An Elegant Solution to Network Inadequacy: How to Better Protect Patients from Inadequate Health Networks and Surprise Balance Billing

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The American health care system is far from ideal. Health insurance is expensive, yet often inadequate, and patients can fall into bankruptcy paying for necessary medical care. Patients often face challenges finding physicians and other providers that accept their insurance due to network inadequacy, which can end up costing them thousands. Federal law offers few protections to patients from the costs of inadequate networks, so some states have passed legislation to protect patients from surprise balance bills. This Note analyzes the enduring nature of the network inadequacy problem and proposes an elegant solution: state single payer. While it would be politically and administratively challenging, a state single payer system would be the most efficient solution to inadequate networks and surprise balance billing.

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INTRODUCTION

Efforts to achieve a high-quality, low-cost health care system in the United States have resulted in a uniquely American combination of public and private payer systems. Private health insurance has long been available, but was not always sufficient, so the health system has slowly changed to meet the needs of the people.

In Part I, this Note will analyze the inadequacies of the U.S. health care system, leading up to the implementation of the Patient Protection and Affordable Care Act (ACA). Part II then turns to overly narrow networks, exploring why and how they have become inadequate to meet patients' needs, including the result of skinny networks—surprise balance billing. Part III addresses the minimal federal regulation on the matter, and Part IV explores state solutions to inadequate networks and surprise balance billing, concluding that regulation alone is insufficient to address consumer risks. In Part V, this Note will assess private sector solutions to overly narrow networks and surprise balance billing. Finally, Part VI concludes that states should work towards implementing single payer systems because current regulations and market solutions are not the optimal way to address network inadequacy and surprise balance billing.

I. BACKGROUND: THE U.S. HEALTH SYSTEM

The U.S. health "system" consists of piecemeal federal legislation, fifty different sets of state laws, and hundreds of private insurers and health providers. It is necessary to understand how different parts of American health care evolved and now work together in order to understand why the United States has been unable to provide adequate health networks, which results in surprise balance billing and widespread medical debt.

A. THE FEDERAL REGULATORY SCHEME

The federal government developed a few health insurance systems, which attempt to cover the most vulnerable members of the population while leaving others to obtain private insurance on their own. Congress established two public health insurance programs, Medicare and Medicaid, in 1965, and in 1997, it created the Children's Health Insurance Program (CHIP).[1] Medicare is a federal health insurance program for people over sixty-five years old and younger people with certain qualifying disabilities, while Medicaid is the insurance program for low-income adults, pregnant women, and those with disabilities.[2] CHIP, as the name suggests, is the federal insurance program for children whose

1. *CMS Program History*, CTRS. FOR MEDICARE & MEDICAID SERVS. (last modified June 20, 2018, 2:36 PM) https://www.cms.gov/About-CMS/Agency-information/History.

2. *Medicaid*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/index.html (last visited July 27, 2019); *What's Medicare?* MEDICARE.GOV, https://www.medicare.gov/sign-up-change-plans/decide-how-to-get-medicare/whats-medicare/what-is-medicare.html (last visited July 27, 2019).

parents' incomes are too high to qualify for Medicaid, yet insufficient to afford private insurance.[3] While created by the federal government, states run their own Medicaid and CHIP programs with varying amounts of federal funding.[4] In particular, Medicare is broken down into four parts labeled A through D, with parts C and D being available through private insurers that contract with Medicare.[5] Furthermore, the Employee Retirement Income Security Act (ERISA) regulates the insurance plans employers provide to their employees.[6] The way Medicaid, CHIP, and Medicare's four parts cover different groups of people through such different mechanisms, and how some health plans are regulated federally but others are left exclusively to state regulation, highlights the fragmented nature of federal health care.

Ballooning health care costs in the 1990s and 2000s finally led to the passage of the ACA in 2010, which imposed new requirements on individuals and insurers and regulated the private insurance market.[7] The ACA gave states the opportunity to expand Medicaid to cover low-income individuals who are technically above the poverty line, and thirty-seven states and the District of Columbia have elected to do so.[8] In addition, the ACA created platforms, referred to as the marketplace or exchanges, for people to shop for and compare health plans.[9] The ACA categorizes plans into metal tiers, based on actuarial values, with bronze being the least expensive and providing the thinnest coverage, and platinum being the most expensive and providing the most comprehensive coverage.[10] While twenty-eight states let the federal government run the marketplaces, twelve states have established their own marketplaces, and the remaining states use a hybrid of state and federal marketplaces.[11] Thus, even

3. *Eligibility*, MEDICAID.GOV, https://www.medicaid.gov/chip/eligibility-standards/index.html (last visited July 27, 2019).

4. *Children's Health Insurance Program*, MEDICAID.GOV, https://www.medicaid.gov/chip/index.html (last visited July 27, 2019); *How Original Medicare Works*, MEDICARE.GOV, https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/how-original-medicare-works (last visited July 27, 2019); *Medicaid*, *supra* note 2.

5. MEDICAID.GOV, *supra* note 2.

6. *Fact Sheet: What Is ERISA?*, U.S. DEP'T OF LABOR, EMP. BENEFITS SEC. ADMIN., https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/what-is-erisa (last visited July 27, 2019).

7. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 42 U.S.C. (2012)).

8. Rachel Garfield et al., *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KAISER FAM. FOUND. (Mar. 21, 2019), https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/; *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND. (Apr. 26, 2019) https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

9. Sarah Kliff, *What Is a Health Insurance Marketplace?*, VOX (Jan. 5, 2017, 2:33 PM), https://www.vox.com/cards/obamacare/what-is-a-health-insurance-exchange.

10. *What the Actuarial Values in the Affordable Care Act Mean*, KAISER FAM. FOUND. (Apr. 1, 2011) https://www.kff.org/health-reform/issue-brief/what-the-actuarial-values-in-the-affordable/.

11. *State Health Insurance Marketplace Types, 2018*, KAISER FAM. FOUND. https://www.kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D#note-2 (last visited July 27, 2019). For

with the ACA, the type and quality of health plans, and the method by which people purchase them, vary greatly across states. This variability allows for more diverse plans and systems, which lead to inadequate health networks.

B. FORMS OF PRIVATE HEALTH PLANS

The fall of health maintenance organizations (HMOs) catalyzed the ACA because it revealed that the market could not control rapidly rising health costs.[12] HMOs provide private health insurance plans that restrict enrollees to a limited network of providers and exclusively pays for care received from those providers.[13] HMOs typically pay in-network providers a capitated amount per member per month, meaning they receive a flat rate per enrollee regardless of what services they actually provide.[14] HMOs gained popularity in the late 1980s and early 1990s, but were met with a strong backlash in the later 1990s as their exclusive networks prevented patients from receiving care from any provider they chose, and in some cases, even necessary care within their networks.[15] As consumer advocates protested limited networks, they also revealed the financial insolvency of many HMOs.[16] The lack of patient choice and the financial problems with HMOs led to state regulation on HMO solvency and health coverage, and a shift away from HMOs.[17]

In the wake of the HMOs' failures, preferred provider organizations (PPOs) emerged as the more popular option.[18] Unlike HMOs, PPOs do not limit their enrollees to a specific network of providers; however, enrollees do have to pay different prices based on the providers they choose.[19] Unlike the capitated, flat fee structure of HMOs, PPOs typically reimburse providers using a fee-for-service model.[20] PPOs gained huge popularity in the 2000s, but while they afford patients more choice, the fee-for-service reimbursement structure was one of the main reasons health care costs spun out of control.[21] The ACA was necessary to address the rapidly rising cost of healthcare from HMOs and then PPOs.

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example, California runs its own marketplace called Covered California. *What Is Covered California?*, COVERED CAL., https://www.coveredca.com/what-is-covered-california (last visited July 27, 2019).

12. Deborah Farringer, *Everything Old Is New Again: Will Narrow Networks Succeed Where HMOs Failed?*, 34 QUINNIPIAC L. REV. 299, 311 (2016).

13. *Id*. at 305.

14. *Id*.

15. *Id*. at 307. Some of the HMO networks were so limited that patients had to go out of network in order to get medically required treatment.

16. *Id*. at 308–09.

17. *Id*. at 308–310. Forty-seven states enacted legislation based on the 2003 National Association of Insurance Commissioners (NAIC) HMO Model Act. *Id*. at 309, 309 n.51.

18. *Id*. at 310.

19. *Id*.

20. *Id*.

21. *Id*. at 311.

C. THE IMPACT OF THE ACA

Before the ACA, insurance companies could determine which patients to insure and at what price, so they often avoided insuring those who would need the most care.[22] For instance, insurers could refuse to offer coverage to individuals with "pre-existing" conditions or only agree to do so at an astronomically high cost.[23] Historically, some states required health insurers to cover certain types of benefits, but the ACA made it illegal across the United States to discriminate on the basis of any pre-existing conditions.[24] The ACA also requires health plans to cover certain "essential health benefits."[25] Because insurance companies now have to cover all individuals, regardless of health status, the ACA forced insurance companies to change the way they were doing business and making profits.

As a result, national spending on health insurance increased.[26] This rise, however, was supposed to be temporary, as experts assumed the individual mandate would bring costs down in the long term.[27] The individual mandate in the ACA was the requirement that all qualifying citizens must have health insurance or pay a tax penalty.[28] Insurance companies make their profits on premiums paid by healthy people who do not use the majority of services that the insurance would cover. However, sick people need a lot of care, so they are more expensive to insure. When healthy people are in the pool of those insured, the health plans can pay for the care of those who are really sick without having to raise overall premiums.[29] The individual mandate is a contentious but necessary part of the ACA, as it keeps the system from falling into a "death spiral."[30] If the only people buying insurance are those who are sick, premiums

22. Elena Gordon, *Pre-Obamacare, Preexisting Conditions Long Vexed States and Insurers*, KAISER HEALTH NEWS (Apr. 26, 2017), https://khn.org/news/pre-obamacare-preexisting-conditions-long-vexed-states-and-insurers/.

23. *Id.*; MARK A. HALL & PAUL B. GINSBURG, A BETTER APPROACH TO REGULATING PROVIDER NETWORK ADEQUACY 2–3 (USC-Brookings Schaeffer Initiative for Health Policy ed., 2017).

24. John V. Jacobi, et al., *Health Insurer Market Behavior After the Affordable Care Act: Assessing the Need for Monitoring, Targeted Enforcement, and Regulatory Reform*, 120 PENN ST. L. REV. 109, 114–15 (2015); *Pre-Existing Conditions*, HHS.GOV, https://www.hhs.gov/healthcare/about-the-aca/pre-existing-conditions/index.html.

25. 42 U.S.C. §§ 300gg-6(a) (2012), 18022(b)(1) (2012). Essential health benefits include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care).

26. Janet Weiner et al., *Effects of the ACA on Health Care Cost Containmen*t, LEONARD DAVIS INS. OF HEALTH ECON., Mar. 2, 2017, at 1–2, https://ldi.upenn.edu/brief/effects-aca-health-care-cost-containment.

27. Harold Pollack, *30 Economists: We Need Individual Mandate*, HEALTHINSURANCE.ORG (July 18, 2013), https://www.healthinsurance.org/blog/2013/07/18/30-economists-we-need-the-individual-mandate.

28. *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 574 (2012) (holding the individual mandate constitutional as a valid exercise of Congress's taxing powers).

29. Pollack, *supra* note 27 ("The mandate expresses a basic obligation of citizenship as well as an economic reality. Without the mandate, some people will choose to gamble or to free-ride, undermining the fairness and financial stability of the health insurance system.").

30. *Sebelius*, 567 U.S. at 619.

skyrocket and health insurance becomes as expensive as paying health costs out of pocket.[31]

While Congress was unable to repeal the ACA in 2017, the 2017 Tax Cuts and Jobs Act removed the penalty for qualifying individuals who choose not to buy health insurance.[32] The penalty removal was expected to cause a sharp increase in insurance premiums and out-of-pocket limits as healthy individuals leave the pool of enrollees, resulting in a version of the death spiral as predicted would happen if the ACA was originally enacted without the individual mandate.[33] However, the markets have been remarkably stable, indicating support for the ACA's reforms and that healthy people, on the whole, still see the value of health insurance.[34] Premiums actually went down one percent, but experts note that given the current strong economy consumers would have seen a much greater decrease had Congress not removed the tax penalty.[35] Overall, the lack of an individual mandate indicates that 2018's stability was probably temporary, and consumers should expect increased prices and decreased coverage over the next few years if nothing changes.

II. THE NETWORK ADEQUACY PROBLEM

Given the fragmented, insufficient, and inconsistent nature of healthcare policies in America, it will come as no surprise that there are flaws in the system which harm consumers. One of the biggest problems facing patients is inadequate provider networks, and the crippling debt that comes from surprise balance billing.

A. THE EMERGENCE OF SKINNY NETWORKS[36]

As a result of these rising costs caused by increased regulation and healthy individuals leaving the market, consumers have been increasingly drawn to less expensive plans, creating a market for inexpensive, overly narrow networks, also known as "skinny networks."[37] As explained previously, health plans typically include a network of covered providers where patients can receive care from an in-network provider, which the plan will cover with lower cost sharing than out-of-network providers. Skinny networks simply have fewer providers in the network and occur in HMOs, PPOs, or other plan structures.[38] Insurance

31. Pollack, *supra* note 27.

32. An Act to Provide for Reconciliation Pursuant to Titles II and V of the Concurrent Resolution on the Budget for Fiscal Year 2018, Pub. L. No. 115-97, 131 Stat. 2054 (2017); Timothy Jost, *The Tax Bill and the Individual Mandate: What Happened, and What Does it Mean?*, HEALTH AFFAIRS BLOG (Dec. 20, 2017), https://www.healthaffairs.org/do/10.1377/hblog20171220.323429/full.

33. *See id*.

34. Sarah Kliff, *Obamacare is Having a Surprisingly Good Year*, VOX (Nov. 26, 2018, 4:35 PM), https://www.vox.com/policy-and-politics/2018/11/26/18113313/obamacare-mandate-tax.

35. *Id.*

36. In the context of this Note "skinny networks" will be used to describe overly narrow networks.

37. *See* Farringer, *supra* note 12, at 313–14.

38. *Id.* at 310–11.

companies started offering skinny network plans as a way to bring down their costs and increase competition, as they would have to pay a smaller number of providers.[39] The insurance market has responded to the high demand for less expensive plans, and skinny networks have become extremely popular.[40]

In theory, narrow networks provide cheaper health plans and increase market competition between providers, producing higher quality and less expensive care.[41] The lower costs result from lower reimbursement rates, as providers agree to accept less money per enrollee or service rendered in exchange for the plan's promise to deliver a steady stream of patients who can only get care from that provider. Because such a steady stream of patients is an attractive offer, providers should compete with each other to be the one the insurance company decides to accept in the network. That provider competition should ensure that only the highest quality and fairly priced providers are in the skinny network. However, patients can experience grave medical and financial consequences from inadequate network coverage.

B. PROS AND CONS OF SKINNY NETWORKS

The problem with skinny networks is that they are, by their nature, inadequate. An adequate network should provide plan enrollees with easy access to a sufficient number of in-network providers so that the enrollee can receive the health services covered by the plan.[42] For healthy patients who do not need as much care, very narrow networks are perfectly adequate to meet their needs. Yet, problems arise when those healthy patients suddenly need specialized care not covered by the network, or if sick patients unwittingly choose a skinny network.

Proponents of skinny networks praise their low costs while maintaining high-quality care and encouragement of market competition.[43] Some even refer to skinny networks as "high performance networks."[44] Those who favor skinny networks point to the fact that they emerged in response to market demands, not the greed of insurance companies that drove the rise of HMOs.[45] When networks are forced to be too broad, health insurers lose the ability to negotiate lower prices with providers.[46] The threat of being excluded from narrow networks

39. Dan Polsky & Janet Weiner, *The Skinny on Narrow Networks in Health Insurance Marketplace Plans*, LEONARD DAVIS INS. OF HEALTH ECON., June 2015, at 1, https://ldi.upenn.edu/sites/default/files/pdf/the-skinny-on-narrow-networks.pdf.

40. *See id.*

41. *See* David Blumenthal, *Reflecting on Health Reform—Narrow Networks: Boon or Bane?*, THE COMMONWEALTH FUND (Feb. 24, 2014) http://www.commonwealthfund.org/publications/blog/2014/feb/narrows-networks-boon-or-bane.

42. *See* Erin C. Fuse Brown, *Consumer Financial Protection in Health Care*, 95 WASH. U. L. REV. 127, 144 (2017).

43. Farringer, *supra* note 12, at 311.

44. *Id*.

45. *See id*. at 313–14.

46. Katherine Baicker & Helen Levy, *How Narrow a Network Is Too Narrow?* 175 JAMA INTERNAL MED. 337 (2015).

should motivate providers to offer efficient and cost-effective care to compete with other providers.[47] In fact, one of the Nation's leading health economists found that narrow networks have reduced premiums for enrollees, while maintaining a high quality of care.[48]

Yet for all the benefits of skinny networks, just as many, if not more, consequences exist. As insurers work to keep their premiums low, the least expensive plans may exclude specialists and highly-regarded academic medical centers in the narrow networks, preventing sick patients from accessing necessary and sometimes experimental care.[49] Proponents of skinny networks focus on the premium rates, but do not take into account how expensive using out-of-network providers can be, which is not reflected in the premiums.[50] Plans may intentionally exclude specialists to discourage already sick or injured patients from enrolling.[51] Unfortunately, patients enrolling in plans with skinny networks are often unaware they are doing so; thus, patients who need a lot of specialized care may inadvertently enroll in a plan that fails to provide for their needs.[52] While the ACA requires all plans to cover essential health benefits, it does not mandate that the plan has to provide those benefits through an in-network provider. Alternatively, healthy patients may knowingly pick skinny networks, optimistically ignoring the possibility of a tragic accident or diagnosis.[53] Patients choose skinny networks for their cheap price tag, but that rate is deceptive when patients need out-of-network care.[54]

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47. Leemore S. Dafny, et al., *Narrow Networks on the Health Insurance Marketplaces: Prevalence, Pricing, and the Cost of Network Breadth*, 36 HEALTH AFFAIRS 1606, 1607 (2017).

48. *Id.*; *see also* Farringer, *supra* note 12, at 331–32.

49. *See* Valarie Blake, *Narrow Networks, the Very Sick, and the Patient Protection and Affordable Care Act: Recalling the Purpose of Health Insurance and Reform*, 16 MINN. J.L. SCI. & TECH. 63, 68 (2015).

50. *See* Dafny, *supra* note 47, at 1608; *see also* HALL & GINSBURG, *supra* note 23, at 3.

51. HALL & GINSBURG, *supra* note 23, at 3.

52. *See* Blake, *supra* note 49, at 113. Blake explains that:

> Narrow networks present a number of ethical and legal challenges for patient care, especially access to tertiary care given that it is often life-saving, typically constitutes an essential health benefit, and is not currently being considered in the law despite the providers of such care being most frequently excluded from narrow networks.

Id. An additional problem stems from a lack of "health literacy," as patients struggle to meaningfully compare plans and navigate America's notoriously complex health care system. *See* Brietta Clark, *Using Law to Fight a Silent Epidemic: The Role of Healthy Literacy in Health Care Access, Quality & Cost*, 20 ANNALS HEALTH L. 253, 259 (2011). The U.S. Department of Health and Human Services recognizes the problem and defines health literacy as the extent to which individuals have "the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions." *Health Literacy Improvement*, U.S. DEP'T HEALTH & HUMAN SERVS., OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION (last updated July 24, 2008), https://health.gov/communication/literacy/default.htm.

53. *See* HALL & GINSBURG, *supra* note 23, at 3.

54. The problem is particularly pronounced in the individual market. Those who do not get health insurance through their employer are left to choose plans for themselves, and insurers are taking advantage of people's ignorance about how health networks function. *See* Katherine Hempstead, *Marketplace Pulse: Percent of Plans with Out-of-Network Benefits*, ROBERT WOOD JOHNSON FOUND. (Oct. 4, 2018), https://www.rwjf.org/en/library/research/2018/10/percent-of-plans-with-out-of-network-benefits.html. In the group markets, the share of employers choosing skinny plans for their employees has been decreasing over the past few years. Drew Altman, *Narrow Health Care Networks Aren't Actually That Common*, AXIOS (Oct. 12, 2018),

C. SURPRISE BALANCE BILLING

Surprise balance billing is the most harmful consequence of skinny networks. Patients with skinny networks often do not realize they are receiving out-of-network care until it is too late—when they have received a bill for an out-of-network provider. This kind of bill is called a surprise balance bill. The surprise typically occurs when a patient seeks care from an in-network provider, but then receives some tangential service from an out-of-network provider or facility.[55] For example, a patient may receive an x-ray at her in-network provider, but the image could be sent to a non-contracting radiology facility for diagnosis, resulting in a surprise balance bill from the radiology center. The "balance" in surprise balance billing refers to the fact that a health plan may cover a nominal amount of an out-of-network service, but the patient must pay the balance on the bill.

D. HOW SURPRISE BALANCE BILLING OCCURS

The rise in balance billing is directly caused by the narrowing of networks. While narrow networks are an effective way to reduce insurance company costs and enrollee premiums, they can harm patients who need specialized care from particular out-of-network providers.[56] Skinny networks lead to greater fragmentation in health care delivery and much higher costs for patients who need out-of-network specialists.[57] Accordingly, patients have seen a rise in surprise balance billing as insurance networks use skinny networks to keep their own corporate costs down in the face of increased compliance costs and present lower up-front premiums to enrollees.[58]

Surprise balance billing often arises in emergency contexts, but is actually more common in non-emergency situations.[59] Frequently, in an emergency someone calls an ambulance and the ambulance takes the patient to the nearest hospital, which happens to be outside the patient's network.[60] Surprise balance billing also often occurs in planned surgery.[61] For example, a patient schedules

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https://www.axios.com/narrow-health-care-networks-arent-actually-that-common-daeb99fb-45dc-43d2-895b-f99c72a2426a.html.

55. Fuse Brown, *supra* note 42, at 137 ("[T]he three common characteristics of a surprise medical bill are that it is unanticipated, involuntary, and out-of-network.").

56. Blake, *supra* note 49, at 68.

57. *Id*. at 114–15.

58. With the increase in regulation from the ACA, insurers have to spend more time and money assessing whether they meet the requirements of each regulation.

59. Karen Pollitz, *Surprise Medical Bills*, KAISER FAM. FOUND. (Mar 17, 2016), https://www.kff.org/%20private-insurance/issue-brief/surprise-medical-bills ("90% of surprise medical bills were not for emergency services, but for other in-hospital care."); *see also* LIZ HAMEL ET AL., THE BURDEN OF MEDICAL DEBT: RESULTS FROM THE KAISER FAMILY FOUNDATION/NEW YORK TIMES MEDICAL BILLS SURVEY 4 (2016), https://www.kff.org/wp-content/uploads/2016/01/8806-the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey.pdf (reporting that 61% of surprise billing came from emergency room visits, while 65% of surprise billing came from routine doctor visits).

60. *See* Pollitz, *supra* note 59.

61. *Id*.

knee surgery with his in-network surgeon at an in-network facility. After the surgery, the patient receives a surprise balance bill from the surgical assistant. While the patient's plan covered the surgeon, the surgeon brought in a non-contracting assistant.[62] Although the patient did everything he could to stay in network, he was still left to pay this surprise balance bill. On average, out-of-network surgical assistants bill $13,914, while health plans only pay $1794, leaving the unsuspecting patient to pay over $12,000.[63] Unfortunately, the problem is not limited to surgical assistants. Surprise balance billing often results from non-contracting anesthesiologists, radiologists, pathologists, and their respective facilities.[64] Many providers choose not to join networks because they can make more money by directly billing patients, instead of getting the lower, negotiated rate from the plans.

E. THE FINANCIAL IMPACT OF BALANCE BILLING

Providers can charge anything they choose for out-of-network care, making the bills often exorbitant, and as such, can cause burdensome medical debt for even those with insurance.[65] Balance bills are often unexpected because the system is so opaque that even the savviest consumers may not be able to predict if their care will be in-network. A recent study revealed about thirty percent of insured patients who had a problem paying their medical bills say the bill came from an out-of-network provider, and almost seventy percent of those people were unaware the provider was not in their network at the time they received the care.[66]

Surprise balance billing particularly harms patients because payments to non-contracting providers do not count towards deductibles or out-of-pocket limitations, such as co-pays or co-insurance payments.[67] A deductible is the amount a plan enrollee pays out-of-pocket before the health plan covers the rest of the health care for the year.[68] A co-pay is typically a nominal amount that the plan requires patients to pay when they go to see their primary care physician, specialist, or visit a hospital for emergency services.[69] Out-of-pocket costs include deductibles and co-pays, but not the premium enrollees pay to have the insurance.[70] Plans typically have an out-of-pocket maximum, which means that

62. "Non-contracting" refers to a provider or entity with which a health plan does not have a contract setting forth the prices the plan will pay for certain procedures. Without a contract, providers may charge the patient any price they choose.

63. Pollitz, *supra* note 59.

64. *Id*.

65. HAMEL ET AL., *supra* note 59, at 14 ("Among those with medical bill problems, almost identical shares of the insured (44 percent) and uninsured (45 percent) say the bills have had a major impact on their families.").

66. *Id*. at 12.

67. Fuse Brown, *supra* note 42, at 141.

68. *What's the Difference Between a Deductible and an Out-of-Pocket Limit?*, CONSUMER REPORTS (Dec. 6, 2013, 8:41 PM) https://www.consumerreports.org/cro/news/2013/12/what-s-the-difference-between-a-deductible-and-an-out-of-pocket-limit/index.htm.

69. *Id*.

70. *Id*.

a plan cannot charge an enrollee co-pays and deductibles once they have reached the maximum for the year.[71] Because insurance companies do not count balance bills towards the out-of-pocket maximum, there is no limit on what patients can be liable to pay for those bills.[72]

Medical debt devastates the finances of many Americans as they drain their savings to pay for their health care.[73] Patients with large medical bills report reducing their spending on food, clothing, and household necessities, increasing their credit card debt, and taking on second jobs to pay their bills.[74] As previously mentioned, people making these sacrifices to pay for medical care often have insurance, but their insurance does not cover all the care they need.[75]

Given the harmful nature of inadequate networks and surprise balance billing, both the private sector and legislatures have responded with solutions. Since the ACA was enacted, the federal government has begun to regulate network adequacy, but has not yet solved the problem of surprise balance billing. As such, the most effective solutions have come from the private sector and the states.

III. FEDERAL REGULATION

The federal government's attempts to regulate network adequacy have been limited by the language of the ACA, and perhaps by an inclination of the Centers for Medicare and Medicaid Services (CMS) to delegate this difficult issue to the states.[76] Furthermore, ERISA limits the ability of state protections from applying to all of the state's citizens.

A. THE ACA

The ACA includes some statutory language about network adequacy,[77] but does not set out requirements for what constitutes an adequate network, and delegates the responsibility of regulating network adequacy to CMS.[78] However, the Trump Administration recently transferred that duty from CMS to the states.[79] Health experts fear that the states are currently unprepared to take on

71. *Id*.
72. Fuse Brown, *supra* note 42, at 138.
73. HAMEL ET AL., *supra* note 59, at 15.
74. *Id*.
75. *Id*.
76. *See* Fuse Brown, *supra* note 42, at 155.
77. *See* 42 U.S.C. § 18031 (2012).
78. *Id*.; 42 U.S.C. § 300gg-1 (2012).
79. Mark Hall & Caitlin Brandt, *Network Adequacy Under the Trump Administration*, HEALTH AFFAIRS BLOG (Sept. 14, 2017), https://www.healthaffairs.org/do/10.1377/hblog20170914.061958/full. Hall and Brandt report:

> Under the Obama administration, the Centers for Medicare and Medicaid Services (CMS) reviewed all qualified health plans (QHPs) in the ACA market in states that did not operate their own exchanges. Through this review process, CMS ensured that all QHPs on the federally facilitated exchanges met basic quantitative standards designed to ensure network adequacy. . . . With this final

this regulation, as most have relied on the federal government, choosing not to establish their own network adequacy standards.[80] Especially with the federal government putting the regulatory burden on states, experts predict skinny networks are not going away anytime soon.[81]

While overly narrow networks are a nationwide problem, the federal government has done nothing to address surprise balance billing. In fact, as the ACA explicitly exempts balance billing from its cost-sharing provisions, CMS has no statutory authority to create regulations that would protect patients from surprise balance billing.[82] Balance billing statutes are integrally linked with cost sharing. As the ACA excludes "balance billing" from its definition of cost sharing, CMS cannot create a regulation that touches on surprise balance billing. Thus, only states have the capability to protect patients from surprise balance billing.

B. ERISA PREEMPTION

Yet, even the most robust state solutions cannot protect all patients, because ERISA prevents state protections from applying to the large proportion of Americans who get their health insurance through employer-sponsored health plans. ERISA completely preempts many state protections, including state balance billing laws.[83] Many people get their health insurance through their employer, and those plans are governed by ERISA.[84] The "black hole" of ERISA makes it so patients who are insured through an employee benefit plan are not protected from surprise balance bills, even in states like California and New York.[85]

C. POTENTIAL FEDERAL LEGISLATION

As exorbitant surprise medical bills grab the media's attention, Congress is considering legislation to address the problem.[86] After President Trump

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rule, the Trump administration eliminated this federal review process, ceding network adequacy regulation to the states, even those that might prefer to wash their hands of the process.

Id. See generally Patient Protection and Affordable Care Act; Market Stabilization, 82 Fed. Reg. 18346 (Apr. 18, 2017) (to be codified at 45 C.F.R. pts. 147, 155, 156).

80. Sarah Hansard, *Many States Not Prepared to Regulate Health Plan Networks*, BLOOMBERG BNA (Mar. 8, 2017), https://www.bna.com/states-not-prepared-n57982084915.

81. Farringer, *supra* note 12, at 304; Justin Giovannelli & Ashley Williams, *Regulation of Narrow Networks: With Federal Protections in Jeopardy, State Approaches Take on Added Significance*, THE COMMONWEALTH FUND, (Feb. 2, 2017) www.commonwealthfund.org/publications/blog/2017/feb/regulation-of-narrow-networks.

82. 42 U.S.C. § 18022(c)(3)(B) (2012); Fuse Brown, *supra* note 42, at 155.

83. Fuse Brown, *supra* note 42, at 184.

84. U.S. DEP'T OF LABOR, EMP. BENEFITS SEC. ADMIN., *supra* note 6.

85. Fuse Brown, *supra* note 42, at 194. For a detailed discussion of ERISA as it relates to patient protections and possible federal solutions, see *id.* at 183-199.

86. For example, Sarah Kliff from Vox has been investigating emergency bills and reporting on them since December 2018, and the Kaiser Family Foundation has an ongoing project with NPR called "Bill of the Month." *See, e.g.*, Sarah Kliff, *I Read 1,182 Emergency Room Bills This Year. Here's What I Learned.*, VOX (Dec. 18,

expressed his support for a solution to this problem, it seems increasingly likely that the federal government could reach a bipartisan agreement.[87] As of July 2019, there are two bills in the Senate and one in the House, modeled on successful State legislation.[88] If one of these bills, or something similar, is enacted, it would go a long way to protect patients insured by their employers.

IV. STATE REGULATION

States have had varying levels of success in regulating networks, which has demonstrated the necessity of striking a careful balance between over and under-regulating. In states with little to no regulation, patients remain vulnerable to surprise balance billing because of their unregulated narrow networks. However, there is a danger in applying too stringent a standard. The best state laws regulate network adequacy as well as surprise balance billing, while giving regulators some flexibility in their enforcement.

A. NETWORK ADEQUACY LAWS

The goal of network adequacy laws is to ensure an appropriate number of providers within each network to meet the needs of those patients. States have crafted legislation to achieve this goal in a variety of ways. Some focus on qualitative measures, others on quantitative, while the best network adequacy laws use both.[89] Other states have focused on requiring plans to inform the insured about the size and scope of their network.[90] Yet, for all the effort states have put into such laws, networks remain inadequate. States have difficulty enforcing the laws for all plans, gathering the information needed to stay updated, and effectively informing patients of their options.

There are three types of quantitative measures of network adequacy: minimum ratios of providers to enrollees, minimum time or distance to travel to certain providers, and maximum wait times.[91] Each is important in its own way as they serve slightly different functions. While some states will only use one of these measures, some states, such as California, use all three.[92] This comprehensive approach provides the most effective way to use quantitative

2018, 7:00 AM), https://www.vox.com/health-care/2018/12/18/18134825/emergency-room-bills-health-care-costs-america; Sarah Kliff, *A $20,243 Bike Crash: Zuckerberg Hospital's Aggressive Tactics Leave Patients with Big Bills*, VOX (Jan. 24, 2019, 4:27 PM), https://www.vox.com/policy-and-politics/2019/1/7/18137967/er-bills-zuckerberg-san-francisco-general-hospital; Julie Appleby, *Meow-ch! The $48,512 Cat Bite*, KAISER HEALTH NEWS (Feb. 27, 2019), https://khn.org/news/biologist-faces-48512-bill-for-rabies-shot-after-cat-bite.

87. Shefali Luthra & Emmarie Huetteman, *Bipartisan Support Builds For Limits On Surprise Medical Bills*, NPR (Feb. 5, 2019, 5:00 AM), https://www.npr.org/sections/health-shots/2019/02/05/691374149/bipartisan-support-builds-for-limits-on-surprise-medical-bills.

88. *Id*. Two bills would follow the California model and impose payment standards, while the other would take the lead from New York and impose an arbitration system to determine the correct amount of payment.

89. HALL & GINSBURG, *supra* note 23, at 12.

90. *Id.* at 7.

91. *Id*. at 7–8.

92. *Id*. at 8, exhibit 2.

measures, as it allows regulators to see the broader picture from multiple viewpoints. California refers to its combination of these qualitative standards as "timely access" laws.[93]

California's timely access laws attempt to ensure patients can obtain necessary services in a reasonable amount of time.[94] California is one of the few states that divides its regulation of health plans between two agencies, the California Department of Insurance (CDI) and the California Department of Managed Health Care (DMHC).[95] CDI promulgates regulations applying to health insurers.[96] Health insurance plans must provide a certain number of doctors per insured in the area; however, few standards exist for how far away providers can be, and the hours per week during which emergency and non-emergency providers must be available.[97] Similarly, DMHC requires the managed care plans under its purview to have providers within a reasonable distance who can adequately serve the enrolled patients.[98] The corresponding regulations also require health plans to ensure a certain number of providers for enrollees, a certain number of hours of provider availability per week, and timelines for when a patient must receive different types of appointment after requesting one.[99] The requirements differ for emergency and non-emergency care, but not for specialties.[100] If plans in California cannot comply with the timely access laws, they cannot sell plans in the state.

However, these timely access requirements in California come with arduous reporting standards for the health plans and insurers and place a heavy regulatory burden on CDI and DMHC.[101] Insurers and health plans must constantly file reports on network adequacy, which CDI and DMHC must review and investigate. These standards are therefore burdensome to enforce as the regulators have to gather "a daunting amount of information," including checking to see if each individual provider is still in the network and accepting new patients.[102] Even when agencies enforce the standards and maintain the directories, patients with low health literacy still struggle to make use of the resources given to them.[103] While other states have network adequacy

93. *Timely Access to Care,* CA.GOV, DEP'T OF MANAGED HEALTH CARE, (last accessed May 12, 2019), https://www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/TimelyAccesstoCare.aspx.

94. *Id.*

95. MAKING SENSE OF MANAGED CARE REGULATION IN CALIFORNIA, CAL. HEALTH CARE FOUND. 5 (2001), https://www.chcf.org/wp-content/uploads/2017/12/PDF-MakingSenseManagedCareRegulation.pdf.

96. CAL. INS. CODE § 10133.5 (West 2019).

97. CAL. CODE REGS. tit. 10, § 2240.1 (2019).

98. CAL. HEALTH & SAFETY CODE § 1367 (West 2019).

99. CAL. CODE REGS. tit. 28, §§ 1300.67.2, 1300.67.2.2 (2019).

100. CAL. CODE REGS. tit. 28, §§ 1300.67.21–1300.67.2.2 (2019).

101. CAL. CODE REGS. tit.10, § 2240.1(l) (2019); CAL. CODE REGS. tit. 28 § 1300.67.2.2(g) (2019); JANE WISHNER & JEREMY MARKS, ENSURING COMPLIANCE WITH NETWORK ADEQUACY STANDARDS: LESSONS FROM FOUR STATES 7–8 (2017), https://www.urban.org/sites/default/files/publication/88946/2001184-ensuring-compliance-with-network-adequacy-standards-lessons-from-four-states_0.pdf.

102. Fuse Brown, *supra* note 42, at 156.

103. *See generally* Helen Levy & Alex Janke, *Health Literacy and Access to Care*, 21 J. HEALTH COMMC'N. (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4924568/.

requirements, their lack of staffing makes their similar standards difficult to enforce.[104] California's DMHC regulates the largest market in the country and is the only state which has full-time staff devoted solely to evaluating network adequacy.[105] Even so, it is a never-ending task for the regulators to ensure compliance with the network adequacy laws.

In some states with quantitative standards to regulate network adequacy, the standards only apply to certain types of plans, leaving other types of plans completely unregulated by the quantitative requirements.[106] Often, when states regulate certain types of plans but not others, the regulations only apply to HMOs, as the regulations are left over from the HMO backlash in the 1990s.[107] When quantitative regulations are limited to HMOs, the states fail to regulate the now more popular PPOs and other similarly structured plans.[108]

In addition to doing their own monitoring, regulators depend on consumer complaints to assess network adequacy.[109] However, consumers with low health literacy often do not understand how to file complaints, grievances, or appeals when faced with problems with provider access.[110] In all likelihood, a large number of patients face inadequate networks and subsequent balance billing, but fail to report it to regulators because they do not know how. Accordingly, regulators have no access to that data and are unable to help solve the problem.[111]

Another focus of network adequacy laws has been to increase transparency, although the effect of these efforts has been limited by the health literacy barriers.[112] Most general efforts to address transparency in health care have been directed towards price transparency.[113] In terms of network adequacy, states are increasingly using provider directories to increase transparency.[114] Provider directories theoretically give patients a database to look at the providers in their area, determine who is accepting new patients, and assess which provider is right for them.[115] However, the providers are not responsible for updating their own information, the regulators must do continual research to keep the directory

104. WISHNER & MARKS, *supra* note 101, at 7–8.

105. *Id.* at 8.

106. *See* HALL & GINSBURG, *supra* note 23, at 4. Sixteen states have quantitative standards that apply to all plans, eleven states have quantitative standards that apply only to plans such as HMOs, and the remaining twenty-three states do not use quantitative measures of network adequacy. *Id*.

107. *See id.* at 1, 4.

108. *See id.* at 4.

109. WISHNER & MARKS, *supra* note 101, at 10.

110. *See id*.

111. *See id*.

112. *See* Blake, *supra* note 49, at 93.

113. *See, e.g*., Ateev Mehrotra et al., *Defining the Goals of Health Care Price Transparency: Not Just Shopping Around*, NEW ENG. J. MED. CATALYST (June 26, 2018) https://catalyst.nejm.org/health-care-price-transparency-goals/; Andis Robeznieks, *8 Ways to Improve Health Care Price Transparency*, AM. MED. ASSN. (Sept. 20, 2018), https://www.ama-assn.org/practice-management/economics/8-ways-improve-health-care-price-transparency.

114. *See, e.g*., 45 C.F.R. § 156.235 (2018).

115. Blake, *supra* note 49, at 93.

accurate.[116] Unfortunately, these directories do not have to be constantly updated and the frequency of the updates depend on the jurisdiction.[117] Furthermore, patients with low health literacy have a difficult time finding these directories, and when they do, they do not understand how to meaningfully compare the providers.[118] While provider directories can be useful and do increase transparency, they are burdensome on regulators, and have limited value given the frequency with which they are updated and whether patients can effectively utilize them.

Regulators require flexibility in enforcing network adequacy laws.[119] Exceptions and waivers are critical when enforcing network adequacy using quantitative measures.[120] Regulators must be able to look at the market factors in play and assess which plans need exceptions.[121] Rural communities often need exceptions, as a strict application of network adequacy standards may disqualify every plan in a rural area.[122] Giving regulators flexibility on quantitative standards also allows for the development of modern medical innovations, such as telemedicine.[123] When quantitative standards are applied strictly in rural areas, the providers could have extraordinary bargaining power over the plan, as the plans would have no choice but to include the providers to meet the requirements.[124] If all the plans in a rural area are deemed inadequate, that means there are no health plans at all for individuals who live in those communities.[125] In that case, an inadequate plan is better than no plan.

B. ANY WILLING PROVIDER LAWS

An alternative approach has been to encourage larger networks by using "any willing provider" laws; however, states have had limited success in enforcing them. For example, South Dakota recently implemented an "any willing provider" law through a ballot measure.[126] The statute requires health insurers to accept all providers within the geographic coverage area who are willing and qualified to meet the terms and conditions of participation as

116. *See, e.g.*, 45 C.F.R. § 156.235 (2018).

117. *See id.* Blake, *supra* note 49, at 93; Some states, such as California, require more frequent updates. *See, e.g.*, WISHNER & MARKS, *supra* note 101, at 9.

118. *See* INST. OF MED., COMM. ON HEALTH LITERACY, HEALTH LITERACY: A PRESCRIPTION TO END CONFUSION 42, tabl. 2-1 (LYNN NIELSEN-BOHLMAN ET AL. EDS., 2004). Many patients do not understand what they require in a provider and fail to anticipate their future health needs when selecting a plan. HALL & GINSBURG, *supra* note 23, at 3.

119. WISHNER & MARKS, *supra* note 101, at 6–7.

120. *Id*. at 7.

121. *See id.*

122. *See id*.

123. HALL & GINSBURG, *supra* note 23, at 17.

124. *Id*. at 6.

125. *Id*.

126. Ashley Noble, *Any Willing or Authorized Providers*, NCSL (Nov. 5, 2014), http://www.ncsl.org/research/health/any-willing-or-authorized-providers.aspx.

established by the plan.[127] This law successfully and severely limits plans in South Dakota from using skinny networks.[128] Yet, it also prevents insurance companies from negotiating lower prices with providers and facilities, so they are less able to contain costs for enrollees and cannot disqualify providers based on quality; hence "any willing provider" laws have been highly criticized.[129] "Any willing provider" legislation alone is an insufficient solution to the problem of overly narrow networks, as it fails to reduce costs for consumers, there is no guarantee that providers will ask to join the networks, and plans have no ability to control the quality of providers with whom they contract.

C. BALANCE BILLING PROTECTIONS

Even when states have network adequacy standards that they try their best to enforce, those standards do not eradicate the problem of balance billing. Network adequacy laws, such as California's, only create minimum requirements, but do not eliminate skinny networks.[130] When paired with surprise balance billing laws, network adequacy standards can protect patients from financial harm. Balance billing laws range from fully comprehensive to ineffective in practice. The best laws include set reimbursement standards for non-contracting providers, and mandate dispute resolution mechanisms which do not involve the patient.[131] Less effective laws simply notify patients that they may receive care from out-of-network providers, apply only to emergency balance bills, or otherwise fail to explain what a prohibition on balance bills looks like in practice, allowing plans and providers to easily avoid the laws and continue charging higher rates.[132]

California passed a prohibition against surprise balance billing in 2016.[133] The statute requires all health plans and insurers to cover these out-of-network costs by reimbursing "the greater of the average contracted rate or 125 percent of the amount Medicare reimburses," also known as the default rate.[134] The enrollee only pays the "same cost sharing that the enrollee would pay for the same covered services received from a contracting individual health professional."[135] Patients are taken out of the equation as the providers and

127. *Id.*

128. Baicker & Levy, *supra* note 46, at 2.

129. HALL & GINSBURG, *supra* note 23, at 5–6; *See* Baiker & Levy, *supra* note 46, at 2.

130. Fuse Brown, *supra* note 42, at 147.

131. *See id*. at 178.

132. *See* Jack Hoadley et al., *State Efforts to Protect Consumers from Balance Billing*, THE COMMONWEALTH FUND (Jan. 18, 2019), https://www.commonwealthfund.org/blog/2019/state-efforts-protect-consumers-balance-billing.

133. Assemb. B. No. 72: Health Care Coverage: Out-of-Network Coverage, ch. 492 (Cal. 2016) (codified as amended at CAL. HEALTH & SAFETY CODE §§ 1371.30, 1371.31, 1371.9 (West 2019), CAL. INS. CODE §§ 10112.8, 10112.81, 10112.82 (West 2019)).

134. CAL. HEALTH & SAFETY CODE § 1371.31(a)(1) (West 2019); CAL. INS. CODE § 10112.82(a)(1) (West 2019).

135. CAL. HEALTH & SAFETY CODE § 1371.9(a)(1) (West 2017); CAL. INS. CODE § 10112.8(a)(1) (West 2019).

health plans must use a binding independent dispute resolution process to resolve payment disputes.[136] A patient may waive her rights to the balance billing protection if she chooses to use a non-contracting provider or facility.[137] However, the statute protects patients by requiring a binding written estimate of the cost and written consent twenty-four hours in advance, so patients are never surprised with a balance bill.[138] While these California protections safeguard patients, they necessarily create even more government overhead, and impose compliance costs on health plans and providers.

Only eight other states have such comprehensive patient financial protections as California, although California's are arguably one of the strongest, with New York coming in as a close second.[139] Only California and New York have both payment standards for all out-of-network care and dispute resolution processes.[140] New York pioneered state laws to protect consumers from the harmful practice of balance billing.[141] Like California, New York prohibits surprise balance billing of patients, requiring written consent when a patient wants to use a non-contracting provider.[142] It also established standards for determining a reasonable fee and imposed a binding dispute resolution process for providers and insurers when either party disputes a proposed fee.[143] New York has served as a successful model of patient financial protection before even the National Association of Insurance Commissioners (NAIC), and states like California have taken note of its success.

Connecticut, Florida, Illinois, Maryland, and more recently New Hampshire, New Jersey, and Oregon have also adopted comprehensive approaches to balance billing.[144] Comprehensive protections apply to both HMOs and PPOs in emergency and in-network hospital settings, holding consumers harmless from surprise balance bills, and creating adequate payment standards *or* a dispute resolution process so non-contracting providers receive payment for their services.[145] These standards have proven fairly effective in protecting patients, although there are problems in establishing appropriate payments for non-contracting providers.[146] The problem with lacking either a

136. CAL. HEALTH & SAFETY CODE § 1371.30 (West 2019); CAL. INS. CODE § 10112.81 (West 2019).

137. CAL. HEALTH & SAFETY CODE § 1371.9(c) (West 2019); CAL. INS. CODE § 10112.8(c) (West 2019).

138. *Id.*

139. Hoadley et al., *supra* note 132132; s*ee also* Fuse Brown, *supra* note 42, at 151–52; Kevin Lucia et al., *Balance Billing by Health Care Providers: Assessing Consumer Protections Across States*, 16 THE COMMONWEALTH FUND 1, 3 (2017), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2017/jun/lucia_balance_billing_ib.pdf (analyzing balance billing protections in the United States).

140. *See* Fuse Brown, *supra* note 42, at 149, 151–52.

141. *Id*. at 149.

142. N.Y. FIN. SERV. §§ 603, 606 (McKinney 2019).

143. N.Y. FIN. SERV. §§ 604, 607 (McKinney 2019).

144. Hoadley et al., *supra* note 132.

145. Lucia et al., *supra* note 139, at 4.

146. *Id*. at 4.

payment standard or dispute resolution process is that patients get dragged into the disagreement.[147]

When working within complicated regulatory frameworks that deal with network adequacy and balance billing, external review processes are crucial. There are two types of processes: external review of a patient's request for necessary medical care and dispute resolution about the payment for that care.[148] When patients require care from out-of-network specialists, states should impose an external review process to ensure fair determinations as to whether the plan should cover those services.[149] Around half the states have such processes, but several require multiple internal reviews before a patient can reach the external review, which can impede the patient's timely access to care.[150] Once that external reviewer determines the patient needs out-of-network care, states should have a clear and just system for determining an appropriate payment without patient involvement.[151]

Fifteen other states have a limited approach to preventing surprise balance billing, but most only pertain to emergency services, which, as discussed above, is woefully insufficient, as ninety percent of surprise balance bills occur in non-emergency contexts.[152] Some states, like Colorado, do not prohibit surprise balance bills, but only provide hold harmless provisions, which can confuse patients who do not understand that they do not have to pay the bill.[153] Other states, such as Texas, limit the protection to HMOs, when most of its citizens have PPOs.[154] The biggest problem for states with only limited protections on surprise balance billing is the lack of dispute resolution mechanisms or payment standards.[155] These gaps in the laws and regulations have led providers to abuse the system, charging even higher prices to insurance companies and patients.[156] Yet the situation is even worse in the other twenty-nine states that lack any such protections for their citizens. In those states, patients can be blindsided with massive surprise balance bills, with no recourse but to pay them at the cost of their own financial security.

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147. *Id*. at 3.

148. HALL & GINSBURG, *supra* note 23, at 13, 16.

149. *Id.* at 13.

150. *Id*. at 13, n.51.

151. *Id*. at 13; Lucia et al., *supra* note 139, at 6.

152. Lucia et al., *supra* note 139, at 4; Pollitz, *supra* note 59.

153. Lucia et al., *supra* note 139, at 6. A hold harmless provision is a "requirement that insurers pay providers their billed charges or some lower amount that is acceptable to the provider." *Id.* at 4.

154. *Id*. at 4.

155. *Id*. at 6.

156. *Id*. According to Lucia et al.:

> Providers have used this lack of specificity to charge high amounts to insurers, who must pay the balance bill to avoid consumer liability, resulting in higher overall health costs. In New Jersey, for instance, the absence of a standard may encourage providers to remain out of network—by opting not to accept a discounted payment rate with an insurer—and then charge higher prices through balance billing, potentially contributing to the state's high hospital charges and high premiums.

Id.

D. MODEL LEGISLATION

The NAIC created a Network Adequacy Model Act in 2015 in response to the narrowing of networks after the implementation of the ACA.[157] The NAIC did not intend for states to adopt the Model Act exactly as written, but to shape it to fit the needs of the individual state.[158] However, four states (Colorado, Georgia, Hawaii and Maryland) adopted it in its entirety.[159] The Model Act requires that all health plans "shall maintain a network that is sufficient in numbers and appropriate types of providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults, will be accessible without unreasonable travel or delay."[160] While the Model Act identifies an important goal, it fails to provide standards for achieving that goal.[161]

In addition to regulating network adequacy, the Model Act also touches on balance billing. It includes a provision which requires health plans to have a "process to assure that a covered person obtains a covered benefit at an in-network level of benefits, including an in-network level of cost-sharing, from a non-participating provider" when the circumstances require a patient to be out of network.[162] In theory, this should eliminate the practice of surprise balance billing, but the Model Act does not fully prohibit balance billing.[163] Even when states adopt the Model Act in its entirety, they still cannot completely protect patients.[164]

V. PRIVATE SECTOR SOLUTIONS

Where state protections are often inadequate, the private sector has stepped in with its own solutions. Health systems have been engaging in different levels of integration, with varying degrees of success for patients and system profit margins. For the large population of Americans who get their health insurance from their employer, the employing companies have the market power to protect their employees from overly narrow networks and surprise balance bills.

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157. HEALTH BENEFIT PLAN NETWORK ACCESS AND 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.

158. NAIC MODEL ACT §§ 1, 2.

159. *State Legislative Brief*, NAIC (Dec. 2018), http://www.naic.org/documents/cmte_legislative_liaison_brief_network_adequacy.pdf.

160. NAIC MODEL ACT § 5(A)(1).

161. WISHNER & MARKS, *supra* note 101, at 4.

162. NAIC MODEL ACT § 5(C).

163. Fuse Brown, *supra* note 42, at 154.

164. *See id*.

A. VERTICAL AND HORIZONTAL INTEGRATION

Many advocates argue for a more integrated private health care system, which would solve some of the problems with balance billing and improve coordination of care.[165] There are two types of integration: horizontal and vertical. Horizontal integration occurs when one entity engulfs another that provides roughly the same product or service, for example, the consolidation of two physician practices.[166] Vertical integration entails the merger of two entities that operate in different sectors of the market, such as a hospital and a physician group.[167] Hospitals have been acquiring physician practice groups, which have also increased in size over the past few years.[168] With more contracting physician practices, there is a decreased chance that a patient will have to go outside his network to obtain necessary diagnosis or treatment. Because patients can remain in-network with larger physician practices, they are less likely to be balance billed. Supporters of greater hospital-physician integration argue that it lowers costs—as care is coordinated within one system—while simultaneously improving quality of care.[169]

On the other hand, too much consolidation leads to abuses of market power.[170] Indeed, research suggests that hospital acquisition of physician practices leads to a fourteen percent price increase per group acquired, with even higher prices being reported when the acquiring entity has a large share of the patient market.[171] Furthermore, as entities leverage their vertical integration into horizontal monopolies, they provide lower quality care as they lack the competition that requires them to compete to provide the best quality of care at an optimal price.[172]

Kaiser Permanente is a successful model of a fully vertically integrated health system.[173] Kaiser has its own hospitals, medical groups, and health plans.

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165. David C. Szostak, *Vertical Integration in Health Care: The Regulatory Landscape*, 17 DEPAUL J. HEALTH CARE L. 65, 69-71 (2015).

166. Miriam J. Laugesen & George France, *Integration: The Firm and the Health Care Sector*, 9 HEALTH ECON., POL'Y & L. 295, 298 (2014).

167. *See id.* at 296.

168. Cory Capps et al., *The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending*, 59 J. HEALTH ECON. 139, 139–140 (2018).

169. *Id*. at 140.

170. *See* Reed Abelson, *The Face of Future Health Care*, N.Y. TIMES, (Mar. 20, 2013), http://www.nytimes.com/2013/03/21/business/kaiser-permanente-is-seen-as-face-of-future-health-care.html.

171. Capps et al., *supra* note 168, at 151. Some doctors who have seen the system evolve argue we should fix payment systems that reward high prices and excessive service use (fee-for-service payments, for example), instead of focusing on vertical integration. Robert Berenson, *A Physician's Perspective on Vertical Integration*, 36 HEALTH AFFAIRS 1585, 1588 (2017).

172. *See generally* Marah Noel Short & Vivian Ho, *Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality*, MED. CARE RES. & REV. (Feb. 9, 2019); Eric C. Schneider, *Provider Mergers: Will Patients Get Higher Quality or Higher Costs?*, THE COMMONWEALTH FUND (Nov. 20, 2015), https://www.commonwealthfund.org/blog/2015/provider-mergers-will-patients-get-higher-quality-or-higher-costs.

173. Szostak, *supra* note 165, at 71–72. Yet, given antitrust laws, even Kaiser is not a completely vertically-integrated health care system as defined by Szostak.

Kaiser and its health plans function as a very large HMO, with a very broad network. Kaiser members do not receive surprise balance bills for planned procedures, because it is impossible for them to unknowingly interact with non-contracting providers or facilities. However, a Kaiser patient could still encounter the situation of being transported to a non-Kaiser hospital in the event of an emergency, where they would be billed according to the state policies on emergency care. While some patients dislike Kaiser because it does not allow them to choose any doctor or hospital they want, Kaiser's incredibly broad network covers the needs of almost all of its patients without them ever having to go out of network.[174] A closed network system like Kaiser's can be appropriate as long as it is sufficiently broad. However, while Kaiser is one of the best solutions from the private sector, it is not a flawless system. Kaiser has not been immune to the overall rising costs of health care; premiums have been rising steadily over the past twenty years, including Kaiser Health Plans.[175] When patients are surprise balance billed, they experience financial harm. Even if they are in the Kaiser system and avoid such bills, they still feel the effect of overall rising costs of health care when they pay increasingly large premiums and co-payments.

B. STRUCTURING AND CHOOSING HEALTH PLANS

Companies that purchase health plans for their employees have a lot of market power, which they can use to address network inadequacy problems. Healthy employees are more productive employees, so many businesses have started to focus on their employees' wellbeing.[176] Large and successful companies have started to offer plans with broad coverage to their employees to better take care of their employees.[177] These large entities have the market power to make wide-network plans more affordable to ensure that their employees are never out of network, and never get left with a surprise balance bill.[178] Unfortunately, small employers do not have the same market power and may struggle to obtain sufficiently broad network plans that protect their employees,

174. Abelson, *supra* note 170. If, for example, a patient wants experimental or specialized care from a certain facility outside of the Kaiser network, the patient would pay for that treatment entirely out of pocket. Furthermore, like almost all health plans and health systems in the United States, Kaiser struggles to deliver convenient care to its rural members. Access to health care in rural areas is an issue this Note does not attempt to address. For an in-depth look at policy in this area, see Nicole Huberfeld, *Rural Health, Universality, and Legislative Targeting*, 13 HARV. L. & POL'Y REV. 241 (2018).

175. *Premiums and Worker Contributions Among Workers Covered by Employer-Sponsored Coverage, 1999-2018*, KAISER FAM. FOUND. (Oct. 3, 2018), https://www.kff.org/interactive/premiums-and-worker-contributions-among-workers-covered-by-employer-sponsored-coverage-1999-2018/.

176. *See generally* Leonard L. Berry et al., *What's the Hard Return on Employee Wellness Programs?*, HARV. BUS. REV. (Dec. 2010), https://hbr.org/2010/12/whats-the-hard-return-on-employee-wellness-programs.

177. *See, e.g.*, Laura Lorenzetti, *These 11 Companies Offer 100% Healthcare Coverage*, FORTUNE (Mar. 11, 2015), http://fortune.com/2015/03/11/companies-offer-all-healthcare-coverage.

178. *See* Patricia A. McDonald et al., *The Employer-Led Health Care Revolution*, HARV. BUS. REV. (July–Aug. 2015), https://hbr.org/2015/07/the-employer-led-health-care-revolution (arguing that employers have the market power necessary to make changes to the healthcare system).

which leaves those employees with only their state's protections to shield them from balance bills.

VI. PROPOSAL: STATE SINGLE PAYER

America's traditional combination of regulation and market competition is failing in the health care sphere. The health insurance and provider markets are highly concentrated with large players wielding too much market power.[179] Because these few companies control so much of the market, they have little incentive to lower their premiums and negotiate better deals with providers.[180] Without an effective market to bring down costs, regulations alone are insufficient and unwieldy. A state-run single payer, "Medicare for All" system similar to Canada's would solve the problem of overregulation and insufficient market competition.[181] In such a system, all citizens of the state would be insured through a state health plan; no one would be insured on the individual market or through their employers.

A. THE BENEFITS OF STATE SINGLE PAYER

State single payer health care would eliminate the problems of surprise balance billing, as patients would not be required to pay for their health care out-of-pocket. If state insurance covered all licensed providers, a patient would effectively never be able to go out-of-network within the state. The single payer solution is elegant, unlike the current system. Healthcare at the state and federal levels remains fragmented and massively convoluted, meaning a lot of money goes into unnecessary overhead costs. When a single entity provides and regulates the health insurance of all citizens, it can greatly reduce the overall administrative costs.[182] There would be no tangled web of health plans and insurers who contract with different providers, medical groups, facilities, employers who provide health plans, and multiple regulatory authorities governing all parties. By streamlining the health care payment system, states could make significant reductions in costs for its citizens.

In addition, establishing a system where the patient does not have to worry about the adequacy of her network or how she will pay for a certain procedure may actually increase health outcomes.[183] Teaching health literacy is a less daunting task when educators do not have to instruct people about how to ensure that the care they need will actually be covered. Furthermore, lower levels of

179. Leemore S. Dafny, *Are Health Insurance Markets Competitive?*, 100 AM. ECON. REV. 1399, 1400–1401 (2010).

180. *See id*.

181. *See* Sara Allin & David Rudoler, *The Canadian Health Care System*, THE COMMONWEALTH FUND, https://international.commonwealthfund.org/countries/canada/ (last visited July 27, 2019).

182. Jonathan Oberlander, *The Virtues and Vices of Single-Payer Health Care*, 374 NEW ENG. J. MED. 1401, 1402 (2016).

183. *See* Clark, *supra* note 52, at 256.

health literacy lead to lower access to care,[184] perhaps in part because people are afraid they will be unable to pay for it. There is a correlation between low health literacy and poorer health.[185] Creating a single payer system will increase access to preventative care and other necessary treatment, which will improve the lives of patients and lower the overall cost on society.

There is also a compelling moral argument for single payer. Health care should be a human right, not a privilege for the wealthy.[186] People should not be able to fall into bankruptcy because they had the audacity to get sick. In the preamble to its constitution, the World Health Organization declared that "[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[187] The United Nations recognized the "right to a standard of living adequate for the health and well-being of himself and of his family, including . . . medical care" in its 1948 Universal Declaration of Human Rights.[188] Yet 70 years later in 2018, people in the United States still bankrupt themselves in order to obtain necessary medical care.

B. THE OBSTACLES TO STATE SINGLE PAYER

One of the biggest obstacles to a state single payer system is the cost, and states need to be able to reapportion federal Medicaid and Medicare funding.[189] The ACA has an innovation waiver provision that went into effect in 2017, enabling states to continue receiving the aggregate federal funding that would have gone to individual residents and to use that funding to finance a new system.[190] This section 1332 waiver allows states to address problems stemming from the removal of the individual mandate penalty and more comprehensively address balance billing and network adequacy using federal funding. Some states have already used these waivers and are implementing new programs.[191] However, the section 1332 waivers likely would not give states sufficient flexibility to fully implement a state single payer system. California's new

184. *Id*. at 268.

185. *Id*.

186. *See generally* Mariah McGill & Gillian MacNaughton, *The Struggle to Achieve the Human Right to Health Care in the United States*, 25 S. CAL. INTERDISC. L.J. 625 (2016).

187. WORLD HEALTH ORG., BASIC DOCUMENTS: CONSTITUTION OF THE WORLD HEALTH ORGANIZATION 1 (45th ed. 2006).

188. G.A. Res. 217 (III) A, A Universal Declaration of Human Rights (Dec. 10, 1948).

189. For example, single payer in California is estimated to cost $400 billion. Patricia Cohen & Reed Abelson, *Single-Payer Health Care in California: Here's What It Would Take*, N.Y. TIMES (May 25, 2018), https://www.nytimes.com/2018/05/25/business/economy/california-single-payer.html; Chad Terhune, *Tab for Single-Payer Proposal in California Could Run $400 Billion*, KAISER FAM. FOUND. (May 23, 2017), https://khn.org/news/tab-for-single-payer-proposal-in-california-could-run-400-billion/.

190. 42 U.S.C. § 18052 (2012); McGill & MacNaughton, *supra* note 186186, at 666.

191. *Tracking Section 1332 State Innovation Waivers*, KAISER FAM. FOUND. (May 10, 2019), https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers.

governor, Gavin Newsom, already called for federal legislation which would allow for a new type of waiver.[192]

Favorable public opinion is also crucial to successfully implementing a single payer system in any state. People across the country are confused about what "Medicare for All" means, and reasonably so as individual politicians define it differently.[193] Once political leaders agree on what kind of system they want to implement, they will need to be able to effectively communicate the nature and cost to their constituents in order to garner their support. Not only is the actual cost of single payer an obstacle, but citizens' perception of that cost impacts the feasibility of such a system. Creating a state single payer system will be politically challenging and administratively difficult, but Democratic-majority states might just have the motivation to achieve it.

C. THE LIMITATIONS OF STATE SINGLE PAYER

Unfortunately, state single payer systems will not be a panacea for America's health care woes. Those in rural communities will still have trouble getting care, even if all providers are covered by their state's insurance system. The state government will need to take on the administrative work currently being done by insurance. While this will likely be a more efficient system in the long term, insurance companies will have to lay off employees, find new business, or go out of business entirely. Policymakers will have to consider how to ensure that providers still compete with each other to maximize quality and innovation. In doing so, they should not limit themselves to a Canadian model, as Canada's system is currently being challenged by those who say its strict ban on private supplementary insurance violates Canadian's constitutional guarantees to certain human rights.[194] Indeed, the current U.S. system may be more conducive to reforms following the Bismarck model as used in countries like Germany and Japan, which maintains private insurance.[195] Yet, a single

192. Letter from Gavin Newsom, Cal. Governor, to Donald J. Trump, President, et al. (Jan. 7, 2019), https://www.gov.ca.gov/wp-content/uploads/2019/01/1.7.19-Letter-to-the-White-House-and-Congress.pdf. While it might seem unthinkable that a Republican controlled Senate and White House would ever agree to such legislation, Newsom's request might be compatible with the kind of state control Republicans have long wanted for health care. *See* Shefali Luthra, *Everything You Need to Know About Block Grants—The Heart of GOP's Medicaid Plans*, KAISER FAM. FOUND. (Jan. 24, 2017), https://khn.org/news/block-grants-medicaid-faq.

193. *See* Ashley Kirzinger et al., *KFF Health Tracking Poll–January 2019: The Public on Next Steps for the ACA and Proposals to Expand Coverage*, KAISER FAM. FOUND. (Jan. 23, 2019), https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-january-2019/; Ezra Klein, *Democrats' Confused, and Confusing, Medicare-for-All Debate*, VOX (Feb. 5, 2019), https://www.vox.com/policy-and-politics/2019/2/5/18209945/medicare-for-all-bernie-sanders-kamala-harris-cory-booker-single-payer.

194. *See* Chaoulli v. Quebec, 2005 SCC 35, paras. 273–78, [2005] 1 S.C.R. 791 (Can.) (holding the prohibition on private insurers, giving citizens no alternative to avoid excessively long wait times to access care, violated the Canadian and Quebec Charters); Cambie Surgeries Corp. v. British Columbia, 2018 BCSC 2084, para. 189 (temporarily enjoining the enforcement of the private insurance ban in British Columbia following the reasoning in *Chaoulli*), *appeal denied* 2019 BCCA 29 (Can.).

195. The Bismarck model is a multi-payor model, but heavily regulates the private insurers to contain costs and ensure universal coverage. *Summary of International Health Systems,* PHYSICIANS FOR A NAT'L HEALTH

payer system would most efficiently eliminate out-of-network bills, because all providers would be in network. Single payer will not be a flawless system, nor will it be painless to implement. However, on the whole, it will get patients the care they need without imposing burdensome medical debt.

CONCLUSION

Working within the framework of the current U.S. health system, there are many solutions available for states to protect their citizens from the financial harm of medical treatment and bills. The private sector can look to the Kaiser model of health integration, which prevents patients from being out of network, but they should be cautious to avoid the problems of monopolistic acquisition of physician practices. The limited approach to balance billing protection taken by many states is insufficient. States can look to California and New York to create balance billing protections and network adequacy standards that actually protect citizens. Yet ERISA prevents even the most robust state protections from actually protecting all citizens. The time is right for states to begin exploring the option of state-run single payer health care systems. While it would be a complicated and daunting enterprise, establishing a single payer system would solve the problems of inadequate networks and surprise balance billing. States should be the great laboratories of democracy and discover what it would look like to have a single payer system in the United States.

PROGRAM (Apr. 2011), http://caphysiciansalliance.org/wp-content/uploads/2011/11/International-Comparison.pdf.

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