December 2019 – Vol. 35 No. 12
Published for Health Care Providers by ACA International
www.acainternational.org

pulse

# Surprise – It's a Bill!

## States Step Up to Resolve the Surprise Billing Issue—But, is it enough?

The dilemma associated with surprise medical bills is the subject of countless debates in Washington, D.C., and in state capitols around the country.

Several months ago, *Pulse* published data released by the Kaiser Family Foundation indicating that about 1 in 6 Americans were surprised by a medical bill after treatment in a hospital despite having insurance. This study, based on 2017 data, also found that on average, 16% of inpatient stays and 18% of emergency visits left a patient with at least one out-of-network charge. Most of those came from doctors offering treatment at the hospital, even when the patients chose an in-network hospital (the study was based on large employer insurance claims).

While these statistics may not seem huge, some of the unexpected bills can be quite daunting to consumers. And, the cost can vary as much as the likelihood of receiving a surprise medical bill, according to written testimony submitted to a U.S. House subcommittee by Jeanette Thornton, senior vice president of product, employer and commercial policy with America's Health Insurance Plans.

Thornton was among several witnesses who testified before the House Energy and Commerce Committee Subcommittee on Health last summer about surprise billing and protecting consumers.

Here's how she explained these billing issues:

"[This is] largely because specialists and emergency rooms in some parts of the country are markedly less likely to accept private insurance. In some regions, there is growing provider concentration on both the physician and hospital side, leading to monopolistic market power that makes it even more challenging to bring providers into an insurance network at reasonable rates in order to deliver an affordable health plan network to patients and their families. We see this in places like McAllen, Texas, and St. Petersburg, Florida, where patients had an 89% and 62% chance, respectively, of receiving surprise medical bills. Conversely, in more competitive health care markets like Boulder, Colorado, and South Bend, Indiana, researchers found the rate of surprise medical bills to be nearly zero," (Thornton's testimony is accessible here: https://tinyurl.com/yy6wf3xs)

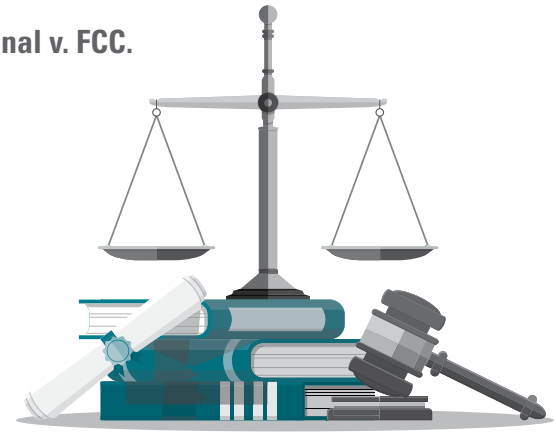
In the absence of federal laws, many states have tried to formulate solutions to shield consumers from the high costs associated with surprise medical bills. The Commonwealth Fund reports that 28 states enacted consumer protections including nine that meet the organization's "standard

*continued on page 3*

IMPACT OF ACA INT'L V. FCC

# Court Dismisses TCPA Violation on Text Messages Reportedly Sent Using ATDS

**The Northern District of Illinois uses precedent in ACA International v. FCC.**



A group of plaintiffs lost their argument in a case based on the ongoing district court debate about the definition of an automatic telephone dialing system (ATDS) and the capacity to randomly or sequentially generate numbers.

According to an article from Drinker Biddle Partner Michael Daly and Associate Vijayasri Aryama, "Court Holds That Text-Messaging System Must Be Able to Randomly or Sequentially Generate Numbers to Qualify as an ATDS ," the Northern District of Illinois entered a summary judgment against the plaintiffs in *Smith v. Premier Dermatology* "because it found the system at issue was not an ATDS."

Plaintiffs in the case brought a putative class action against the defendants claiming they used an ATDS to send text messages about medical marketing communications without consent of their clients' customers, according to the article.

The plaintiffs based their argument on *Marks v. Crunch San Diego* after the defendants moved for summary judgment, specifically "to claim the TCPA's statutory definition would include devices that could not generate random or sequential numbers, but could 'dial stored numbers automatically,'" Daly and Aryama report.

However, the decision in *ACA International v. FCC* swayed the court in this case.

"Based on *ACA International v. FCC*, 885 F.3d 687 (D.C. Cir. 2018), the Smith Court determined that, although '[t]here is a certain allure to the conclusion in Marks,' the 2003 FCC order 'is no longer binding or in force' and the TCPA's statutory definition did not support Plaintiffs' interpretation of an ATDS," according to the article.

Ultimately, the court determined the text messages from the defendants did not qualify as a TCPA violation.

Read the complete article here: https://tinyurl.com/y5o8kw4o

FINANCIAL ACTIVITY

# Health Care M&A Volume Declines in Q3

Health care merger and acquisition activity slowed compared with the second quarter, according to a statement released by HealthCareMandA.com.

The number of deals announced fell 13%, to 408, compared with the previous quarter and was 15% lower than the 478 deals announced in the same quarter in 2018.

Combined spending in the third quarter totaled $51.5 billion, down 63% compared with the previous quarter's extraordinary $139.1 billion. It was 65% greater than the $31.1 billion reported in the same quarter in 2018, according to HealthCareMandA.com.

Healthcare technology deals accounted for 33% of the third quarter's deal volume. The eHealth sector was the busiest, posting 53 deals and making up 13% of the quarter's total. Year-over-year, eHealth was the only one of the technology sectors to post an increase in deal volume, up 43% compared with the second quarter of 2018. Combined spending among the technology sectors was more than $31.9 billion, the statement said.

Additional information may be obtained here: https://tinyurl.com/y46yquzw

## Surprise—It's a Bill! *cont. from page 1*

for comprehensive protections." For the Commonwealth Fund, comprehensive protection is achieved when a "law holds the consumer harmless by limiting his or her financial exposure to normal in-network cost sharing and:

- extends protections to both emergency department and in-network hospital settings;
- applies to enrollees of HMOs and PPOs;
- prohibits providers from balance billing; and
- adopts a specific payment standard or process for resolving payment disputes between providers and insurers."

Some states have adopted such standards. Consider this, in California, New York, New Jersey, Connecticut and Maryland providers are prohibited from billing consumers above their predetermined copayment, coinsurance and deductible levels. And, these prohibitions apply to both emergency services at in-network and out-of-network facilities as well as to all out-of-network providers at in-network facilities, according to the National Governors Association's report, "Protecting Consumers from Surprise Medical Bills."

The report also notes that some states enacted hold-harmless protections, which are distinct from and less protective than surprise medical billing prohibitions. Stand-alone hold-harmless provisions protect consumers from the legal responsibility to pay a surprise medical bill, but they do not stop providers from sending such bills. In this circumstance, consumers can send a surprise medical bill to their insurer and the insurer will cover the total cost of the bill above the patient's predetermined cost-sharing amount. Hold-harmless policies are effective, however, only if consumers understand that they are protected and should contact their insurer to cover the bill. If consumers do not understand this, they may pay the bills, causing unnecessary financial hardship and stress, according to the report.

But, there are hurdles and roadblocks when it comes to states trying to manage this situation.

Under the Employee Retirement Income Security Act of 1974 (ERISA), states are preempted from regulating insurance policies that private employers offer through self-insurance, where the employer bears the primary risk for employee health care costs and contracts with a private insurance company to act as plan administrator. With as many as 60% of individuals with employer-sponsored coverage enrolled in self-insured plans, states are unable to require that surprise billing protections extend to all residents, the NGA report said.

Meanwhile, back in Washington, the U.S. House and Senate are working on the issue.

The Senate Health, Education, Labor and Pensions Committee in June passed the Lower Health Care Costs Act, which would end surprise billing, create transparency related to some insurance issues and increase prescription drug competition. And in the House, the House Ways and Means Committee, and the House Energy and Commerce Committee are also working on legislation to address the issue. At press time, there no further updates.

For more information on this article:

Kaiser Family Foundation data may be accessed here: https://tinyurl.com/y54s9ccv

Thornton's testimony may be accessed here: https://tinyurl.com/yy6wf3xs

NGA's report, "Protecting Consumers from Surprise Medical Bills," may be accessed here: https://tinyurl.com/yyog9xu5

The Commonwealth Fund's Blog, "To the Point," may be accessed here: https://tinyurl.com/y3296ktg

# NEWS & NOTES

### Updated List of Hospital Closings

Becker's Hospital Review compiles a state-by-state list of all hospitals that have closed within the year. Under the publication's Hospital CFO Review, there's a list of 22 hospital closures from Jan. 1 to Oct. 31 (press time), 2019. To read more, click here: https://tinyurl.com/y4k7uy3k

### Grassley Asks UVA About Debt Collections Practices

Senate Finance Committee Chairman Chuck Grassley, R-Iowa, followed up with the University of Virginia's Health System in reference to recent reports that the Charlottesville, Va.,-based facility is reviewing policies related to placing holds on student accounts when medical debts are outstanding. Grassley raises several questions about UVA Health System's debt-collections history and process, charity care and financial assistance offered, patients' rights and transparency guidelines, potential overcharging and process for determining its prices. To read more, click here: https://tinyurl.com/y3skb9lp

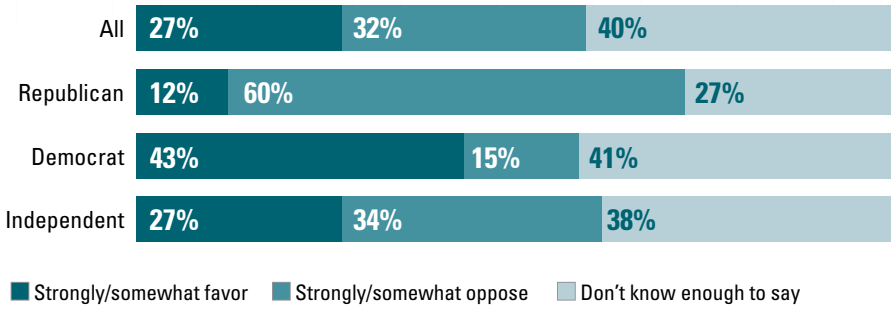
For more health care collections news, visit ACA's Health Care Collections page at www.acainternational.org/pulse.

# datawatch

## From Private to Public

Would you favor or oppose eliminating all private health insurance and making public insurance like Medicare the ONLY health insurance option for everyone, or do you not know enough about this to say?

*Percent of adults ages 19-64*




Note: Segments may not sum to 100% because of rounding. Data: Commonwealth Fund Health Insurance in America Survey, Mar.-June 2019. Source: Sara R. Collins and Munira Z. Gunja, *What Do Americans Think About Their Health Coverage Ahead of the 2020 Election? Findings from the Commonwealth Fund Health Insurance in America Survey, March-June 2019* (Commonweath Fun, Sept. 2019. https://doi.org/10.26099/4ybc-gf46


pulse

is a monthly bulletin that contains information important to health care credit and collection personnel. Readers are invited to send comments and contributions to:

**Communications Department**
**ACA International**
**P.O. Box 390106**
**Minneapolis, MN 55439-0106**
comm@acainternational.org

*Note: Requests for reprints or additional information on material herein must be made through the ACA International member who sponsored your receipt of this publication.*

Do we have your correct name, title and address? Please advise your sponsor of any corrections.