

SOLVING SURPRISE MEDICAL BILLS

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The Schaeffer Initiative for Innovation in Health Policy
A Brookings Institution – USC Schaeffer Center Partnership

October 2016



Acknowledgements

This White Paper is part of The Leonard D. Schaeffer Initiative for Innovation in Health Policy, a partnership between the Center for Health Policy at Brookings and the USC Schaeffer Center for Health Policy and Economics. The Initiative aims to inform the national health care debate with rigorous, evidence-based analysis leading to practical recommendations using the collaborative strengths of USC and Brookings.

This White Paper benefitted from thoughtful comments received from the following reviewers, who, naturally, do not necessarily endorse the positions taken here: Carmella Bocchino, America's Health Insurance Plans; Jack Hoadley, Georgetown University; Timothy Jost, Consumer Liaison to the National Association of Insurance Commissioners; Chip Kahn, Federation of American Hospitals; Karen Pollitz, Kaiser Family Foundation; and Kathleen Shure, Greater New York Hospital Association.

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INTRODUCTION

The problem of surprise medical bills for out-of-network care is receiving increasing attention by lawmakers, media, and the public policy community. In various situations—such as emergencies and with consulting specialists—patients are billed by providers that do not participate in their health plan’s contracted network, even though patients did everything they reasonably could to remain in network. As a result, patients incur much higher charges, which sometimes are exorbitant and can lead to financial distress.

As documented below, there appears to be no genuine dispute, and in fact, there is bipartisan agreement that this problem exists, is increasing, and needs to be addressed. Important differences exist, however, over how the problem should be solved. As described below, over a dozen states have enacted important protections, and federal and state officials have proposed additional remedies, but these efforts are incomplete.

This White Paper aims to identify a satisfactory solution to surprise medical billing. It begins by describing the nature and extent of the problem, and then analyzes the competing merits of the different approaches that governments have taken and others have proposed. The paper concludes with the following recommendations:

- 1) Take comprehensive action that targets surprise billing situations systematically to include at least all common hospital scenarios, rather than merely emergency situations.
- 2) Take federal action that either addresses patients covered by self-funded employer plans, or authorizes states to do so.
- 3) Improve transparency and notice to patients about out-of-network situations and charges, but recognize that improved transparency and voluntary efforts alone will not eliminate situations of unfair surprise.
- 4) Enact firm measures that hold patients financially harmless from additional costs associated with non-network bills.
- 5) Encourage hospitals to increase network participation by key physician specialists.
- 6) Select from among several regulatory and dispute-resolution approaches to fairly compensate nonparticipating providers, without distorting health plans’ and providers’ market negotiations.

The Nature and Extent of Surprise Medical Billing

What Are Surprise Bills?

Surprise medical bills result from providers (physicians, hospitals, out-patient facilities, laboratories, etc.) that patients reasonably assumed would be in-network, but actually are out-of-network, or when patients have no real choice over the network status of their provider. This can happen in several typical situations.

Emergencies. The most obvious situation is when patients seek emergency care, in which case they have no time to determine which hospital is in-network, or they have no choice. An ambulance driver decides where to take the patient, or the situation compels going to the nearest facility that has the necessary service capacity. In many locations, even the ambulance ride itself, unbeknownst to patients, can be out-of-network (Rosenthal 2013; Andrews 2011). As one patient explained (Tolbert 2016):

I broke my arm and my hip and everything. I was covered by the insurance but the ambulance wasn't. It was \$900 just to take me to the hospital... Nobody tells you; I didn't know that it wasn't covered. I thought it was a free service.

Hospital Specialists. Even when a hospital is in-network, patients unavoidably, and unknowingly, can receive out-of-network care when physicians at the hospital are not in-network. Many patients simply are not aware that network status can, and often does, differ between hospital facilities and the physicians who practice there. According to one surprised patient (Kyanko and Pong 2013):

I just never even questioned who was going to do what because I knew the hospital was in-network, I knew this doctor that was doing the procedure was in the network and because the hospital was in-network that means their anesthesiologists are all in-network. And I just assumed that pathology would be in-network also. But that was an assumption that I guess I shouldn't have made.

Even if patients might be aware (or made aware) that network status can differ between hospitals and various doctors, patients often have no choice over which doctors care for them in hospitals. According to another surprised surgery patient who was billed by a nonparticipating anesthesiologist (Kyanko and Pong 2013):

INTERVIEWER: "So in the future, how do you think you would do anything differently?"

RESPONDENT: "I suppose I could ask the [surgeon]...But I don't know if the surgeon would even know. If you ask the surgeon who is the anesthesiologist, she probably wouldn't know... if they're on the list. And I don't even know would the hospital give me the name of the anesthesiologist so that I could call ... and say, 'are they on the list'? You're just kind of in a catch 22."

Certainly, patients have no opportunity to inquire or choose in emergencies, but this is also true for planned treatment that involves ancillary specialist services from hospital-based physicians, such as those in anesthesia, pathology, or radiology. Such services obviously are common, and patients and their attending physicians often

have no prior knowledge or real choice over which hospital-based ancillary specialists will assist them.

Other Facility-based Situations. Surprise billing also arises in recurring situations beyond the common hospital scenarios of emergencies and ancillary specialists. A patient at an in-network hospital might be transferred during treatment to a non-network facility. Hospital patients are also seen by consulting specialists in community practices, selected or recommended by their attending physician. Patients often have little or no notice of an in-hospital consult, and no real opportunity to determine the consultant's network participation. Additionally, surprise billing has been reported when parts of a network facility are excluded from the network based on nonobvious technical distinctions, such as a separate rehabilitation unit within a hospital, or an adjoining ambulatory surgery center, that is nonparticipating (Pollitz 2016; Kyanko and Pong 2013).

Outpatient Settings. Patients obviously have more opportunity to determine network status in outpatient settings, but even there, unavoidable surprises arise. For instance, primary care and other "ambulatory" physicians usually choose which laboratories to send samples to for testing, without advising patients. Additionally, physicians that are in-network might practice at one or more facilities that are out-of-network with a particular health plan. For instance, a patient might choose an in-network surgeon with clinical privileges at several hospitals or ambulatory surgery centers, some of which are not in the network for that patient's health plan.

Unfair out-of-network billing can arise from circumstances other than simple surprises of the types just outlined. Patients might be forced to go out-of-network due to inadequate coverage of certain services or specialties in the network. Alternatively, directories of network providers might be out of date or otherwise inaccurate. Public policy and regulatory initiatives are needed, and are under way, to address those important concerns.

To keep the focus on the "surprise element," this White Paper assumes that accurate information and an adequate network are available, and considers surprise bills that arise nevertheless, because patients had no opportunity to determine a provider's network status, no reason to doubt network inclusion, or had no suitable means of accessing an in-network alternative.

The Financial Consequence of Surprise Bills

When situations like these produce surprise medical bills, patients can suffer substantial financial harm. Not only do patients and their health plans lose the advantage of the substantially lower rates negotiated with participating providers, out-of-network care is not covered at all by certain types of health plans, such as closed-network health maintenance organizations (HMOs) and exclusive provider organizations (EPOs). Although out-of-network care is covered by open-network plans, such as preferred provider organizations (PPOs) and point-of-service (POS) HMOs, patients generally have to pay much higher deductibles and coinsurance out-of-network.

Moreover, even after patients meet their higher out-of-network deductibles and coinsurance, insurance

with out-of-network coverage typically leaves patients exposed to an additional portion of the bill that the insurer does not pay. Insurers will only pay bills they consider to reflect reasonable market rates. (One common phrasing is that non-discounted rates are “allowable” only if they are “usual, customary, and reasonable” – abbreviated “UCR.”) Thus, out-of-network providers usually bill patients not only higher cost-sharing amounts, but also for the balance that exceeds what insurers consider allowable. Insurance contracts and regulators protect patients from such “balance billing” from providers that participate in contracted networks, but generally speaking under private insurance there are no balance-billing protections for out-of-network care.¹

Substantial controversy surrounds how insurers determine when non-discounted rates are allowable. Insurers claim widespread price-gouging by providers (AHIP 2015). Providers note that they often have good reason to charge patients more when they are out-of-network, and they complain that insurers use inaccurate information on prevailing charges in a market when they calculate UCR (Lucas 2009; Beck 2016). To sidestep the dispute over what rates are “usual, customary, and reasonable,” health plans have started to contractually specify a standard metric, such as a percentage of Medicare rates, as a limit of what they will consider allowable out-of-network (where this is permitted by regulators).²

When insurers and providers disagree on what rates are reasonable, the financial consequences for patients can be serious, or even ruinous. This is especially true for the lower-income people who have acquired insurance recently under the Affordable Care Act, but surprise bills can be a financial burden for middle or upper income people as well.

Outside of emergency care, closed-network plans (HMOs and EPOs) offer no contractual protection against surprise medical bills. Open-network plans (PPOs and POS plans) provide some, but only partial, protection. Even though coverage in open-network plans may appear more generous by offering some out-of-network reimbursement (subject to higher deductibles and coinsurance), most plans do not count balance bills toward their out-of-pocket maximums, and some plans do not even count patients’ out-of-network deductibles and coinsurance toward this total cap on out-of-pocket expenses (Hempstead 2015).

To illustrate, consider the sample surprise billing scenarios in the accompanying table. These scenarios are based on a hypothetical medical service that, in-network, is billed at a contracted rate of \$4,000 – for instance an expensive test or a simple procedure. If a patient otherwise satisfies the deductible sometime during the year, that service would be free or subject to only a moderate copayment (depending on the type of service and the specifics of the plan). Out-of-network, however, the provider is able to charge whatever she wants or feels the “market can bear.” Not uncommonly, that is two or three times more, and sometimes is ten-fold more (\$10,000 in our example) than the discounted rates negotiated by insurers with network providers.

1. Balance-billing protections are more robust under public insurance. Federal and state law substantially eliminates the ability of providers to balance bill for Medicare or Medicaid patients, if they choose to accept any payments from these programs (Hammond 2014).

2. NY State 2012; Milliman 2012; Kyanko & Busch 2013. In some states, regulators require insurers that offer out-of-network coverage to allow full UCR rates. But, due to pre-emption of state law by the federal law known as ERISA, health plans offered by self-funded employers are free to specify benchmarks based on Medicare or proprietary sources. According to one report, some health plans set allowable out-of-network rates as low as 110 percent of Medicare (NY State 2012). That is a level that is lower than the discounted rates achieved in-network by many plans. T.M. Selden, et al., *The Growing Difference Between Public And Private Payment Rates For Inpatient Hospital Care*, *Health Affairs* 34(12): 2147-2150; 2015.

Sample Balance Billing Scenarios				
	HMO In-Network	HMO Out-of-Network	PPO In-Network	PPO Out-of-Network
Provider Charge Plan Contracted Rate	\$10,000	\$10,000	\$10,000	\$10,000
	\$4,000	N/A	\$4,000	N/A
Plan's Allowed Amount for Out-of-network Care Cost-Sharing	N/A	\$0	N/A	\$6,000
	\$30 copayment plus any remaining deductible	100%	20% coinsurance (after deductible is met)	30% coinsurance (after deductible is met)
Deductible What the Plan Pays	\$1,200	NA	\$1,200	\$2,400
	\$3,970 if deductible was previously met, otherwise at least \$2,770 (\$3,970 - \$1,200).	\$0	\$3,200 (\$4,000 x 80%), if deductible was previously met, otherwise \$2,240 [80% x (\$4,000 - \$1,200)].	\$4,200 (\$6,000 x 70%) if deductible was previously met, otherwise \$2,520 (\$3,600 X 70%).
What Patient Owes	\$30 if deductible was previously met, otherwise up to \$1,230.	\$10,000	\$800 (\$4,000 x 20%), if deductible was previously met, otherwise \$1,760 (\$4,000 minus the \$2,240 paid by the plan).	\$5,800 if deductible was previously met, otherwise \$7,480 (\$10,000 minus what the plan pays).

The health plan might refuse to pay some part or all of that extra charge, either viewing it as price-gouging—beyond “usual, customary, and reasonable” rates—or simply because the bill exceeds what the health plan has agreed to pay in its contract with an employer. If so, the patient is left holding the balance of the bill for the excess amount if the patient’s health plan includes coverage for out-of-network bills; or, if the health plan is one that covers no care at all out-of-network, the patient is left to pay the entire non-discounted bill. Even with full coverage, the health plan will charge the patient an out-of-network deductible that usually is at least twice as high as the deductible for in-network care (Andrews 2012). And even if that deductible is met, health plans also usually require patients to pay a substantial coinsurance percentage out-of-network – anywhere from 10 to 40 percent of the allowable charge (plus 100 percent of the amount above the allowable charge).

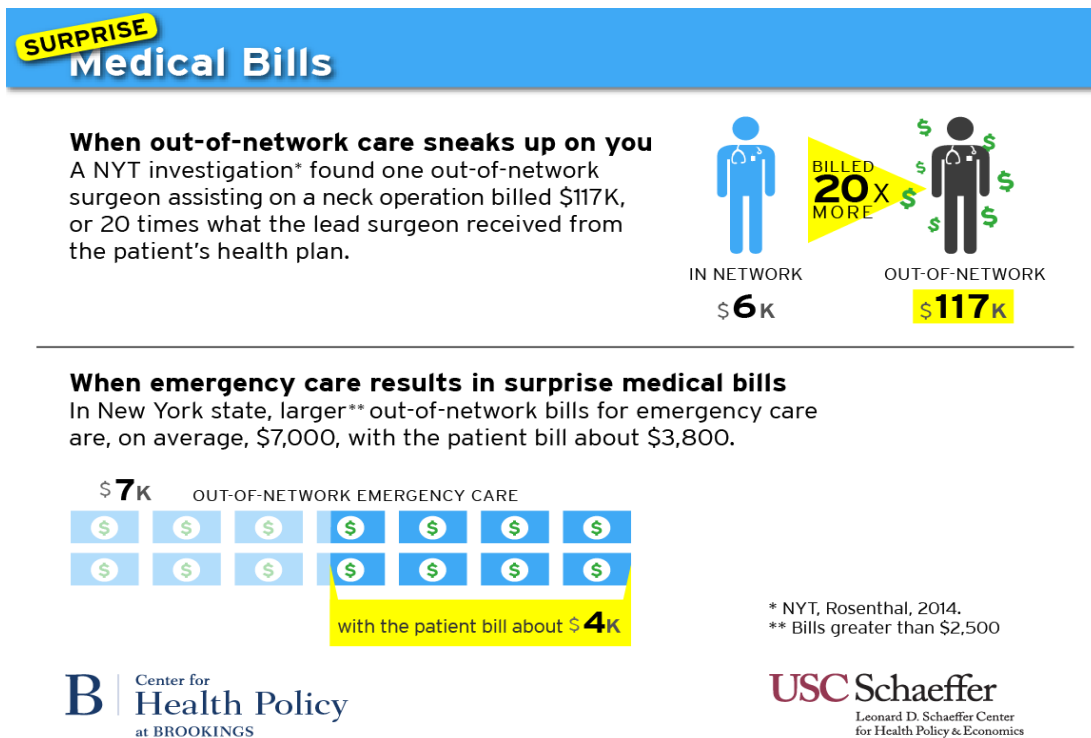
In the \$10,000 example just given, a surprise medical bill could result in the patient paying thousands of dollars more than if care was received in-network. A 2010 study of larger out-of-network bills submitted

under New York health plans found that, on average, patients who received these larger bills were charged for about half of the cost of emergency care delivered out-of-network, which amounted to patient charges of \$3,778 per case (NY State 2012).³ The same study reported that larger balance bills from out-of-network assistant surgeons averaged \$12,120.

In other perfectly realistic examples, a patient's financial exposure might be tens of thousands of dollars or more. The New York Times (Rosenthal 2014a), for instance, reported that a nonparticipating surgeon who only assisted with a neck surgery billed \$117,000, almost twenty times more than what the lead surgeon, who was in-network, received from the patient's health plan. The same investigation also reported about two plastic surgeons who billed \$250,000 for stitches following back surgery; the insurer was willing to pay only \$10,000, leaving the patient holding the balance bill for the remainder.⁴

How Often Does Surprise Billing Happen?

There is no serious dispute among observers or stakeholders that surprise medical billing happens to a significant extent. There are numerous case reports in academic literature, widespread media accounts, and other credible sources, such as the New York Times, the Wall Street Journal, Time magazine, and Consumers Union.⁵ In addition, a number of research studies more systematically document the dimensions of this problem.

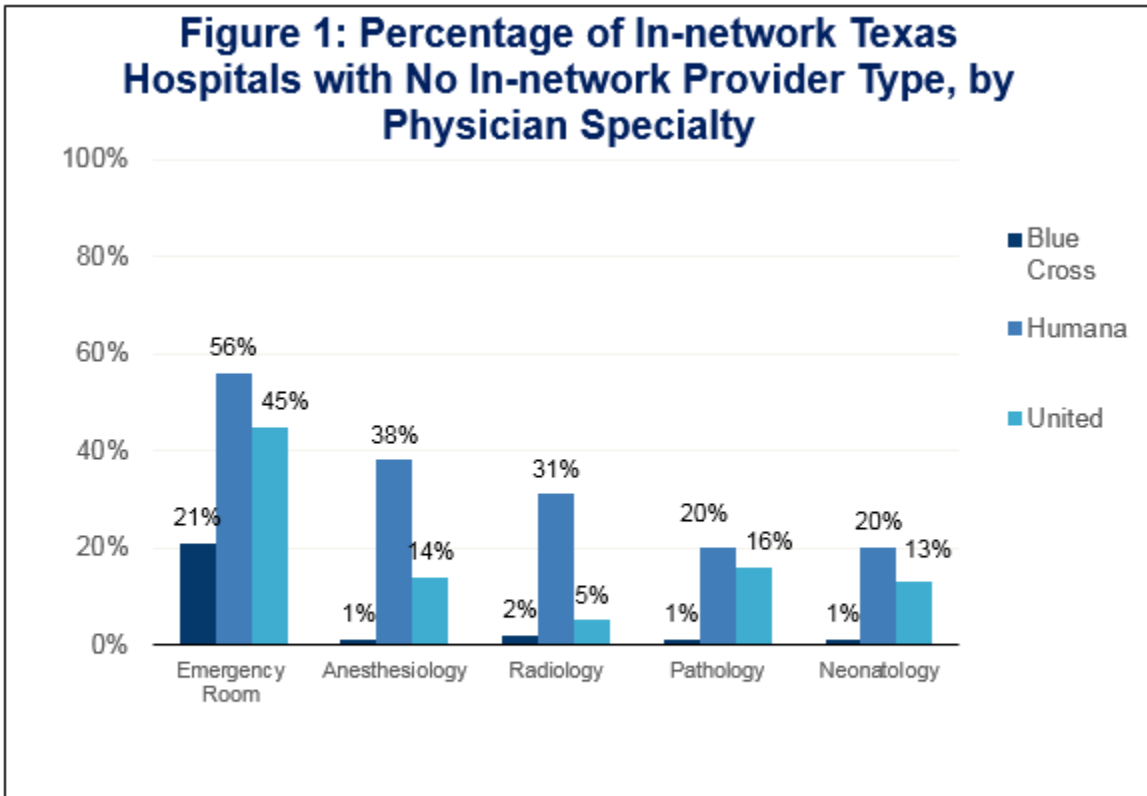


3. These were bills greater than \$2,500 that were also more than 200 percent of the Medicare payment rate; thus, they do not represent an overall average, but instead a reflection of the higher end of billing.

4. Additional examples of this magnitude can be found in other credible sources, such as Kyanko & Busch 2013; NY State 2012.

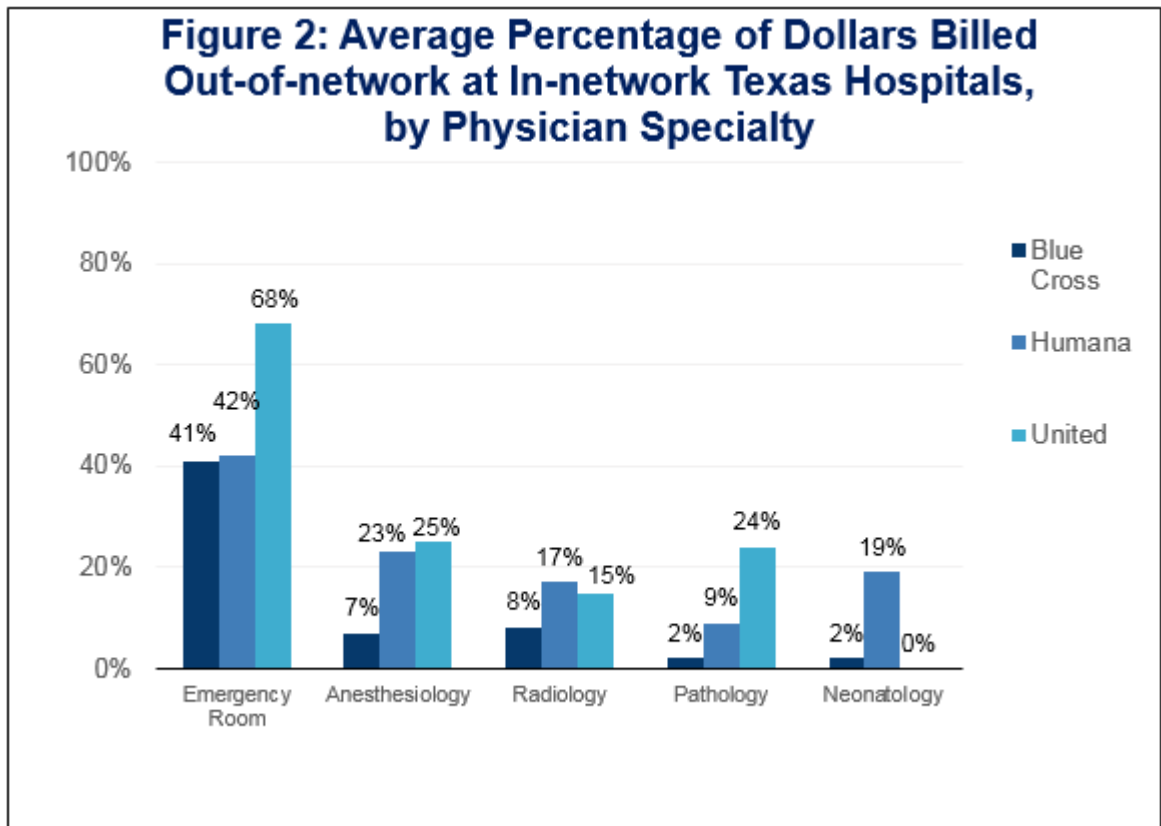
5. See for instance Edwards 2016; Beck 2016; Armour 2015; Testimony of Charles Bell 2015; Rosenthal 2014a; Rosenthal 2014b; Bernard 2013; Kaiser Family Foundation 2014; Kyanko, Pong 2013; Public Citizen 2014; NY State 2012; Rabin 2012; Mathews 2008.

A nationally representative survey in 2016 (Gunja 2016) reported that 21 percent of non-elderly adults have, at some time, received care at a hospital they thought was in-network but were billed by a non-covered physician. Viewed over a shorter time span, several national studies indicate, through various measures, that approximately five percent of people with private insurance experience a surprise medical bill within the span of a year or two.⁶



Source: Center for Public Policy Priorities (CPPP), *Surprise Medical Bills Take Advantage of Texans* (Sept. 2014)

6. A 2015 national survey (Hamel 2016) reported that, over the past year, six percent of households with insurance had problems paying medical bills stemming from receiving their care from a provider whom they were unaware was not in their plan's network. Similarly, a 2011 national survey (Kyanko, Curry 2013) reported that eight percent of privately-insured adults who received care in the prior year used an out-of-network physician. Among those, over half (58 percent) of the hospital-based instances were classified as "involuntary," meaning the patient had no choice due either to emergency, lack of knowledge, or unavailability of a network physician. (Medical emergency was the reason for classifying two-thirds of the hospital instances as involuntary.) In 2015, yet another nationally representative survey (Consumer Reports) found that 30 percent of privately insured people had bills in the past two years where their health plan paid much less than they expected. A quarter of those "surprised" patients were billed by a doctor from whom they did not expect a bill, and a seventh of surprised patients (or four percent of all privately insured adults over the prior two years) were charged an out-of-network rate when they thought the provider was in-network.



Even more extensive problems can be seen in particular markets.⁷ A 2014 study of the top three insurers in Texas (CPPR 2014) reported a series of striking findings. A fifth of hospitals covered by Texas' largest insurer had no in-network emergency physicians on staff, and this was true for about half the hospitals covered by the other two large insurers [Figure 1]. These insurers reported that, on average, 41 to 68 percent of billings for emergency professional services at network hospitals were by nonparticipating physicians [Figure 2].

The Texas study found similar issues, but to a lesser extent, for hospital-based specialists [Figures 1 and 2]. With one of these large Texas insurers, a third of network hospitals had no participating radiologists or anesthesiologists, and a fifth of its network hospitals had no participating pathologists or neonatologists [Figure 1]. Viewed as a percentage of billings at the second and third largest Texas insurers, about a quarter of

7. In addition to studies above:

- Over the 2007-2009 period, Colorado insurers reported that out-of-network providers accounted for about eight percent of the number of claims, and about six percent of claim amounts, from in-network facilities. Division of Insurance, Report of the Commissioner of Insurance to the Colorado General Assembly on Consumer Protections Against Balance Billing (Jan. 2010), <http://hermes.cde.state.co.us/drupal/islandora/object/co%3A8599/>.

- In 2010, New York insurers reported receiving 1,261 complaints from subscribers about surprise medical bills for non-emergency physician care at out-of-network facilities (NY State 2012). New York had fewer complaints about this for emergency care because its law then already required HMOs to hold patients financially harmless for balance billing in emergency situations.

- A fifth of all health plans in the individual market offered through the federally-facilitated marketplace exchanges in 2015 lacked any identifiable emergency physicians in their provider networks (Dorner et al. 2016).

SURPRISE

Medical Bills

Out-of-network care is often a surprise to patients



1/3 of adults having trouble paying medical bills say the problem stemmed from surprise out-of-network care.



70% of people having trouble paying out-of-network bills were unaware the care was out of network.

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anesthesiology billings from network hospitals were by nonparticipating physicians, as were about a sixth of radiology billings [Figure 2]. Out-of-network billings were similarly substantial for pathology and neonatology at one of these three large insurers.

Will Surprise Billing Increase?

Not only is surprise medical billing fairly widespread, it is a problem that is likely to continue growing for several reasons. First, the parties involved are not likely to solve the problem themselves, under existing market structures and rules. The surprise element means, almost by definition, that this is not something consumers are likely to focus on when selecting insurance; thus, health plans have diminished market incentives to pay providers more in order to avoid the problem. Also, the ability of health plans' and hospitals' to negotiate reasonable rates with nonparticipating physicians is especially hampered for emergency services by the legal requirements that hospitals must provide such services, and plans must cover them, regardless of network participation.




Second, under existing market forces, provider networks are becoming narrower, creating more situations where patients encounter a mix of network and non-network providers. This is particularly the case in the non-group (individual) market, where narrow networks are especially pronounced as a result of competition on premiums for cost-conscious consumers (Cousart 2016; Bauman 2015; Polsky 2015), though network narrowing is also seen to some extent in the group market (Kaiser Family Foundation 2015).

In some instances, narrower networks are due not just to health plan strategies, but also to specialist physicians consolidating into larger groups that can then wield enough market power to refuse the payment terms that health plans offer. For instance, some hospitals have no anesthesiologists or emergency physicians in-network because the only anesthesia or emergency physician groups in the area have not reached an agreement with area health plans (Kaiser Family Foundation 2014; Rosenthal 2014b).

Regardless of network size, when care is out-of-network, the financial consequences for patients are becoming more severe. Individuals and small employers are more frequently choosing HMO and EPO health plans that have no out-of-network coverage (Hempstead 2015), leaving patients exposed to the full brunt of non-network billing. Also, health plans with some out-of-network element are making that coverage leaner, with higher deductibles and coinsurance (Andrews 2012), or more restrictive definitions of allowable charges (NY State 2012). Finally, some, perhaps many, providers are more aggressively taking advantage of opportunities that the market presents to charge rates that greatly exceed network rates (AHIP 2015). Simultaneously, many providers are becoming more disciplined about collecting unpaid medical bills (Hall 2008). The combination of these various trends is pushing more patients into financial distress, and even bankruptcy (Hamel 2016).

SURPRISE
Medical Bills

Are you protected from surprise medical bills?

		
FULLY	POTENTIALLY	NOT
<ul style="list-style-type: none"> ✓ Medicare ✓ Medicaid ✓ VA healthcare ✓ Tricare 	<ul style="list-style-type: none"> ✓ Fully insured employer plan ✓ ACA exchange and other individual market plans <p style="background-color: yellow; padding: 5px; text-align: center;">1/4 of states have taken some action to protect their insured.</p>	<ul style="list-style-type: none"> ✓ Self-funded employer plan <p style="background-color: red; color: white; padding: 5px; text-align: center;">Only the federal government can regulate these plans, but there's been little federal action to-date.</p>



The obvious unfairness to patients of the prototypical surprise billing situations, coupled with the increasingly severe financial consequences, has produced widespread recognition of a need for legislative/regulatory action. President Obama’s current budget proposal calls on Congress to “eliminate surprise out-of-network health care charges for privately insured patients,” as does Presidential candidate Hillary Clinton (US DHHS 2016; HillaryClinton.com 2015). On the Republican side, one of the bills introduced recently to rework the Affordable Care Act (H.R. 5284, titled the “World’s Greatest Healthcare Plan Act of 2016”) limits how much

hospitals and physicians can charge patients for emergency services out-of-network.

At the state level, support for some type of reform is even more clearly bipartisan. More than a dozen states have enacted various protective measures (Hoadley 2015; Public Citizen 2014). Notably, these reform leaders are a mix of “red” states (e.g., TX, WV, UT), “blue” states (e.g., CA, NY, IL, CT, MD), and “purple” states (e.g., CO, MN, FL). Bipartisan support can also be seen among lawmakers in additional states where reforms are being proposed (Cousart 2016), and in the adoption of a model act by the National Association of Insurance Commissioners that addresses surprise billing (NAIC 2015).

The consensus for meaningful reform is reflected by the absence of any serious opposition to taking some well-considered action. None of the major relevant interest groups or stakeholders appear to dispute that surprise medical bills are a problem that deserves attention.

Despite this broad-based consensus, there are divisions about what action lawmakers should take. Moreover, even where public policy has coalesced around a course of action, it inevitably has failed to address some important dimensions of the problem—in part because a federal law, the Employee Retirement Security Act of 1974 (ERISA), limits the applicability of state measures to fewer than one half of the privately insured, yet federal lawmakers, so far, have not undertaken a comprehensive solution.

To advance public policy deliberations and contribute to the existing literature (which is substantial), this White Paper shifts its focus away from the details of what states so far have been able to do, and considers more systematically what might or should be done (or not done), either at a state or federal level, considering all of the major dimensions of surprise medical billing.⁸

Solutions to Surprise Medical Billing

Surprise medical billing is a multifaceted problem; thus, we should not expect a single, simple solution. Instead, a combination of approaches is required, some of which are inevitably controversial. To understand why this is the case, we begin with measures that have achieved significant support but, on their own, are less effective.

Transparency and Consent

Perhaps the most straightforward way to mitigate surprise billing is to attempt to eliminate the element of surprise, by informing patients in a meaningful way when providers are out-of-network. At a minimum, directories of participating providers should be accurate, up-to-date, and reasonably accessible. State and

8. See, for instance, Pollitz 2016; Hoadley et al. 2015; Massachusetts Health Policy Commission 2015; Public Citizen 2014; Kyanko & Busch 2013.

federal regulators are doing more to bring that about.⁹ However, accurate directories do not resolve the surprise element in the prototypical situations outlined above, where a patient does not have reason, or opportunity, to investigate a provider's network status, or where no network provider is available.

Going further, therefore, some states and the NAIC's model act (2015) require health plans and/or hospitals to be more active in notifying patients that providers might not be in-network.¹⁰ Improved notice is the principal approach taken in a model act from the National Conference of Insurance Legislators (which, to our knowledge, only Louisiana and Texas have adopted; NCOIL 2011). The Act requires both health plans and healthcare facilities to provide "conspicuous written disclosure" of network status and to warn that nonparticipating physicians might balance bill. That Act also allows patients to request a full list of network participation for all providers based at the facility, but it contains no substantive protections beyond these (and other) disclosure requirements.

It is unrealistic to think that posted or form notification will be sufficient. Some patients may notice these, but many may not, and those who do not will still be genuinely surprised. Moreover, even if "warnings" are noticed, concerns remain over what patients reasonably can and should do if they are aware of the potential for surprise situations.

Obviously, nothing can or should be expected of patients in emergency situations. In non-emergency situations, though, one approach might be to give patients specific information on what out-of-network charges will be and allow them to consider whether to agree to the charges or to pursue other options. New York, for instance, stipulates that a referral from a network physician to a nonparticipating provider is a surprise billing scenario, thus subject to surprise billing protections unless the patients have given written consent that they knew the services would be out-of-network and would incur more costs.

In many of the situations previously described, patients may not have a meaningful choice, which limits the efficacy of this remedy. But, where meaningful choice sometimes exists, we might call this approach "informed financial consent." That phrase is used in Australia to describe their approach to the issue of balance billing (2012). In Australia, which has socialized health insurance, in order to bill patients for more than the government fee schedule allows, physicians must inform patients of the specific extra costs prior to the patient's agreeing to treatment.

California's new surprise billing law (AB-72) also adopts informed financial consent for private insurance. Noncontracting providers can bill full amounts for out-of-network services at in-network facilities only if the patient consents in writing at least 24 hours in advance, after receiving an estimate of the costs and notice that in-network options are available.

9. Mannatt, Directory Assistance: Maintaining Reliable Provider Directories for Health Plan Shoppers (California Healthcare Foundation, Sept. 2015), <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20D/PDF%20DirectoryAssistanceProvider.pdf>; Families USA, Improving the Accuracy of Health Insurance Plans' Provider Directories (Oct. 2015), http://familiesusa.org/sites/default/files/product_documents/ACA_Provider%20Directory%20Issue%20Brief_web.pdf

10. Also, at the federal level, in order for Qualified Health Plans (QHPs) that sell through the federal marketplace to not count toward the out-of-pocket maximum count a patient's cost-sharing for ancillary specialists at network hospitals, the health plan must give patients written notice at least 48 hours before admission that some their hospital providers might be out-of-network. 81 Fed. Reg. 12304, March 8, 2016, https://www.regulations.gov/#!documentDetail;D=CMS_FRDOC_0001-1904.

Informed financial consent is also, essentially, the approach that U.S. Medicare takes in allowing physicians to privately contract with fee-for-service Medicare beneficiaries. Medicare does not permit participating providers to both receive Medicare payments and balance bill patients for amounts beyond the limited amount that Medicare allows. Physicians, however, can choose not to participate in Medicare at all, but still must give Medicare-enrolled patients extensive written disclosures that they will be fully responsible for their medical bills, despite being eligible for Medicare (Hammond 2014).¹¹

Similarly, some private health insurers require participating physicians to pursue an informed consent approach when making referrals to nonparticipating providers, such as for laboratory services or home treatment. These insurers require the participating physician to give the patient written notice of the referral provider's nonparticipating status, the likelihood of being billed more, and the opportunity to obtain services in-network if desired.¹²

Patients who knowingly agree to incur extra costs cannot complain of mere surprise. They might, however, complain of coercion or undue pressure. Surprise billing situations do not typically arise in the calm atmosphere of selecting a primary physician; instead, they arise when patients are sick—looking mainly to the physician or hospital they chose, but then are confronted with the news that a secondary provider is required but is not in-network. Ideally, the principal provider would present in-network options alongside any recommendation for a nonparticipating provider. But, sometimes, no in-network provider is available (such as in an in-network hospital that lacks any participating anesthesiologists). Even when in-network options exist, referring physicians often do not know who is and is not in-network. And, patients in vulnerable situations will be hard-pressed to go against their principal provider's recommendation in the midst of treatment.

Coercive aspects are difficult to avoid once a course of treatment has begun. Taking that fact, and other inherent limitations, into account greatly reduces the potential scope of situations where informed financial consent might realistically be a satisfactory primary solution to surprise billing.

Nevertheless, informed financial consent might be a useful adjunct to a more aggressive regulatory approach. If regulators, for instance, were to ban balance billing in some circumstances, they might consider, as Medicare does, lifting that ban in prescribed situations where it seems appropriate to allow physicians to ask their patients to consider paying more than what others usually pay. Alternatively, regulators might withhold stronger remedies if patients are given adequate notice of providers' network status and rates. Federal legislation proposed by Rep. Lloyd Doggett (D-TX), for instance, would ban balance bills from nonparticipating physicians that treat patients at network hospitals unless the physician notifies the patient in advance and provides a cost estimate, which the patients agrees to pay.¹³

11. Sample private contracting forms can be found at http://www.aafp.org/dam/AAFP/documents/practice_management/regulatory_compliance/MedSampContractAff.doc and http://www.aapsonline.org/index.php/site/article/sample_medicare_opt-out_forms/.

12. See, for instance, Anthem Blue Cross, Advance Patient Notice for Use of a Non-Participating Provider (2012), <http://www.cmanet.org/files/assets/news/2013/02/apn-form-11-15-12-2.pdf>

13. H.R. 3370, End Surprise Billing Act of 2015 (114th Cong.), discussed at <http://familiesusa.org/blog/2015/10/surprise-medical-bills-rep-doggetts-bill-would-protect-consumers>.

Informed financial consent may eliminate the element of surprise, but patients may still feel pressure to continue with a planned course and timeline of treatment, and may lack the necessary information and control to reschedule care so that all providers involved are in-network. When mere notice or specific consent is insufficient to avoid unfair out-of-network billing, patients should be held harmless. Holding patients harmless means either that the health plan should pay the difference, that the provider should absorb the difference, or that some compromise should be struck between these two options. We next explore each of those possibilities for where the onus should lie.

Require the Health Plan to Pay

The tendency in emergency situations is to hold the health plan responsible for paying what is necessary, and to hold patients harmless. Emergencies are where patients have the least choice, and where the need for patient protection is most compelling. Providers also have less choice in true emergencies. Their professional ethics, backed by federal and state law, compel providers to treat patients in serious emergencies, regardless of how much they will be paid. Because, ultimately, someone must pay for such treatment, we naturally tend to look to insurers to foot the bill for emergency care.

The Affordable Care Act (ACA) forbids health plans (including employer self-funded plans) from treating emergency care as out-of-network (defining “emergency” from the perspective of a “prudent layperson,” 45 CFR 147.138). This builds on similar laws previously adopted by most states, but because this is federal law, it can apply to self-insured employer plans as well as insured plans, which states may not do on their own (due to ERISA preemption). However, this law does not restrict balance billing by the doctors and hospitals that provide emergency services.

Treating emergency care as in-network means only that health plans cannot deny coverage, or impose higher deductibles or coinsurance, simply because a provider is out-of-network. Instead, health plans must regard patients as having received emergency care from network providers. But, federal law still allows the providers themselves to charge patients what they want. Although the ACA requires health plans to reimburse nonparticipating emergency providers at normal out-of-network UCR rates, this does not fully solve surprise billing issues because the ACA allows health plans to adopt their own methodology for determining “usual and customary.” As noted above, health plans are becoming increasingly stringent about the market benchmarks used to determine allowable payment. If health plans pay less than providers’ full charges, the ACA leaves providers free to bill patients for the balance (U.S. Dept. of Labor 2016).

One obvious solution is to require health plans to hold patients fully harmless by paying emergency providers’ full charges (perhaps subject to an outside limit). However, doing that would tie the hands of insurers attempting to negotiate network participation with emergency facilities and physicians, and likely would lead to even higher charges. Why should emergency providers avoid price hikes or agree to substantial discounts if the law requires payment of full (or nearly full) charges in most treatment situations that apply to them?

Lawmakers should be reluctant to tilt market forces to this extent, even for emergency scenarios.¹⁴ Doing that not only distorts market forces, it invites price-gouging. Indeed, some critics claim that emergency physicians sometimes refuse to negotiate at all with health plans (or refuse reasonable discounts), realizing that patient protections in emergency settings allow them to pressure health plans to pay much higher rates out-of-network (Lucas 2009; Goldsmith 2016). Similar accusations have been made about anesthesiologists, realizing that analogous rules about network adequacy can require health plans to pay full charges to nonparticipating hospital specialists.

Such tactics, to the extent they exist, are aimed at collecting more from health plans rather than from patients. But, these strategies entail billing patients for charges that might be considered inflated, leading to consumer debt and patient distress. Even if only health plans are required to pay the charges, that then drives up insurance premiums that consumers and employers pay.

An additional consideration about requiring health plans to hold both patients and providers harmless for emergency care is that doing so would be an incomplete solution unless the same requirement applies to self-funded employers. They cover roughly half of privately insured people. Although the federal government is free, legally, to regulate employers as if they were insurers, traditionally there is reluctance to doing so based merely on an employer opting to self-fund their workers' health insurance benefits. Thus, in considering comprehensive solutions to surprise billing, lawmakers should be cautious about placing requirements on insurers that they are not also willing to require of employers that are self-funded health care payers. Otherwise, there may be unintended distortions in the protections and obligations under insured versus self-funded plans.

Require Participating Hospitals to Protect Patients from Surprise

Instead of requiring health plans to pay nonparticipating physicians more, a different approach is to look to hospitals to use their leverage over, or relationship with, physicians to keep patients from receiving care from any nonparticipating physicians at network facilities. Insurers often include provisions in contracts with participating hospitals that require hospitals to use their best efforts to obtain participation by hospital-based ancillary physicians on the medical staff, and sometimes insurers insist that hospitals obtain physician participation (NY State 2012). Building on that practice, President Obama's budget proposal would require hospitals "to take reasonable steps to match individual patients with providers that are considered in-network for their plan" (US DHHS 2016).

Operationalizing norms such as "best efforts" or "reasonable steps" could be difficult. Even if it is possible, this approach would not solve all surprise billing situations because some number of unfair out-of-

14. Another concern about solutions limited to emergencies is the difficulty in defining the boundary of "emergency." Two widely different definitions are currently in use: that under the Emergency Medical Leave and Treatment Act (EMTALA), which requires only "stabilization" that keeps a patient from suffering permanent harm (as judged by physicians), and the definition under insurance regulation, which judges emergency from the perspective of a "prudent layperson," meaning anything a reasonable person thinks might be an emergency. Other conceptions and definitions are possible between these two ends of the spectrum.

Moreover, even if the boundaries of emergency can be drawn clearly, emergencies often lead to a longer course of hospitalization. After emergency patients are stabilized, sometimes they can be transferred to network facilities, but when that is not done, it would appear anomalous to have a protective measure that applied only in an emergency room but not in the hospital room to which a patient might be admitted for extended care.

network situations arise outside of hospitals, like in increasingly common free-standing ambulatory surgical or testing facilities.. However, much of the problem currently appears to be concentrated in hospitals, which have some leverage over medical staff physicians.

In theory, hospitals could take a “good citizen” approach to surprise balance billing by requiring physicians to accept network rates, or refrain from balance billing beyond insurer-determined “accepted” (UCR) rates, when treating patients in surprise scenarios. This could be done either as a requirement of medical staff membership, or as a contract condition when hospitals selectively engage physician groups as the exclusive source for ancillary specialist services.

Looking to hospitals to exert this much leverage through medical staff privileges or contracting, however, might not be realistic. In competitive hospital markets where physicians can choose among hospitals, the hospitals that do this more aggressively might find themselves with inadequate staffing. On the other hand, if all hospitals were expected to do something similar, affected physicians might not have much choice unless the physicians also act mostly in concert, perhaps because most of those in a relevant specialty are affiliated. Antitrust enforcers could be more active in scrutinizing situations where most hospital-based physicians refuse to join health plan networks, but such refusals do not necessarily violate antitrust law.

In many situations, hospitals may need to pay specialists extra to convince them to join networks; paying physicians directly is what hospitals often do currently in order for consulting specialists to agree to be on call for emergency patients (because many such patients are uninsured; O’Malley 2007). But, if additional hospital payment became commonplace across a broader range of patients and specialists, hospitals would have to add much of those extra costs into the rates they seek from health plans.¹⁵ In that way, consumers could end up paying for uncompetitive specialist fees after all.

One possible way to avoid that inflationary outcome might be to use one of the dispute resolution mechanisms described below to arbitrate between health plans and hospital-based specialists who fail on their own to reach agreement on network participation. Doing that could relieve some of the pressure on hospitals to ensure network participation by physicians seeking high compensation.

Nevertheless, if pressure intensified (from one source or the other) for designated specialists to join networks, these physicians might legitimately question whether forcing network participation is fair to them. In the same way that forcing health plans to pay full charges would distort market negotiations, forcing certain classes of physicians to accept network rates could give health plans too much power to reduce those rates below reasonable or fair-market levels.

Public policy should encourage hospitals to do what they reasonably can to ensure participation by key specialists in the hospital’s primary insurance networks. However, a firm requirement that hospitals do so is too fraught with a risk of untoward market effects. In the end, it may be difficult to avoid biting the bullet of adopting some public mechanism to determine how much insurers must pay nonparticipating providers in surprise

15. For instance, according to Goldsmith 2016, “the average daily call pay stipend for orthopedics is around \$1,200; the amount for neurosurgery and interventional cardiology exceeds \$2,000.”

situations. The following sections examine two general approaches: overt rate regulation and alternative dispute resolution.

Limit What Providers Can Charge Patients in Surprise Scenarios

Viewed from a Goldilocks perspective, we could hold patients harmless in surprise billing situations by placing the onus on health plans, but that could lead to provider payments that are too “hot.” Placing the onus on providers, though, could lead to payments that are too “cold.” Some policy analysts believe the “just right” middle approach is to regulate the rates that nonparticipating providers may charge, and that health plans must pay, in surprise billing situations (Murray 2013). One regulatory advantage of regulating providers rather than health plans is that ERISA, generally speaking, does not preempt states from regulating providers (New York State Conference of Blue Cross & Blue Shield Plans v. Travelers 1995).

A limited form of rate regulation could take the form either of a prescribed fee schedule that must be paid or a cap on rates that leaves market forces to operate below the cap. President Obama’s budget proposal, for instance, would require hospital-based physicians “to accept an appropriate in-network rate as payment-in-full” in certain instances (US DHHS 2016). For out-of-network emergency services, a pending bill (H.R. 5284), sponsored by Rep. Pete Sessions (Rep. TX), would cap hospital payments at 110 percent of Medicare rates, and physician payments at 85 percent of UCR rates (as defined by states). Maryland provides a similarly detailed example. There, HMOs must pay out-of-network providers at least 125 percent of their average in-network rates or 140 percent of Medicare rates, depending on the circumstance.¹⁶ California’s recent enactment requires health plans to pay the greater of their average contracted rates or 125 percent of Medicare. Others propose to cap out-of-network billing in surprise situations at 200 percent of Medicare rates (Public Citizen 2014).

In theory, an approach like this is workable. The difficulties are in determining the appropriate benchmarks for payment rates, and in the political and policy willingness to undertake any form of regulating provider payment rates under private insurance. Many stakeholders view provider rate regulation as anathema, and so would resist it in any form, even in surprise or emergency settings, fearing a slippery slope that leads to regulating all forms of balance billing (as Medicare does). Or, if limited rate regulation were considered, views would differ strongly on whether Medicare is a legitimate benchmark for payment rates, and what multiple of Medicare might be reasonable or excessive.¹⁷ Starting with a generous multiple could give way to ever tightening limits (as Medicare did in a series of steps that limited physician balance billing 25

16. These levels apply to all out-of-network billing under HMOs, not just “surprise” billing. Maryland applies higher limits to “surprise” situations under PPOs, requiring insurers to pay out-of-network hospital-based physicians the greater of 140 percent of the insurer’s network rates or the rate that the insurer recognized as allowable in 2009 inflated by a medical cost index, with the goal, essentially, of controlling out-of-network price inflation (Social & Scientific Systems 2015). These mild limits attach, however, only if the hospital-based physician opts to be paid directly by the insurer (by agreeing to “accept assignment”); otherwise, as of this writing, out-of-network PPO providers are (generally speaking) free in Maryland to balance bill patients, even in surprise situations.

17. In favor of using a Medicare benchmark, its rates are easier to determine than privately-negotiated network rates. Also, Medicare rates are often used as the basis for private market negotiations. Jeffrey Clemens & Joshua Gottlieb, In the Shadow of a Giant: Medicare’s Influence on Private Physician Payments, NBER Working Paper No. 19503 (Jan. 2015), <http://www.nber.org/papers/w19503>. However, Medicare does not consistently track private market rates, which are affected considerably by the market position that different specialties occupy. Thus a fixed percentage of Medicare that is reasonable on average is likely to produce a relative shortfall for some specialties and a relative excess for others, compared with negotiated market rates.

years ago).

Lawmakers' reluctance to take on these lightning-rod issues has more often led them to embrace an alternative approach. To hold patients harmless without distorting market negotiations or regulating rates, states increasingly require health plans and providers to settle between themselves, on a case-by-case basis, how much to pay for surprise out-of-network care.

Require Health Plans and Providers to Settle Surprise Balance Bills Between Themselves

Another approach to holding patients harmless who do their best to stay in-network, while being fair to both providers and health plans, is to prohibit providers from balance billing patients in situations of surprise out-of-network care and leave them to work out with health plans how much to pay for this care. In essence, this approach mimics the Biblical wisdom of King Solomon by requiring providers and health plans to “split the baby” of balance billing by forcing these two parties to decide between themselves who owes what, without involving the patient. This payment resolution can occur in several different ways.

The most straightforward approach (used in Colorado, for instance) is simply to prohibit billing patients beyond the normal cost-sharing they would have to pay for in-network care, but leave providers free to bill the health plan for the balance. The health plan can then challenge particular bills for being excessive, and those challenges can be resolved like any other billing dispute – through negotiation and settlement, or in court, under governing principles of contract law.¹⁸

Resorting to courts routinely, however, is expensive and uncertain. The uncertainty is enhanced by the lack of clarity and consistency in judicial approaches to determining the reasonableness of out-of-network billing (Hall 2008; Richman et al. forthcoming). States might improve the judicial process by enacting standards that guide courts in deciding these cases. For instance, legislatures might declare that insurers are obliged to pay only reasonable, market-comparable amounts, and they might specify how reasonable market rates should be derived.^{19,20} Expensive and time-consuming litigation, though, would still be needed to apply these governing standards to particular cases.

An alternative approach is to create some more efficient means of non-judicial dispute resolution between providers and health plans over balance bills. Again, the idea is to hold patients harmless in prescribed circumstances of surprise billing. But, rather than leaving providers and plans to the own legal devices, several

18. Interestingly, some self-funded health plans do this routinely – for all medical bills – by declining to form any contracted provider network and instead setting strict limits on what rates they will consider to be reasonable, based on either a percentage of Medicare rates or on a maximum mark-up over facility costs. These health plans then protect covered patients from balance billing by negotiating on their behalf or defending them in court, if necessary. Tina Rosenberg, The Cure for the \$1,000 Toothbrush, NY Times Opinionator Blog, Aug. 13, 2013, <http://opinionator.blogs.nytimes.com/2013/08/13/the-cure-for-the-1000-toothbrush/>; Jay Hancock, How to Keep Down Sky-High Hospital Bills: Don't Pay, (Newsweek/Kaiser Health News, May 15, 2015), <http://www.newsweek.com/how-keep-down-sky-high-hospital-bills-dont-pay-332271>

19. Prevailing charges might be a poor basis for determining a fair market rate for medical services where market forces are muted because patients do not choose their providers. In such cases, fair market rates could be based instead on comparable services from providers that are chosen by patients.

20. States often do so, for instance, in determining how much to pay for medical care under workers compensation programs or under no-fault automobile insurance.

states (notably FL, IL, NY, TX) and the NAIC's model act (2015) either allow or require them to use mediation, arbitration, or independent administrative review to determine appropriate payment amounts for out-of-network care.

Each state's approach differs.²¹ Some provide non-binding processes (such as mediation, e.g., TX). Others are binding, but voluntary (the parties decide whether they want to use the process, e.g., CA, FL). When participation is optional, these processes are seldom used, reportedly because providers feel they are not likely to receive favorable decisions (Hoadley 2009; Hoadley 2015). Accordingly, at least one state (IL) calls for mandatory arbitration, but full formal arbitration can be complex and expensive. Therefore, in the latest advance, New York has enacted a streamlined form of mandatory and binding dispute resolution for surprise medical bills.²²

In the New York approach—which is referred to as “baseball style” or “final offer” arbitration—the provider and the health plan each submit their best and final offer, and an independent reviewer (under contract with the state) then must select which side best approximates UCR rates, without compromising between the two sides.^{23,24} This approach is considered to be more streamlined for two reasons (Shorter 2009; Monhait 2013). First, when cases are decided, it may be more efficient for the reviewer to make a choice between one of two predetermined figures rather than needing to determine what is the precisely correct number.²⁵ Second, the distinct possibility that either side can lose outright creates a strong incentive for both sides to negotiate and settle without having to submit to “coin-toss” arbitration. Moreover, if arbitration decisions are made public, this process has the added advantage of developing a set of precedents that make future outcomes more predictable, which further increases the prospects that the two sides will reach agreement on their own.

Experience with New York's final-offer process is still too new to know much about how it is working. After the first six months, 60 cases had been decided involving regulated insurers; 58 percent of those (35) were decided in favor of the health plan, and 42 percent (25) in favor of the provider.²⁶ In theory, judicial

21. States also differ considerably on who pays for the process and the extent to which the state subsidizes the process. And, states differ a good deal on which kinds of surprise bills (emergency vs. hospital ancillary), and which kinds of health plans (HMOs vs. PPOs), are subject to the process.

22. This process applies only to bills from non-hospital providers.

23. Reviewers have experience in medical billing and must consult with a physician from the relevant specialty. The reviewer is told, broadly, to consider the usual and customary fees charged and paid out-of-network when similar providers treat similar patients. New York Department of Financial Services, Protection from Surprise Bills and Emergency Services, <http://www.dfs.ny.gov/consumer/hprotection.htm> (updated Feb. 18, 2016).

24. This rule applies where coverage comes from regulated insurers. When coverage is from self-funded employers, ERISA pre-emption precludes involvement of the health plan; then (and when patients are uninsured), the reviewer is free to determine the appropriate amount for the provider to bill the patient.

25. A version of this approach proposed, but not adopted, in California, for instance, would have limited the parties' submissions to minimal documentation, including a 1,000 word written justification, rather than an evidentiary hearing, as occurs in many commercial arbitrations (Shorter 2009).

26. An additional 13 decisions were “split,” presumably because they involved self-funded employers and so there was no health plan involvement. Chuck Bell, Programs Director Consumers Union, Letter to Pennsylvania Department of Insurance, Feb. 29, 2016, <http://www.insurance.pa.gov/Documents/Balance%20Billing%20Comments/Balance%20Billing%20Comments%20-%20Consumers%20Union.pdf>. Across all 73 decisions, all but two involved emergency care, even though New York also covers hospital ancillary providers, and outpatient referrals by network physicians to nonparticipating providers without notice of their network status.

Similar, but less complete, summary data for the first full year is reported by Crain Business News, April 7, 2016, at <http://www.modernhealthcare.com/article/20160407/NEWS/304079996>.

appeals or challenges are possible, but so far none have occurred (to our knowledge).

Overall, we lack much comparative experience with the different dispute resolution approaches taken by various states, except to know that those with voluntary approaches (CA, FL) are seldom used.²⁷ Among mandatory processes, reasonable minds can certainly differ on what the best approach might be, but currently New York's approach is receiving the most attention.

It is also possible, however, to combine the rate regulation and dispute resolution approaches. A payment rate could be established as a default ceiling or floor that, absent unusual circumstances, applies if a provider and health plan fail to reach agreement, or that limits what a dispute reviewer may impose. For instance, providers might be limited to no more than two times what Medicare pays, or health plans could be required to pay at least 50 percent above Medicare rates – unless one of the parties establishes that this multiple of Medicare is out of sync with reasonable market rates.²⁸ The intent of such an approach would be to leave the parties free to seek payments that are below a ceiling or above a floor. Realistically, however, deviation from a limiting rate might prove to be uncommon, and so a hybrid approach might end up collapsing into a de facto rate-regulated approach. To avoid that, a dispute resolution mechanism is needed that keeps the burdens low to challenging the limiting rate when appropriate.

Another hybrid approach worth considering is to use mandatory streamlined arbitration to resolve negotiation stalemates with key hospital-based specialists whose inclusion is needed in order for the network's hospital services to be adequate. Above, we outline ways in which hospitals might encourage network participation by key specialists. But, when that does not succeed, or becomes too expensive for the hospital, the failed negotiations could be submitted to an arbitrator to determine fair payment rates for the particular specialty market.

Recommendations

Unfortunately, there is no single, simple solution to surprise medical billing. Instead, the complexity of the U.S. health care system requires a multifaceted approach – one that leaves room for ongoing adjustment and further development. Based on the experience to date, the following are our major recommendations, which are further distilled on page 26.

1) Take a Comprehensive Approach

The need for protection is most compelling in emergency situations, but patients clearly deserve protection from surprise bills in other common hospital scenarios (ancillary and consulting specialists). Thus:

27. A broadly analogous form of independent review designed to resolve insurance coverage disputes over medical necessity has worked reasonably well. Kelch Associates, Ten Years of California's Independent Medical Review Process (California HealthCare Foundation, Jan. 2012), <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20/PDF%20IndependentMedicalReviewHistory.pdf>. However, those disputes involve different parties (patients), and different issues (medical expertise).

28. The NAIC's Model Act (2015), for instance, establishes a "benchmark" payment rate that is "presumed to be reasonable" if it is a specified percentage of Medicare's payment rate or of some other "public, independent, database of [prevailing] charges." California recently enacted a similar approach for surprise billing (AB-72) that requires plans to pay the greater of 125 percent of Medicare rates or the health plan's average contracted rates for the services in question. However, if providers are not satisfied with this amount, they may seek independent review to determine if the amount is "appropriate" based "on all relevant information" (which is a standard taken from California case law regarding reasonable charges or value for medical services)..

- Solutions should target all out-of-network billing at in-network facilities, along with all care resulting from emergency screening and patient transfers (including ambulance transport) at out-of-network facilities.

Doing this avoids the need to draw difficult or arbitrary distinctions among different types of hospital services or urgent care situations. In addition:

- Patients also deserve protection from surprise billing in various outpatient settings, such as ambulatory surgery facilities and laboratory testing.
- Protections should extend to all types of health insurance plans (HMOs, PPOs, etc.).

Although solutions should be comprehensive, there may be reason to adopt somewhat different solutions for different aspects of the problem. For instance, the more severe market failure that accompanies emergency services may call for more overt regulation than for other hospital-based services.

2) Take Federal Action to Protect More Patients

State enactment provides the greatest room for adapting to local market conditions and for continuing to try different approaches. However, federal action may be necessary to protect the half of the privately-insured market that is in self-funded employer plans. States have sufficient authority over people in self-funded plans if the remedies are directed only to providers. But if health plans are included, either a federal remedy is needed, or a federal enactment that provides states the necessary authority.

Without a Congressional enactment, the Department of Labor lacks full authority on its own to impose a comprehensive solution. Its authority under ERISA includes informing subscribers and resolving disputes with plans. Although these are two important elements of a comprehensive solution, currently lacking is any authority over appropriate payment amounts by plans to providers. It might be possible, however, to craft a partial solution under existing ERISA law by combining state authority over provider payment with Department of Labor authority over dispute resolution with health plans. This more complex federal/state hybrid would require further legal analysis, and most likely would remain incomplete.²⁹

A more comprehensive federal remedy could be extended from the Affordable Care Act's existing patient protections for emergency treatment. Or, federal legislation could give the states flexibility to tailor alternative measures that are at least as protective as those provided by a federal default solution.³⁰

29. For instance, other than for emergency treatment, existing state and federal authority would not appear to encompass a requirement that self-funded employers waive out-of-network cost sharing.

30. This is essentially the approach used in the Health Insurance Portability and Accountability Act of 1996, for portability of group insurance coverage, and in the Affordable Care Act, for insurance exchanges.

3) Recognize that Improved Information Is Necessary but not Sufficient

Patients need good access to current, accurate information about network membership, but this alone will not solve most surprise billing situations. Notifying patients sometimes makes it feasible to freely consent to out-of-network billing. However, for notice to be adequate, it should include a case-specific estimate of the extra costs, and information about feasible in-network alternatives. These options should be presented at a time, and in a fashion, that does not pressure capitulation.

4) Hold Patients Harmless when Unfair Surprise Cannot Be Avoided

Although the best remedies for surprise billing can be controversial, the controversy should not deter lawmakers from crafting a solution that holds patients financially harmless when they take reasonable steps, or have no reasonable opportunity, to avoid out-of-network billing.

- Holding patients harmless means that health plans charge them only in-network deductibles and cost-sharing and that providers not “balance bill” patients for the portion of their charges not paid by health plans.

5) Encourage Hospitals to Increase Physician Participation In-networks

When hospitals contract with specialists for hospital-based services (emergency, pathology, radiology), the preferred policy approach to address surprise billing among specialists at in-network hospitals would be to have hospitals require participating physicians to join at least the primary health plan networks that the hospital joins. They could also require network participation as a condition of medical staff membership, for these and other key hospital-based specialists such as anesthesiologists. Health plans could require hospitals to do so, in order to join their networks, as long as doing so does not add unduly to insurance costs.

To encourage hospitals and health plans to use this leverage where it exists:

- Regulators could question whether health plan subscribers have adequate access at hospitals that lack sufficient network participation by key hospital-based specialists.³¹
- Regulators should also use antitrust authority more actively to determine whether market power is being used inappropriately when most hospital specialists refuse to join networks.

Depending on local market conditions, hospitals might not be able to implement the preferred approach. If hospital-based specialists refuse to accept network payment rates, meeting a more robust network adequacy standard for hospitals might require either that health plans pay higher rates or that hospitals subsidize a portion of payments to specialists – either of which could increase insurance premiums. To avoid that:

31. Declaring that a hospital provides “inadequate” access does not bar it from network participation. That means only that a health plan would have to rely on some other area hospital to satisfy network adequacy standards.

- Failed contract negotiations with key hospital-based specialists could be submitted to mandatory dispute resolution.³²

Strong measures that affect the negotiating relationships among hospitals, physicians, and payers are fraught with a risk of unintended market consequences. Therefore:

- The fairness and cost impacts of steps taken to increase network participation should be further evaluated.

6) Resolve How Much Health Plans Should Pay Nonparticipating Providers in Surprise Situations

Lawmakers have two basic options for determining how much health plans should pay nonparticipating providers, keeping in mind the need for administrative feasibility and to avoid unduly distorting market dynamics:

- Regulate provider rates in surprise situations; or
- Mandate a form of dispute resolution.

Rates can be regulated as a multiple of rates either that Medicare pays, or that health plans negotiate in their networks.³³ The advantage of health plan negotiated rates is that they are market-determined. Medicare rates, however, are easier to determine and are often used as the basis for private market negotiations (Clemens 2015). Either way, it is a legislative policy judgment what multiplier to apply to the reference rate. A rate regulation approach would need to be evaluated periodically to determine its market impacts and its fairness to the respective parties.³⁴

An alternative to rate regulation is mandatory dispute resolution of surprise medical bills.³⁵

- The most efficient method appears to be “baseball-style” arbitration, which requires the reviewer to choose one of the two parties’ final offers.

Arbitration can also be used to resolve disputes over fair payment terms in contracts that health plans negotiate with hospital-based specialists, in order to reduce situations where these specialists are out-of-

32. A different or modified form of dispute resolution might be required, however, than the simplified “baseball” approach outlined above.

33. A third approach is to limit rates to a percentile of UCR, as defined by a credible source. Connecticut, for instance, requires insurers to pay up to the 80th percentile of the range of undiscounted charges from similar providers, as determined by FAIR Health, an independent nonprofit firm that maintains a database of provider charges (Beck 2016). Although this database reflects what billing practices are actually “usual and customary,” prevailing charges are not necessarily “reasonable,” especially for specialties where consumers do not choose the physician and so normal market forces are absent.

34. See for instance Social & Scientific Systems (2015).

35. Ideally, dispute resolution should be only between plans and providers, and not involve patients. If this is done under current law, however, ERISA bars states from mandating dispute resolution for employer self-funded plans. Nevertheless, for subscribers in such plans, states may mandate dispute resolution between patients and providers. If so, states should arrange for advocates to assist patients at no cost.

network.

Other dispute resolution methods may be feasible, but whichever is chosen, the results should be made public (providing information that will help others to reach settlements efficiently).

- A hybrid method could be considered that combines rate regulation with mandatory dispute resolution. In this approach, a payment rate is established as a default ceiling or floor that applies if the provider and health plan fail to reach agreement, or that limits what a dispute reviewer may impose.
- A state that does not either regulate rates or mandate dispute resolution for surprise medical bills should, at a minimum, establish (or clarify) the standards that govern courts in determining the reasonableness of out-of-network billing under contract law.³⁶

36. For instance, state law could require that providers' charges must be reasonable, as determined in reference either to market-negotiated rates or to Medicare rates. Moreover, state legislation could establish a multiplier for either of these reference points that sets the outer bounds of reasonableness, but allows courts to determine in individual cases whether a lower multiplier is more appropriate.

Key Steps to Solving Surprise Medical Billing

Because our recommendations encompass a range of potential responses, by either federal or state government, they appear complex. To some extent, this complexity is unavoidable due to the complexity inherent in the U.S. health care system. It is possible, however, to distill a simpler set of preferred steps, as follows:

A. Federal Action:

Due to the importance of the surprise billing problem and the difficulty states have in solving it on their own, federal action is needed, especially to assure that protections apply to both insured and self-funded policies. That could consist of two elements: i) capping out-of-network billing rates for emergency services at a specified multiple of Medicare rates; and/or ii) authorizing states to set billing limits or to require binding dispute resolution mechanisms between providers and health plans, for surprise medical bills more broadly.

B. State Action:

States could either regulate what out-of-network providers may charge in a full range of surprise situations, or they could craft an efficient dispute resolution mechanism. Based on emerging experience, one recommended approach is a “baseball” style of arbitration, which requires choosing the final offer from one of the two sides if they fail to settle. States should further streamline the dispute resolution process by setting outer bounds on what rate the parties can seek or the arbitrator may impose, and making arbitration results public.

C. Other Measures:

Additional measures, outlined above, should be pursued both by federal and state regulators to improve consumer information about provider networks and out-of-network charges, and to encourage hospitals to increase participation in health plan networks by key physician specialists.

D. Ongoing Evaluation:

This full set of measures should be evaluated periodically to assess both their effectiveness in protecting patients, and any unintended consequences for market dynamics.

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