A "surprise medical bill" describes the situation when a patient receives a bill for medical services that is much higher than he or she expected because it reflects some part of the treatment process that was not part of their insurer’s coverage. When you hear about a shockingly high bill for a treatment in the news, it is almost always because of this.

Surprises come in a variety of flavors. Some are avoidable, at least from a patient perspective. If a patient’s in-network primary care physician tells the patient to see a specialist, the patient can check to see if the specialist is in the network. Similarly, when undergoing an elective procedure, the patient can make sure to choose an in-network surgeon at an in-network facility.

Other surprises are relatively unavoidable. If, for instance, a patient goes to an in-network emergency department for care and is then treated by an out-of-network emergency department physician, the patient can be charged almost anything. But how is a patient to know which physician is working at any given time?

This occurs too frequently. Last year, a study in JAMA Internal Medicine showed that more than 40% of emergency department visits and inpatient admissions at an in-network facility still resulted in a surprise bill for out-of-network services.

The same holds true when a patient is hospitalized at an in-network facility, but his or her admitting team calls for a consult to an out-of-network specialist. Similarly, unanticipated care from an out-of-network clinician can happen when a patient is being operated on by an in-network surgeon but the anesthesiologist is out of the network. Patients can choose the former, but rarely know the latter until the day of the procedure.

**A Common Problem**

Lest anyone think this is rare, a recent study published in JAMA showed that more than 20% of almost 350,000 patients who underwent 1 of 7 common elective operations at an in-network facility by an in-network surgeon received a bill for out-of-network services. Most of these bills were the result of work by an out-of-network surgical assistant or anesthesiologist. The average additional financial liability was more than $2000.

Legislation that provides comprehensive protection from surprise medical bills must cover all these potential problems. It also needs to apply to both health maintenance organizations and preferred provider organizations. It must protect patients from financial liability, and when there is a dispute as to what can be charged, it should have a solution to how a fair price can be set.

Fewer than 10 states have comprehensive protections in place. More have laws that provide some of these protections but not all of them. Almost half of the states have no protections at all.

The biggest problem, though, is that even when laws exist, they only apply to state-regulated insurance. More than 60% of covered workers work for (mostly large) employers who self-insure. Such insurance is not regulated by the state, but instead is regulated by the federal government.

There are no federal protections. That means that even if every state passed comprehensive laws to prevent surprise billing, most US consumers would not benefit.

In fact, it is not even clear how much of an effect state-based policies are having. The researchers who conducted the recent JAMA study on surgical procedures performed a subanalysis that looked at how surprise bills by out-of-network clinicians at in-network facilities differed in states...
that had passed protections vs those that had not. They found that in the states with protections (California, Connecticut, Florida, Illinois, Maryland, Massachusetts, Mississippi, and New York) the rates of such bills were above the national median, not below.

That does not mean that the laws have not made things better. It is possible that things were worse before, and the legislation was passed in reaction to high rates of surprise bills. It does, however, mean that the state-based solutions are not sufficient.

Congress has tried to act, but without much success. It is not that they do not know what to do, though.

Options for Fixing the Problem

A report 1 year ago laid out some clear options to fix this problem. Regulation could help to fix it. This could, for example, include a stipulation that clinicians could bill only up to a limit, some multiple of the average billing rate of commercial insurers or Medicare. In addition, some contracting regulation could be added that would not allow out-of-network clinicians to bill through in-network facilities independently.

Other potential approaches involve arbitration. Some nod toward a "baseball-type" method, where the insurer and the physician both submit what they think is a fair payment to a neutral third party, and one of them gets chosen. New York has used this approach with mixed results.

Recently, a number of proposals have surfaced again. The House's Ways and Means committee proposed to use benchmarks for bills less than $750 and arbitration for bills more than that amount. Benchmarking is easier and requires less administrative overhead. But the benchmarking rate (ie, what percentage of the existing median or average payment to accept) will be hotly disputed.

Arbitration is more acceptable to many stakeholders, but it is much more difficult to implement. If the number of disputed bills gets large, it is hard to see how this would be tenable. An alternative is to have arbitration over a contract or agreement between insurers and clinicians instead of arbitration over individual bills. It is also possible to implement benchmarking with an arbitration backstop if clinicians want to appeal a bill.

Physicians could take the lead on this. After all, almost all of the surprise medical bills originate from health care clinicians billing for services. The amounts often charged are outrageous, orders of magnitude above what those same physicians charge when in the network. If physicians and the medical community will not stop this, it is likely Congress will have to.