

## 6 ways insurers drive the surprise-billing phenomenon

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Health care is providing another rare instance where there is bipartisan concern in Congress, as both parties and both chambers seek to solve the problem of so-called surprise billing—where patients are faced with unanticipated medical bills for care they thought their insurance covered.

Fifty-seven percent of U.S. adults have received a bill for medical services they thought were covered by their health insurance, according to an August 2018 survey conducted by NORC, a University of Chicago-based nonpartisan research institution.

For many years, the AMA has been working with state medical associations and national medical specialty societies to support state legislative solutions that protect patients from these unanticipated medical bills and promote network adequacy. While several fair and comprehensive state laws have been enacted, a national solution may be needed. These state laws do not protect consumers covered by self-insured employer health plans, which means 61% of privately insured employees are not protected, says the Kaiser Family Foundation.

It is no surprise that Congress is addressing this issue. A Gallup poll conducted just before the Nov. 6 midterm elections found that health care was the most important issue on voters' minds. And "protecting people from surprise medical bills" was considered a top priority by half of respondents in a Kaiser Family Foundation April 2019 health tracking poll.

The House Education and Labor Committee held an April 2 hearing on the issue, but none of the witnesses who spoke was a doctor. To make sure the physician voice is heard, the AMA sent letters to the leaders of three House and two Senate committees detailing the six insurer practices that lead to surprising patients with unexpected bills.

**Health insurance market concentration and narrow networks.** An AMA report found that the majority of U.S. commercial health insurance markets were highly concentrated and that leads to higher premiums for patients, lower payments for physicians, and fewer people with coverage.

“One of the major drivers of surprise bills is the deliberate decision by health insurance plans to narrow the networks of providers available to their insureds—core network adequacy requirements should be an essential component of any solution,” AMA Executive Vice President and CEO James L. Madara, MD, wrote in the letters to committee leaders. “Shrinking networks increase the likelihood that patients may receive care from an out-of-network provider, particularly in emergency situations.”

**Plans shifting costs to patients.** Patients are shouldering more of the costs through larger deductibles and higher copays. The median out-of-network deductible for individual marketplace is \$12,000 and almost a third of individual market plans have deductibles of more than \$20,000 according to research by the Robert Wood Johnson Foundation cited in the letter.

“Limited networks of providers and unaffordable deductibles for care outside those networks can expose patients to high out-of-pocket costs,” Dr. Madara wrote.

**Denying care though utilization management.** Often insurance companies will use tactics such as prior authorization or “fail-first” step therapy protocols to make patients pay out of pocket for medically necessary treatment they refuse to cover.

**Disparity in mental health coverage.** Despite federal mental health-parity requirements, patients can feel squeezed by their health plans when it comes to mental health and substance-use disorder treatments—and that leads to a greater reliance on out-of-network care.

“Plans frequently require prior authorization for substance-use disorder care, even when time is of the essence to get a patient into treatment,” Dr. Madara wrote. “Unfortunately, the record is replete with stories where care was out of reach with devastating consequences.”

**Retroactive denials of emergency care.** Some insurance companies have enacted policies of not paying for emergency care after it was determined that patients did not require it—even though the severity of their symptoms at the time made it prudent to go to the nearest emergency department.

**Mid-year formulary changes add costs, can threaten health.** Insurance companies often change their drug formularies after patients are locked into their plan. This can lead to restricting access to treatment that has proven to work for them and has stabilized their condition. Patients may seek to pay out of pocket to continue their treatment rather than jump through their insurance company’s prior-authorization hoops.