provider seeks or what the health plan offers; the law prevents the arbiter from considering Medicare (and other public health plan) rates or provider charged amounts in determining the appropriate payment amount. State laws can preempt the federal rules in some cases, so protections may still vary across the U.S.

Methodology

The dataset used for this analysis includes claims from Elevance Health's affiliated commercial plans, which cover more than 23 million consumers across 14 states.[8] All the claims analyzed are for services rendered in 2018. The data analysis was conducted by HealthCore.[9]

A surprise bill is typically sent directly from a healthcare provider to a consumer. The occurrence and amount of a surprise bill is not part of the claims data held by a health plan. As a result, researchers typically create a set of criteria that are applied to out-of-network claims to approximate surprise bills.[10] Detailed below is the approach used in this analysis to estimate surprise bills.

This analysis includes only care that occurred in the ED, hospital, a ambulatory surgery center (ASC), or hospital outpatient department (HOPD). This is consistent with other research on surprise bills (with the exception of HOPDs which is unique to this analysis).[11] HOPDs are a common setting for ambulatory surgeries similar to those that occur in ASCs. Notably, HOPDs unlike ASCs, also frequently house clinics where standard office visits occur (e.g., primary care, neurologist, rheumatologist). Therefore, visits without a procedure occurring at a HOPD were removed from the analysis.

This analysis looked at care in an **ED, hospital, ASC, or HOPD.**

All visits to these facilities—regardless of whether they incurred an out-of- network charge—are referred to as "eligible episodes." Eligible episodes were characterized as either emergency or non-emergency.[12] There were over 8 million eligible episodes included in the analysis.

Next, the following criteria were applied to eligible episodes to identify those with an out-of-network charge, and the potential for a surprise bill for the consumer.

- **Emergency episodes.** Defined as a series of claims where a consumer was either transported by ambulance or presents at the ED. An episode originating in the ED or in an ambulance may also include a subsequent hospital admission. If the consumer arrives by ambulance and there are one or more out-of-network charges by any provider or service (e.g., ambulance, ED facility, hospitalist), the episode is categorized as potentially resulting in a surprise bill. If the consumer arrives at the ED by non-emergency transport (e.g., they drive themselves), the episode is categorized as resulting in a potential surprise bill only if the ED itself is in-network and there are one or more out-of-network provider charges (e.g., hospitalist).
- **Non-emergency episodes.** Defined as a series of claims where a consumer receives a procedure that is primarily performed by an in-network physician (e.g., surgeon) practicing at an in-network facility (i.e., hospital, HOPD, ASC). If there are one or more out-of-network charges by any ancillary provider or service (e.g., lab test, anesthesiologist) the episode is categorized as potentially resulting in a surprise bill.

One continuous health event can result in **multiple surprise bills.**

Most of the analysis in this paper is at the episode level. At a minimum, an episode includes a facility and provider claim (e.g., a short visit to the ED). However, an episode can also include multiple claims from multiple facilities and providers for care over the course of one continuous health event that spans days, weeks, or longer (e.g., a visit to the ED that leads to a two week inpatient stay that includes diagnostic imaging, surgery, and other treatment). As such, multiple surprise bills can occur within one episode.

Examining the prevalence of potential surprise bills across specific specialties and ancillary services requires an analysis at the claim level where each distinct potential bill can be counted and attributed to a specialist or service.

The dollar amounts of potential surprise bills are estimated by taking the difference between the charged out-of-network amount and the total allowed amount for a given service. The out-of-network charges normally reflect list prices and do not resemble what is typically paid for a service. A plan's allowed amount reflects the total amount a plan will reimburse an out-of-network provider for a service. The allowed amount includes any consumer cost-sharing obligations. As noted above, an episode can include multiple surprise bills; as a result, the average potential consumer liability calculated for an episode may include more than one charge (e.g., an emergency hospitalization that includes charges from both an out-of-network radiologist and pathologist).

In some cases, an out-of-network provider's charges may be equal to or less than the health plan's allowed amount. In these instances there is no potential for a provider to balance bill, and therefore, no possibility for additional consumer liability above standard cost sharing amounts. For that reason, we have excluded these cases from counting as a potential surprise bill.

There are several limitations to using out-of-network claims and charged amounts to estimate the volume and dollar amount (i.e., consumer liability) of a surprise bill that a provider sends to a consumer.

Factors that may over estimate potential surprise bills:

- Importantly, there is no way to know whether a provider decided to forego balance billing the consumer or whether the provider applied a discount to the balance bill thereby reducing the consumer's liability.
- There is no way to identify episodes in which a consumer knowingly chose to go to an out-of-network provider (e.g., ED), and so the resulting bill was not a true surprise bill.
- This analysis also did not make any adjustments to the dollar amount or number of potential surprise bills to account for state laws that might limit consumer liability.

Factors that may under estimate potential surprise bills:

- Consumers may also receive and pay surprise bills directly from providers, and the health plan may never have a claim for the service.
- Consumers seeking care at an out-of-network ED, who did not arrive by ambulance, may still encounter surprise bills, though they would not be categorized as such under the methodology used in this analysis.
- There are some surprise bills that occur in a clinic or other ambulatory setting (e.g., a primary care physician sends a blood sample to an out-of-network lab), but care in these settings was excluded altogether from this analysis.

Findings

Overall, 1.8 percent of Elevance Health's affiliated commercial health plan members and 6.2 percent of episodes generated an out-of-network claim that might have resulted in a surprise bill in 2018. While those percentages are low, they represent $1.5 billion in possible surprise bills that would be the responsibility of the consumer.

The analysis found substantial variation across episode and facility type. Emergency care had a greater proportion (11.1%) of episodes with an out-of-network charge(s) that could result in a surprise bill(s) compared to non-emergency care (1.8%). Accordingly, facility types associated with emergency care had a greater proportion of episodes with the potential for a surprise bill(s) with nearly one quarter of emergency hospitalizations (23.8%) and 9 percent of ED visits possibly leading to a surprise bill.

Facility types associated with non-emergency care (i.e., services the consumer has selected and scheduled) had smaller proportions of episodes that could potentially yield a surprise bill, including hospitals with 5.8 percent, ASCs with 1.8 percent, and HOPDs with 1.0 percent. (Figure 1)

Figure 1
Episode by Potential for a Surprise Bill and Facility Type
2018

Source: Claims data from Elevance Health's affiliated commercial health plans for services rendered in 2018.

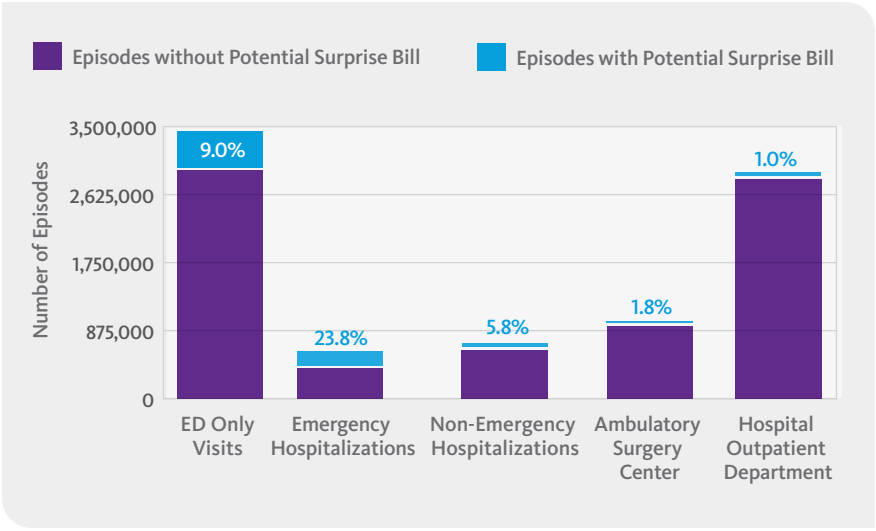
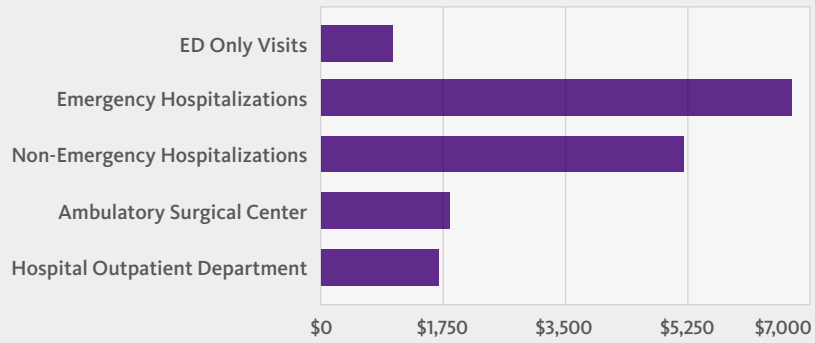


Figure 2

Estimated Average Consumer Liability for Potential Surprise Bills by Facility Type

2018

Source: Claims data from Elevance Health's affiliated commercial health plans for services rendered in 2018.



The highest estimated average consumer liability for a potential surprise bill occurred in episodes with a hospitalization. Potential surprise bills for emergency hospitalizations had an estimated average liability of over $6,700, followed by non-emergency hospitalizations at nearly $5,200.

The average consumer liability per episode without a hospital stay appeared to be lower at roughly $1,800 for ASC episodes and $1,700 for HOPD episodes. Notably, while ED only visits yielded the lowest estimated average consumer liability at around $1,000, they generated the largest volume of episodes with a potential surprise bill when compared to other facility types. (Figure 2)

Among the most common specialties and ancillary services to potentially result in a surprise bill were emergency physicians, hospitalists or generalists, ambulances,[13] and radiologists. (Figure 3)

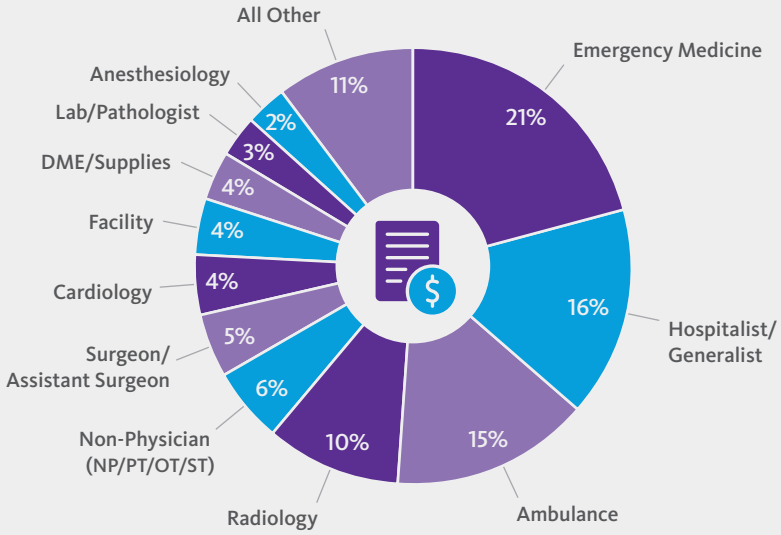
Figure 3

Potential Surprise Bill By Specialty/Ancillary Service Type

2018

DME Durable Medical Equipment
NP Nurse Practitioner
OT Occupational Therapy
PT Physical Therapy
ST Speech Therapy

Source: Claims data from Elevance Health's affiliated commercial health plans for services rendered in 2018. Figures are rounded and may not add up to 100%.



There are a variety of factors that make these providers and services more likely to be out-of-network. For instance, these services and specialists are often not employed or owned by the hospital or facility in which care is received by the consumer. Specifically, it is very common in the U.S. for specialists such as emergency physicians to be contracted by a hospital.[14, 15] Those contracted staff frequently do not participate in the same insurance plans as the hospitals and emergency departments in which they practice. In addition, ground ambulances are funded through a variety of arrangements that frequently involve state, county, and municipal entities.[16] Many markets only have one ground ambulance provider and depending on factors such as volume and the size of the provider's service area, operating costs and participation in health plans vary widely.[17]

Table 1

Potential Surprise Bills By Specialty/ Ancillary Service and Setting Type

2018

	ED Only Visits	Hospital Stay	Ambulatory Procedure
Total Number of Out-of-Network Claims Yielding a Potential Surprise Bill*	417,000	600,000	56,000
Specialty/Ancillary Service Type			
Emergency Medicine	42%	8%	0%
Ambulance	19%	13%	1%
Radiologist	11%	10%	5%
Hospitalist/Generalist	8%	22%	3%
Non-Physician (NP/PT/OT/ST)	5%	5%	12%
DME/Supplies	2%	4%	10%
Surgeon/Assistant Surgeon	1%	6%	11%
Lab/Pathologist	1%	2%	29%
Anesthesiologist	0%	2%	18%
All Other	10%	27%	10%
Total	**100%**	**100%**	**100%**

* This table displays data at the claim level. Multiple claims can occur within a single episode.

DME Durable Medical Equipment
NP Nurse Practitioner
OT Occupational Therapy
PT Physical Therapy
ST Speech Therapy

Source: Claims data from Elevance Health's affiliated commercial health plans for services rendered in 2018. Figures are rounded and may not add up to 100%.

The specialties and ancillary services that were most commonly attributable to potential surprise bills varied notably by setting. (Table 1) The differences appear to reflect the type of providers that are ordinarily found in each setting. Specifically, episodes with a hospital stay (emergency and non-emergency) had a greater share of claims that could yield a surprise bill from hospitalists/generalists (22%), ambulances (13%), and radiologists (10%). For ambulatory surgeries (procedures in an ASC or HOPD), there was a greater prevalence of potential surprise bills from labs/pathologists (29%), anesthesiologists (18%), and non-physician providers, such as nurse practitioners (12%). Lastly, for episodes that only include an ED visit, emergency physicians (42%), ambulances (19%), and radiologists (11%) are most frequently attributable to potential surprise bills.

Comparison to Other Estimates of Surprise Billing

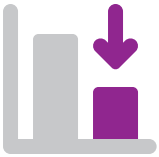
Several studies have examined out-of-network claims that could result in surprise bills[18-21] but none have included the more than 23 million consumers in Elevance Health's affiliated commercial health plans. Data from these plans offer additional insight into the magnitude and frequency of surprise billing. The episodes in this analysis are from 2018—also offering more recent data on this topic.

Compared to other analyses of surprise billing and out-of-network charges for the commercially insured, the results of this analysis shows that members of Elevance Health's affiliated health plans experienced lower rates of potential surprise bills for emergency department visits, planned hospitalizations, and ASC encounters.[22-25] Surprise billing for emergency hospitalizations was within the range of published estimates.[26-28] We could not find a published figure for HOPDs for comparison.

The relatively low prevalence of surprise billing found in this study could be driven by a number of factors, including the size, breadth, and design of Elevance Health's affiliated health plan networks as well as local market conditions.

Conclusion

Consumers in both emergency and non-emergency situations may encounter out-of-network care from providers they did not select and that generate unexpected charges resulting in a surprise bill.



Compared to other studies, **this analysis shows lower rates of potential surprise bills.**

Such charges occurred in 6.2 percent of the episodes analyzed from 2018. Emergency hospitalizations and visits to the ED were the most likely to result in a potential surprise bill, though a notable share of non-emergency hospitalizations also led to potential surprise bills. Across all episodes and sites of care studied, the average cost of these potential surprise bills ranged from $1,000 to nearly $7,000. To put this in perspective, 40 percent of U.S. adults report that they would struggle to afford an unexpected expense of $400.[29]

States that continue to explore legislation to address surprise bills and federal regulators charged with implementing new legal authorities should consider the variety of settings, ancillary services, and specialists that contribute to surprise bills. Health plans and policymakers can work together to ensure that protections designed to shield consumers from costs that are out of their control are effective, without discouraging consumers from seeking in-network options when feasible nor discouraging providers from participating in health plans' networks.

Endnotes

[1] Commonwealth Fund. (2020, November 30). State Balance-Billing Protections. Retrieved on July 16, 2020, from https://www.commonwealthfund.org/publications/maps-and-interactives/2020/apr/state-balance-billing-protections.

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[3] Pollitz, K., et al. (2020, February 10). An Examination of Surprise Medical Bills and Proposals to Protect Consumers from Them. Peterson-Kaiser Family Foundation Health System Tracker Retrieved on July 16, 2020, from https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them-3/#_ednref1.

[4] Ibid.

[5] Ibid.

[6] The 116th U.S. Congress. (2020, December 21). Consolidated Appropriations Act, 2021. Retrieved January 4, 2020, from https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf.

[7] The No Surprises Act does not address surprise bills resulting from transportation by ground ambulance.

[8] In addition to members residing in the 14 states (CA, CO, CT, GA, IN, KY, ME, MO, NH, NV, NY, OH, VA, and WI) the data also includes claims from members that live outside of these states and access care through Elevance Health's extended network (called BlueCard).

[9] HealthCore is a wholly owned, independently operated subsidiary of Elevance Health, Inc., that focuses on health outcomes research.

[10] Garmon, C., & Chartock, B. (2017, January). One In Five Inpatient Emergency Department Cases May Lead to Surprise Bills. *Health Affairs 36*(1), 177-181. Retrieved on July 16, 2020, from https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0970.

[11] Pollitz, K., et al. (2020, February 10).

[12] Pollitz, K. (2016, March 17). Surprise Medical Bills. The Henry J. Kaiser Family Foundation. Retrieved October 1, 2020, from https://www.kff.org/private-insurance/issue-brief/surprise-medical-bills/.

[13] These vast majority of these charges are for ground ambulance transportation, although air ambulance bills are also included.

[14] Young, C., et al. (2019, October 15). What is Surprise Billing for Medical Care? Brookings Institution. Retrieved on July 16, 2020, from https://www.brookings.edu/policy2020/votervital/what-is-surprise-billing-for-medical-care/.

[15] Sun, E., et al. (2019, August 12). Assessment of Out-of-Network Billing for Privately Insured Patients Receiving Care in In-Network Hospitals. *JAMA Internal Med 179*(11), 1543-1550. Retrieved on July 16, 2020, from https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2740802.

[16] Kliff, S., & Sanger-Katz, M. (2020, December 22). Why Ambulances Are Exempt From the Surprise-Billing Ban. The New York Times. Retrieved January 2, 2021, from https://www.nytimes.com/2020/12/22/upshot/ground-ambulances-left-off-surprise-medical-bill-law.html.

[17] Ungar, L. (2020, September 14). With No Legal Guardrails for Patients, Ambulances Drive Surprise Medical Billing. Kaiser Health News. Retrieved on January 2, 2020, from https://khn.org/news/with-no-legal-guard-rails-for-patients-ambulances-drive-surprise-medical-billing/.

[18] Pollitz, K., et al. (2020, February 10).

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[21] Duffy, E., et al. (2020, April 15). Prevalence and Characteristics of Surprise Out-of-Network Bills from Professionals in Ambulatory Surgery Centers. *Health Affairs 39*(5), 783-790. Retrieved on July 16, 2020, from https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01138.

[22] Pollitz, K., et al. (2020, February 10).

[23] Sun, E., et al. (2019, August 12).

[24] Garmon, C., & Chartock, B. (2017, January).

[25] Duffy, E., et al. (2020, April 15).

[26] Pollitz, K., et al. (2020, February 10).

[27] Sun, E., et al. (2019, August 12).

[28] Garmon, C., & Chartock, B. (2017, January).

[29] The Board of Governors of the Federal Reserve. (2018, May). Report on the Economic Well-Being of U.S. Households In 2017. The Federal Reserve. Retrieved December 1, 2020, from https://www.federalreserve.gov/publications/files/2017-report-economic-well-being-us-households-201805.pdf.

ABOUT US

Elevance Health Public Policy Institute

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