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LEONARD D. SCHAEFFER CENTER
FOR HEALTH POLICY & ECONOMICS

PROTECTING PATIENTS FROM SURPRISE MEDICAL BILLS

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Introduction and Welcome

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Presentation of "Solving Surprise Medical Bills"

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Panel #1: Addressing the Growing Problem of Surprise Medical Bills: Stakeholder Perspectives

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Panel #2: Addressing the Growing Problem of Surprise Medical Bills: Policymaker and Policy Thinker Perspectives

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P R O C E E D I N G S

INTRODUCTION AND WELCOME

MR. GINSBURG: Good morning. I'm Paul Ginsburg, and I want to welcome you to today's event, Protecting Patients from Surprise Medical Bills. The event is hosted by the Schaeffer Initiative for Innovation in Health Policy, which is a collaborative effort between the USC Schaeffer Center at the University of Southern California and The Brookings Institution.

For those either in person or joining us on the webcast, I invite you to join the discussion and pose questions to panelists using "#Surprisebills" on Twitter.

I have the pleasure of introducing Leonard Schaeffer, who is the reason why we are all here today. Leonard Schaeffer was the founding Chairman and CEO of WellPoint, now called Anthem. He is currently the Judge Robert Maclay Widney Chair and Professor at USC.

In 1986, he was recruited as CEO of WellPoint's predecessor company, Blue Cross of California, when it was near bankruptcy. He managed the turnaround of Blue Cross and the IPO creating WellPoint. Under his leadership, the value of the company grew from $11 million to over $49 billion.

Before that, Mr. Schaeffer served in the Federal Government as Administrator of the Health Care Financing Administration, now known as CMS, where he was responsible for the Medicare and Medicaid programs. In 2009, Mr. Schaeffer established the Schaeffer Center for Health Policy and Economics at USC, and he serves as the Chair of the Center's Advisory Board.

He also has endowed academic chairs in health policy and economics at USC and also at Brookings, the University of California-Berkeley, National Academy of Medicine, and Harvard Medical School.

Mr. Schaeffer is a graduate of Princeton University, and was the Regents' Lecturer at the University of California, Berkeley, a Gilbert Fellow at Princeton,

and a Williams Fellow at Rand.

Please join me in welcoming Leonard Schaeffer to kick off today's event. (Applause)

MR. SCHAEFFER: Well, somehow I don't think you all came to hear about my trouble holding a job over the years. We are here because the world of health care is changing and continuing to change in surprising ways.

The good news is the uninsured rate is at a record low, 9.1 percent, in 2015. That means that it is increasingly important that Americans understand and effectively use their insurance coverage. Unfortunately, there are times when an insured individual receives care from an out of network provider that they did not choose, and then receives a significant surprise medical bill for those services in an amount that can be overwhelming.

There are one-third of insured adults who have trouble paying medical bills and report that the problem of medical debt is the result of an out of network bill. Nearly 70 percent of those who had trouble paying out of network bills were unaware of the provider's network status at the time services were rendered.

In addition, as health care plans move to high deductible and narrow network products, especially those are offered on the exchanges, the number of people impacted by this issue is going to increase.

Some states have taken action to limit the added cost of surprise medical bills. Most recently, in California, lawmakers capped how much providers can charge for these surprise out of network costs. However, as you are going to hear from the speakers today, state action to date doesn't really address the problem for the majority of working age adults who get coverage through self-funded employers.

Today's event will look at the scope of surprise medical billing, policy reforms to address this problem, and will lay out some future action that is required.

That completes my paid political announcement. I'm going to begin our

conference by welcoming Mark Hall. He is the lead author of today's policy paper. He is the Fred D. & Elizabeth L. Turnage Professor of Law and Public Health at Wake Forest University, and a new Nonresident Senior Fellow here at Brookings.

He is the author/editor of 20 books, including Making Medical Spending Decisions and Health Care Law and Ethics. Heavy duty. He brings an expert voice to the discussion here today having published papers on medical billing and consumer consent.

Please join me in welcoming Mark Hall to present the paper Solving Surprise Medical Bills.

PRESENTATION OF SOLVING SURPRISE MEDICAL BILLS

MR. HALL: Good morning. It's a pleasure and honor to be here to present this paper, which is very much a collaborative effort. I was thrilled to take the lead in sort of doing the research and pulling the draft together, but the other authors had really an instrumental role in this. I think it is the most enjoyable and productive collaborative project I've ever worked on, so I also want to thank Paul, Steve Lieberman, who is here, Loren Adler, Caitlin Brandt, and Magie Darling, who all helped me with this.

Let's start with sort of a basic conceptual definition. "Surprise billing" I think could be characterized as any out-of-pocket billing, out of network billing, where the patient lacked what we could call fair opportunity to seek care in network.

What would be absence of fair opportunity? Obviously, number one is the network is simply inadequate, maybe the patient knows that they're going out of network but they have no choice. That is an aspect of the problem that we're not addressing. Others are working on network adequacy and what the remedies should be. The Schaeffer Center might take that up in its next project.

We are really looking more at situations where there is an adequate network but the patient still ends up out of network for reasons that are outside their control. The most obvious would be emergency care, where you simply go to the nearest

hospital. There, you really have no control over the situation.

You can imagine telling the ambulance to take you to whatever hospital, but that is not realistic. Often times, even the ambulance might be out of network, because it's whoever 911 sends over.

Even if you go to an emergency hospital in network, you have no control over whether the providers who come to your aid who are on call or what have you are in network, so that is a classic situation. It typically is the one that is first addressed by lawmakers.

Beyond the emergency setting, we have other sort of physicians that are facility based that are often times non-participating even though the facility is participating.

As you all know, doctors typically are independent from hospitals and make their own decisions about who to contract with, so we have many situations of hospital in network but surgeon isn't or surgeon is in network for assistant surgeon isn't, but surgeons are but anesthesiology isn't, or anesthesiology is, but pathology isn't, and on down the line.

Again, those are situations where patients have essentially no notice, and even if they did, there's very little they could do about it.

Beyond that in outpatient settings, there are other situations to be concerned about. In patient care, referring them to labs that may or may not be in network, or sending patients to see consulting physicians and not realizing that, or diagnostic testing.

Really, up and down sort of the chain of treatment, it is quite possible these arrangements could arise. As Len said, it is appearing they are rising more frequently than before.

The paper has an example. There are various sorts of extreme examples that the press would tend to focus on to show the magnitude of the problem,

where the patient is left owing a bill for hundreds of thousands of dollars, and of course, sometimes the patient is left owing a bill for only a few hundred dollars.

We picked a scenario that was sort of in the middle where you could imagine being not uncommon. Let's say a procedure that is billed out at a Chargemaster rate of $10,000, where the plan contracts to cover for $4,000. You might say that is a big difference, but as you know, a difference between Charge Master and contractor rate is not at all unusual.

If you then look at in network care, follow it all the way to the bottom, no problem, if you met the deductible, which here I put up as modest, but whatever it is. If you met it, you only pay your co-pay or you pay your deductible and your co-pay.

If it is a HMO, classic HMO, you have no coverage whatsoever out of network, so that $10,000 flows all the way to the bottom line. There is no contribution from the plan. As we know, these HMOs or EPOs are becoming more common, particularly on the marketplace exchanges where who qualify for the subsidy are the least able to pay for a large bill out of network.

In a more classic PPO situation, you would have some coverage but often times the plan will have its own review of whether that $10,000 is usual, customary, and reasonable. Perhaps it would decide only $6,000 is sort of the market rate for that, so the patient would still owe the provider the remaining $4,000. Plus, even with respect to the $6,000, there is often times a financial penalty imposed by the plan for going out of network, which would be a co-insurance rate, say 30 percent, and perhaps a higher deductible.

Depending on where you are with your deductible and these other assumptions, even though there is out of network coverage, you could well end up owing anywhere from over half to three-quarters of the full charge.

These are very typical scenarios, and as you heard, they are happening more commonly. In terms of the extent of the problem, what really struck me as I got into

it is that there really is no disagreement among stakeholders and among the public policy community that this is a problem that needs to be addressed.

I see sort of broad agreement to that basic principle from stakeholders, all the specialty groups, all the provider groups, all the plans, not every single one of them, but with the major representative organizations, I didn't see anyone saying, oh, this is a minor problem that the market should fix or regulators should leave alone.

I also see broad bipartisan agreement in that the states that have done something on this include blue, red, and purple states. We heard about California, but also Texas was an early actor, Colorado, Florida, New York, some others. There seems to be across the political spectrum interest in dealing with this, and the paper points to various pieces of pending legislation, you know, that probably won't go anywhere in this Congress, but shows the willingness among some congressional leaders to pursue this, both from the left and right.

Rather than spending more time -- one other example of how extensive it is. Leonard gave you some figures about how many people are affected, but this is just one example from Texas, but it is very revealing.

It's a survey of the major carriers in Texas (Blue Cross, Humana, United)—what percentage of their hospitals had zero specialists in network for key specialties. For emergency physicians, anywhere from a fifth to over half of the hospitals of these leading networks, leading carriers, had no emergency physicians on staff.

For anesthesiology, good coverage for one. All the hospitals had at least one anesthesiologist but for the other two carriers, anywhere from 14 to 38 percent of the hospitals had zero anesthesiologists, radiologists, pathologists, neonatologists.

This is a large state with the largest carriers. This is more than anecdotal, and represents the extent of the potential problem.

Understanding there is wide recognition of the problem, this paper really focuses on what are the solutions. Other papers have done a great job mapping out the

extent of the problem and mapping out what is it that states are doing. This paper sort of looks at the gaps and says what else needs to be done or which of these approaches by the states and potentially by the Feds appear to hold the most promise.

First, there are a series of ideas that might be helpful but are incomplete. The first response is well, all right, let's hold the plan responsible in some way, and we tend to do this with emergency care.

Require providers to cover emergency care so there is no choice, so the ACA has a rule that is replicated in a number of states that patients who seek emergency care out of network have to be held harmless in the sense that the plan may not charge them any more than the standard co-payments.

That is a good starting point. It goes as far to address some of the impact on the patient and the plan's responsibility, but it doesn't address the extent to which providers can balance bill. The ACA says the plans must pay the providers the greater of usual rates or Medicare times 125 or contracted rates, I believe, so the ACA says the plan must pay the provider a certain amount, but that certain amount still might not be the full bill, so providers are still allowed to balance bill under the ACA with respect to emergency care.

Another approach is to try to diminish the extent of the problem in non-emergency situations where patients might be better able to choose providers based on network status, what about giving them better notice? Better directories of who their providers are so they can look them up, that is certainly seriously needed, but where does that lead us in terms of patients who still seek care out of network?

How do we know they really did that sort of voluntarily and with good information versus in a more surprise or unfair scenario where they didn't have much choice?

You would need something along the lines of what they happen to call in Australia "informed financial consent," a nice little junket I had. They use this idea every

day. I said, well, that's an interesting little phrase, I'll build on it.

What would it mean to really give true consent to being sent out of network, using an anesthesiologist? Well, you would have to think about what the notice says, that this is what is happening, and not just this is what is happening, but this is how much it is going to cost you. These elements are built into the California recent law, by the way, as well as a couple of others.

You would have to think about the timing of the notice that is being given sufficiently in advance, and I think California says 24 hours or something to that effect, so the patients can make other arrangements, and you have to think about this being done in a non-coercive way. Even with 24 hours in advance, you know, you have already sort of made your major decisions about which surgeon and which hospital and what procedure, and you're getting down to the wire, and suddenly someone says, oh, here's a piece of paper that says you're going to have to pay your anesthesiologist $1,500.

How realistic is it that you're going to sort of call everything off and say I have to go find myself another doctor in the hospital because this hospital doesn't have anybody in network. I think there are serious concerns there about enforcing the informed financial consent in ways that are non-coercive.

To be most effective, those would also have to say we're proposing a non-network provider but if you don't like that, here's how you make an alternative choice, and really make it truly feasible.

That being said, certainly we want to preserve the right of patients to seek out their preferred doctors and not do anything that penalizes the doctors for working with patients who truly desire their services despite being adequately informed.

Another idea that is in discussion that we think is useful but only goes so far is to think to what extent hospitals have some leverage over their hospital based specialists.

If the hospital is in network, to most people's logic, can that mean the

hospital's specialists are, because we know they are independent, but hospitals could assert a certain amount of influence through their contracting.

So, if they have a selective contract for emergency care or radiology or what have you, couldn't that contract say well, you know, to be part of this selective contract, you have to at least belong to our major networks, maybe not every single one, or even further, credentialing to be part of the medical staff. You know, we want to present ourselves as a single integrated ACO type whatever, so we can contract with plans and providers, we can't do that unless we are all sort of on board here. If you want to be part of the institution, you know, we need to all be willing to contract together.

There is a lot of attraction to that but there is also a lot of realistic limitations. In many places, hospitals lack the leverage to do this or to get this leverage because there is enough competition, physicians can go elsewhere, physicians have consolidated, and simply are going to push back, or if they're going to get that leverage, they're going to have to pay for it.

We read about how hospitals already have to pay specialists to do on call coverage because many of those patients aren't insured, and that can get to be expensive. If we do that more across the board, that could be built into the hospital rates that get passed on to the consumers. It doesn't constitute a full solution, although it is something well worth thinking more about.

The point so far is there isn't a magic bullet solution, we can't simply say health plan, fix it, provider may not balance bill, just simply get the patient better informed. It's a much more complex problem that requires a multi-faceted response. We want to think more comprehensively. How do we fix the problem in the most comprehensive way as possible?

I will start with a few basic principles and get on to our sort of bullet point suggestions. The main principle is the first rule of surprise billing is hold the patient harmless. The judgment is it's not fair to the patient and whatever disagreement there is

ought to be worked out between the plan and the provider, let the patient off the hook.

To some extent, that does mean ban balance billing, once you have decided what the payment rules are between the plan and the provider. That is a simple, clear, kind of edict that we shouldn't lose sight of in crafting these things.

The next thing is once we hold the patient harmless, there is a genuine dispute between the plan and the provider, and we have to figure out what is the fair and efficient way to resolve that disagreement over what should be paid between two, by definition, non-contracting parties. They could go to court and work it out, but that approach is expensive, clumsy, time consuming, and courts really lack guidance on what are the governing principles here.

Sort of the governing concepts that might come out of regulation, is the network adequate, is there an obligation to pay reasonable rates are too mushy for courts to really be enthusiastic about getting in and resolving all of this. They see it as messing with an area that ought to be regulated or we ought to leave the parties alone or something.

It is not as if the courts shouldn't be resorted to, but they hardly are sort of the first and best process on an ongoing basis.

Whatever we come up with, think about the potential distortion of market mechanisms. A rule that says put the onus on the health plan would mean providers have much less incentive to negotiate, because they're going to get paid anyway, particularly if they are in a specialty for whom most of their business or much of their business can come from out of network, such as emergency care.

If you say let's cap what we pay the providers, you know, something close to Medicare, then what incentive do providers have to negotiate further to join the network. If this is all I'm going to get, I'll take my Medicare times whatever, 25 percent, and just go out of network.

You want a process that sort of sets boundaries on either side but still

leaves room and incentive for negotiation. That is a tricky balance to call for, but it is something to be aware of.

Finally, the solution needs to be comprehensive in ways that existing law fails to do. First, need to cover all plan types. A number of states have laws that govern HMOs because if there's no out of network coverage, the problem is not severe, but we need EPOs, which are indemnity regulated versions of HMOs, and we also need PPOs covered, because as networks get narrower and penalties for going out of network get stronger, the problems are significant there.

Most importantly, we need to remember that only half the market in terms of private insurance is state regulated. The other half is not state regulated because it is self-funded plans. It seems silly to construct a comprehensive solution that leaves out half the market. We have no reason to believe that the incidence of this is any different in large groups than in small groups, except possibly differences in the size of the network could mean it is less significant.

Certainly, all the fundamental elements are just the same, and in fact, in self-funded plans, it's possible that the financial consequence could be more severe because self-funded plans have more freedom to limit what they pay out of network and in reports, they are paying UCR, they are paying just contracted rates, Medicare plus 60 percent or some other number, which could leave patients exposed to even more balance billing.

Obviously, to get to self-funded plans, we need a federal solution, and also all the major treatment areas, not just emergency, but all facility based, and some thought about whether you go beyond facilities to outpatient.

Here are the specifics, and I believe my final two slides. Federal action is needed or you're not going to get a comprehensive solution. A starting point, since the Feds already regulate what is emergency care, and says you have to treat, rule says this has to be considered an emergency if it feels like one, and for these situations, the plan

has to pay the highest of three rates to the provider.

If you go that far, there is only one final modest step to go ahead and ban balance billing. It seems logical that would be built into federal action, and to recover, all plan types.

With respect to non-emergency care, states need authority to regulate or the self and serve plans, which would require congressional amendment, or you need a federal fallback for states that don't regulate following kind of a HIPAA model that first started that idea, a federal standard that states are welcome to emulate, or some combination of federal and state regulation, and this gets more complex.

Commented [MK1]: Unclear what this is

States are authorized to regulate provider payment rates under ERISA. The Feds are currently authorized to regulate dispute resolution mechanisms by plans, so there might be a creative way of combining the federal authority over dispute resolution with the state authority over provider rates and create some kind of ERISA hybrid thing, you know. It would need some more thought. Creative minds can work this out. Or just a piece of legislation that says here is what we are doing.

Tricky terrain, but it has to be worked through if you want a comprehensive solution, something other than half the population.

What does a solution entail? Dispute resolution. We hear a lot about this in terms of New York, Florida, and California. Some states use independent review, the same type of process they use to resolve medical necessities disputes. That would be perfectly fine.

Other states, New York has been a leader in this, come up with a really expedited streamlined resolution process known as "baseball style" or "best offer," meaning the parties come to the table with their best or final offer.

Then the arbitrator can only pick one or the other, those numbers can't split the baby. That is done on sort of limited presentations. It's an incentive to settle, because it's all or nothing kind of stakes, and it can be set up in a way that it is done

expeditiously.

There is interesting sort of experimentation going on. This is different than other concepts such as mediation, which is simply trying to achieve settlement, does not produce binding results or voluntary arbitration, which is binding but the parties don't have to engage unless they want to.

You have to be careful in terms of dispute resolution, is it mandatory, is it binding, and is there an efficient form of it.

With that said, then we come back to sort of the whatever, 800-pound gorilla. What do we do with rates? We simply can't avoid some attempt to benchmark rates, because these dispute resolution mechanisms have to have some standard that governs what is the payment rate.

Right now, we just have, you know, UCR, usual, customary, and reasonable. That could give better definition, but there are other ideas out there that are worth considering.

First of all, to benchmark rates doesn't mean you have to set rates. You could benchmark rates in ways that are presumptive, that say in the absence of party dispute or in the absence of party agreement, these are presumptively the most the provider can get paid or the least the plan has to pay, so you can have sort of a floor or ceiling that is set, sort of default payment rates, that then can be further challenged if one of the parties feels that the ceiling is too high or the floor is too low or what have you.

Both of those can be done, and we see examples in different states, that benchmarking can be done as a percentage or percentile, which are two different concepts, one of three things. You can work off VADCare, which I understand is controversial but some people say 200 percent of Medicare, just because it's Medicare doesn't mean it needs to be 25 percent of Medicare.

You could take this idea of amounts generally billed that has been built into the tax code as the reference point for charging low income patients by tax exempt

hospitals, so it's a formula for calculating what's the typical amount that the health plan pays under its commercially negotiated managed care contracts, and you could take that and add a percentage to that, so you could say 20 or 25 percent over sort of their standard contracted rate, however phrased. The concept and the phrasing is already in the IRS law without the add on amount, you could add on an amount for others.

You could designate a certain sort of commonly accepted database, and we often hear about FAIR Health, and this is a reference in New York law, Connecticut law, as the place where you go to find what is UCR, and say well, usual and customary is in their database. Reasonable is say the 85th percentile or 75th percentile or whatever percentile the regulators agree to.

With all that said, I ended up with my Goldilocks analogy, which I used in the paper, again, there is not a silver bullet magic solution. You have approaches that seem too lenient, approaches that seem too aggressive, but in the middle, I think, there is this sort of just right mix of solutions. It's not a single ingredient thing. It requires a number of elements working together.

We hope that through this paper and this analysis to sort of bracket out what we think are sort of the most viable ideas moving forward, and we hope as we engage with the stakeholder panel and the public policy panel that we can get more thoughtful reaction to this.

With that, I will conclude my remarks. I'll take sort of more discussion during the stakeholder process, but thanks for your attention, and let me next call up our next moderator, Dana Goldman. Dana Goldman is a distinguished economist at USC where he directs the Schaeffer Center for Health Policy & Economics.

Let me also call for the next panel, the stakeholder panel, if you all will take seats here on the stage.

All right. Thank you very much.

PANEL #1: ADDRESSING THE GROWING PROBLEM OF SURPRISE

MEDICAL BILLS: STAKEHOLDER PERSPECTIVES

MR. GOLDMAN: Thank you very much, and welcome, everyone. I think Mark set the stage quite nicely, and the key theme, of course, is always health care is very complicated. Now we are going to get a chance to hear from the stakeholders. I want to introduce our panelists.

We have Betsy Imholz. She is Director of Special Projects from Consumers Union. Tom Priselac, who is the President and CEO of Cedars-Sinai Health System in Los Angeles. Colin Drozdowski, who is Vice President for National Provider Solutions at Anthem. Jeffrey Plagenhoef, President-Elect of the American Society of Anesthesiologists.

I think we are going to let each of them provide a 5 minute to 7 minute background on this topic because we do want to make sure all the positions are represented.

I think to set the stage, the Partnership for Fighting Chronic Disease published a survey recently, and 7 out of 10 people are reporting one or more coverage issues with insurance not covering as much as they expected, and with an unexpected medical bill being the primary problem in 58 percent of the cases. This is widely prevalent in a way people may not understand.

On the other hand, as I think Leonard Schaeffer pointed out, the best tools we have right now for controlling health care costs are co-pays, deductibles, and also the ability to select now networks and providers that provide efficient care. So, the challenges for us as we think about where health care is going are enormous, and we need to keep those in mind.

Let me turn it over to Betsy first.

MS. IMHOLZ: Good morning. He has just shrunk our time from 7 to 5 minutes. I'm going to race through what I can here.

MR. GOLDMAN: You can have your full seven.

MS. IMHOLZ: I think it is fitting and appreciate that the consumer perspective is jumping this off because, of course, it is consumers who are the ones who get stuck with these surprise unexpected bills.

Consumers Union has a national campaign to stop surprise out of network bills, and our work started with some egregious cases that came to your attention in New York, including one of a woman named Claudia Neff, and I have to just put the human face on this for a minute to start out.

She is a concert pianist in New York. When she needed cervical spine surgery in 2012, she did her due diligence. She's a savvy consumer, like a Consumer Reports' reader. She wanted to make sure that the surgeon was in network, the recommended surgeon, by checking with the hospital website and several different sources, and they all confirmed this was an in network surgeon.

Yet, a month after the surgery, she found that she got a $100,000 bill, and it is one of those alarmingly huge bills for the total amount of services. The insurance sent her a check for $67,000, which is a pretty good chunk. She endorsed it over to the doctor, but only then learned that the doctor for several years had not been in the network, so she was going to be liable for $33,000.

It's a saga that led to some heavy-handed collection tactics, to her even considering divorce as a strategy to protect her family assets, and incredible stress for a woman recovering from a major surgery.

Luckily, her story has a happy ending, because with her perseverance and with the intervention of the New York State Department of Financial Services, the bill was waived. Her story ended well, but not so for the many thousands of people who have contacted Consumers Union over the past couple of years from across the country with these stories.

Our National Research Center did a representative survey, nationally representative survey, in 2015, and found that 1 in 4 people over the prior 2 years had a

bill from a doctor that they didn't know and didn't expect to get a bill from. Of those who had been hospitalized in the prior 2 years, 1 in 4 had a bill that was charged at out of network rates when they expected it to be in network.

We know from secret shopper work we have done in California, as other speakers have mentioned, for some specialties, such as anesthesiology, in network hospitals may have no providers at all in network.

As to whether the problem is growing, just to keep the discussion lively, I have to offer a counter view. I'm not necessarily convinced that the problem is growing. Several reasons why the issue has gained prominence.

First of all, many more people are covered with individual market coverage for the first time, so the sheer number of people covered is more, and therefore, any problems in the market are going to be compounded.

Secondly, some products are rising in prevalence. Someone mentioned EPOs, and that kind of product that doesn't cover out of network costs at all. Those are growing, at least we see it in California, in prevalence.

Third, there is this issue of some specialist consolidation going on, so that we have found, for example, anesthesiologists coming together in groups and then being unable to negotiate a contract with the carrier, and therefore, not joining in network.

Many of the stories we have gotten are older stories, stories prior to the Affordable Care Act. I know in California for many years -- we have been working on this issue since 2009 and probably before that. There was a case involving emergency coverage. I'm not totally convinced it's a growing problem. It is certainly not a new one.

I do agree with the paper that the market incentives are not there for the providers and carriers to correct it themselves, so we do need policy solutions.

I was asked to talk about what we think are good policies from the consumer perspective. Obviously, it is to get the consumer out of the middle of these contract and reimbursement disputes between carriers and providers. The consumer

interest also is in the longer term to contain premiums and health system costs.

Here are three elements I would give of a good policy solution, and I'm speaking on the state level, because that is primarily where we have worked and we have had a lot of success. First, require that consumers pay no more than in network costs for those out of network services where they didn't choose to go out of network but it was sort of foisted upon them, and count that cost sharing that they do pay toward their deductibles and out of pocket maximums.

Second, explicitly ban balance billing. It's probably also a good idea to prohibit providers from even sending a bill at all for the in network cost sharing until they have gotten word from the insurance company about what the correct amount is. There will still have to be some kind of billing, but we want it to be the correct amount.

Third, base the default reimbursement or the presumptive reimbursement, as Professor Hall called, to out of network providers on the average contracted rate or Medicare plus a percent. In California, we ended up with Medicare plus 125 percent, the greater of that or the average contracted rate. Create an independent dispute resolution process for providers and plans to allow for speedy, inexpensive resolution. This is basically what the new California bill enacted this year does provide.

As an adjunct issue, I would say correcting provider directories is also essential. It is right, but it won't take care of this surprise billing problem, but it may in some cases help people avoid going out of network, and it may also give regulators a cross check mechanism about network adequacy, which is really hard to track.

While a comprehensive solution is ideal, I totally agree with Professor Hall on that, we know legislation is the art of the possible, and so in many states, they started out with emergency room protection or HMO protection. We take what we can get to some extent. We aim for the moon but we will accept something a little less if it takes away some of the pain that consumers are really experiencing.

Of course, I mentioned the states but we would love a federal solution, a comprehensive federal solution that takes care of everything, all the self-insured folks, as well as the commercial market would be terrific. So, Congress does need to act, I agree.

A leader in this has been Congressman Lloyd Doggett, who has a bill he has introduced that would take care of the balance billing and emergency situations, but certainly more is needed.

The paper notes that Congress could simply give states the authority to fix the ERISA plans in their states, and that is an interesting alternative that seems like something simple Congress could do that would at least empower the states to move.

As to bad policy ideas, there are a lot of them. Professor Hall listed a number of them, and I'll just tick off a few things. Requiring consumers to go to mediation regarding their bills is a bad idea. Our survey last year found that people just don't complain. 90 percent of people in our nationally representative survey didn't even know what state agency was charged with handling insurance complaints.

When consumers have to initiate the process, it's not a good idea. Instead, the law explicitly needs to set the amount as the in network cost in these different circumstances, and have that kind of clarity, and then prohibit balance billing.

In Texas, they do have a statute that requires consumer mediation and even sets dollar thresholds, and there are problems with it. Consumer advocates there are trying to work that out and amend that.

Another inadequate solution is the notice point that Professor Hall mentioned, assuming that notice alone is enough. People just don't have the opportunity in many of these situations to shop around, and that certainly is not going to be sufficient.

In a foundational sense, I'd say that basing out of network provider reimbursement on billed charges may simply perpetuate inflated costs and unreasonable system costs, which in the end drives up premiums for all consumers. There is just really no basis for believing all those billed charges are reasonable charges. In fact, studies

have shown, as you all know, I'm sure, that billed charges are many times the Medicare rate.

I would just add there is a lot of griping about the Medicare rate, but Medicare rates are set by a committee, RUC, and don't ask me what the acronym is, I always forget, but it's a group of doctors and dominated by specialists, which examines what the appropriate intensity of the service is and what the appropriate rate is. There have been complaints about that being dominated by specialists, the very specialists who are now saying the Medicare rate is too inadequate.

In conclusion, I would say it is not a red or blue issue. Every legislator on the state and federal level and every staffer we have talked with knows someone who has had this problem of the surprise out of network bill, so the issue really has traction, and in 2016, nearly two dozen states took a step of some kind to try to address the issue and protect consumers. Not all succeeded but many were bipartisan and we are hoping that in 2017, the states and Congress will come back and really try to tackle the issue because it is a major pain point for consumers.

MR. GOLDMAN: Thank you very much. Tom, go ahead.

MR. PRISELAC: Thanks. Good morning, everyone. Before I begin my remarks, a quick disclaimer. My comments from the provider perspective hopefully represent many and maybe even most provider perspectives, but I want to be clear it doesn't represent all provider perspectives. I'll offer that in the beginning.

Second, quickly, the context in terms of where I'm coming from at Cedars-Sinai is that we have about 2,000 physicians who are associated with Cedars-Sinai' about two-thirds of them are in some sort of economic relationship with the institution, but a third of them are also private practitioners.

I bring this up because as an organization, and this is not uncommon in other organizations, this is an issue that we deal with both as a provider of physician services but also as a hospital in which private practice physicians are coming to treat

their patients every day.

In terms of the issue, I think the root of the issue really is the tension that we continue to struggle with in health care, it is not unique for the question of out of network coverage between market forces on the one hand and also having a regulatory framework that is adequate to address both broad public interest issues as well as individual patient issues, and in that regard, again, this is not kind of a unique item.

We don't have any sort of overarching mechanism either at the state or federal level to deal with these kinds of issues holistically, and so once again on this issue, we find ourselves in a situation where ultimately there is enough social interest in a matter of sufficient economic consequence for people that you get political action, in this case, on a specific item.

The rest of my comments will be oriented towards AB 72, both because I think they do represent some of the principles that were covered by the prior speaker, but also because that is my own reality and our reality in California. It is one I can speak to the best.

First, I want to start by saying I believe and I think many providers believe that we are very glad that the patient is being taken out of the middle of this. I think unfortunately as we struggle in the American health care system around some of the issues I described earlier, we often times fail to think about how do we keep the patient out of the middle of this. I think the fact that has occurred is a good thing.

In California, it comes on the heels of prior actions. This matter has been dealt with as it relates to hospital services out of network and emergency department services out of network with prior legislation in California on both of those.

The law states, on July of next year, and as plans are issued, amended, or created -- which is important language I'll come back to in a moment with regard to the implications. As the plans are issued or amended, there is a provision that essentially prevents patients from having an out-of-pocket cost for out of network services any more

than they would have had as in network. That is the definitive solution in terms of individual patients' out-of-pocket.

There is a mechanism for 24 hour, at least 24 hour consent by the patient, if they are to have an out-of-pocket payment more than that, so it does provide for that mechanism that was mentioned.

In terms of the payment rate, the payment rates will be determined by the average in a particular region. How the regions are going to be defined is yet to be, as with many of the regulations, yet to be answered, or 125 percent of Medicare, whichever is greater.

There is a provision for an annual increase according to Medical CPI, and there is a provision for independent dispute resolution, if there is an issue with regard to the rates.

The issue of providing incentive for the health plans to have an adequate in network in the area is an issue that the law addresses. It uses a 15 mile or 30 minute rule to determine network adequacy, which is probably okay in some parts of California, but in Los Angeles, where it can take an hour to go four miles, I'm not sure exactly how that definition works.

The law does not apply to emergency circumstances, as I said earlier, that has been covered by prior legislation, and has been observed by the prior speaker, it does not apply to ERISA.

From my perspective, I've been in California for 38 years, I would just observe that I think the root cause of this has been a 30-year tug of war that has existed between physicians and health plans over what is fair and reasonable compensation. That is not a critical statement. That's the reality of how markets work, but it is, I think, what has led to this.

We have a solution now. We have a political solution that has pro's and con's associated with it, like all political solutions do. As I said earlier, the most important

thing is the patient is out of the middle.

Whether the balance, the market power balance between health plans and physicians has been reached as a result of the legislation, I think it is too early to tell by definition.

A couple of things about the law that I would just mention as possible concerns and to keep an eye on going forward. First, by definition, the law does create in essence a rate cap, and all the issues associated with rate caps are potentially at risk.

Given the way the rate system is set up, there is an incentive for health plans to lower the payment rates to the higher paid physicians or physician groups, whether deserved or not, but there is that incentive because by lowering the higher limit, you will lower the average payment rate, which is what would be used.

I think for many community hospitals will find themselves being approached again by various specialists who will be looking to the hospital to provide some payment to them in order for them to be available for services that patients in those hospitals may need, as physicians seek what they think is an adequate income level, they will seek that income from whatever sources might be available.

There is increased administrative complexity associated with this. Again, not a reason not to do this, but I also think we should be honest with ourselves and acknowledge that because that does come a cost. In California, the complexity is maybe more complex because we have two regulators, we don't just have one regulator for health insurance, we have two. There are conflicting rules of how an emergency case is defined between those two regulators as of right now.

I mentioned earlier the rolling implementation, so this will take effect as plans are issued, as new plans are issued, so for those people administering physician billing, over some period of time, they will be dealing with is this an AB 72 patient or not.

Many of the implementing regs have not yet been written, including exactly how the independent dispute resolution process will work. The law calls for a

certain way for the rates to be determined between now and 2019, and then in 2019, there is going to be an uber solution to this, so that is unknown exactly how it is going to play out, and then the ERISA issue.

I think there are legitimate issues to keep our eye on in order to make this successful going forward.

My last comment is I do think this is an example where the issue of creating health care services organizations, more economically aligned integrated organizations that are inclusive of hospitals, physicians, and perhaps others, is a good thing. I'm sure there is probably a meeting here tomorrow about why that is not a good thing.

I personally believe it is a good thing for other reasons, for on this matter, it is a good thing because it does allow institutions in the course of their relationship with physicians and that organization to be able to put in place the kind of mechanisms which we have done at Cedars-Sinai, which is physicians who are aligned with us in that way, either agreed to accept in network payments or some mechanism is established where this issue is taken away from an individual patient situation.

There are implementation issues associated with that, and we wrestle with that every day, but it does create an environment. People have raised the question, and the prior speaker mentioned, why can't this be done through the hospital/physician relationship, the typical hospital/physician relationship, and the reality is that the nature of the hospital/medical staff relationship is just not designed, frankly, to deal with these kinds of issues. That is why it hasn't been dealt with until now.

MR. GOLDMAN: Thank you. Colin?

MR. DROZDOWSKI: Good morning. I'm Colin Drozdowski, and I'm pleased to be here today, so thank you for having me. I'm with Anthem Blue Cross and Blue Shield, and will bring to you the perspective from the payer's side.

In my professional career for the last 25 years in some way, shape, or

form, my team and I have been provider facing, so this problem is very real to us on a day to day basis, and I'll try to give you some practical observations that I hope will shape and inform our conversation.

From the perspective of the health plan, I think it is safe to say that we can generically and loosely classify physicians into two categories, those who want to contract and work with payers, and frankly, those that do not. Those who want to contract and work with payers represent the vast, the overwhelming majority of physicians, and there is that healthy tug of war that Tom referenced, and that exists, and has existed for decades. That, I don't think, is going to change.

The much smaller category are those physicians who really are seeking to game the system in some way, shape, or form, and candidly, I think they are seeking to game the system at the expense of the patient, at the expense of the consumer, at the expense of the employer, at the expense of the health care system, and at the expense of the health plan.

That is sort of a category in many ways that I think we are talking about today, where you bring in this idea of the surprise bill or the balance bill.

From the viewpoint or perspective of the consumer or the patient, I would say they also classify non-participating, non-contracted physicians into two categories, those that are non-contracting, that they have the opportunity and awareness of, that they are non-contracting, and therefore, in advance of care, they can make a reasonable decision, a reasonable determination of what is best for them, do they want to continue to receive these services from a non-participating provider or do they not.

The other category which again is what we are here to talk about today, those instances where they really don't have a choice in that physician, or the choice is made available to them so close to the event that it's not practical for them to sort of cause a pivot or a change in care.

The problem of surprise bills or balance bills is not new. As I said, it's

been ongoing for as long as I've been in this industry. What I would suggest is there are two things that maybe are new or different.

One is the degree of the balance bill. What we are experiencing at Anthem on behalf of our consumers is that the amount of the bill, the amount that the consumer, the patient, is now being subjected to, is growing and growing exponentially. It is not uncommon to see a bill for $100,000 on a service that at a contracted rate might be $5,000, and we have more egregious examples.

The other piece is the breadth. Historically, this problem generally has been constrained to or confined to what are known as "hospital based physicians," think radiologists, anesthesiologists, pathologists, emergency room physicians, neonatologists. That is generally the cluster of physicians where this surprise bill existed.

The breadth that I'm referencing is more in this creative solution that is really, really detrimental to the consumer, and the best example I can give you is a physician that is a surgeon will either employ or work with an assistant surgeon. This is a designed scheme, if you will.

The primary surgeon will contract with the health plan or will contract with all health plans at their standard rates, but he or she will then bring in this non-participating assistant surgeon into the OR, and in some cases or in many cases, where that assistant surgeon isn't even needed, and then the patient finds out after the surgery because they were frankly unconscious at the time, that an assistant surgeon was brought in, and now they find this bill for whatever the amount may be. That breadth is somewhat new to the equation. I think it introduces a unique and distinct dynamic to this problem.

I know time is tight, so I will abbreviate my comments. There are no simple solutions. You have heard that from every single presenter. It is a complex problem. I would agree with all of my predecessor presenters that there is a shared desire to address the problem. There is no one single solution that I think is most fitting.

I agree the Professor has brought forth some very thoughtful solutions, but those in and among themselves are not easy.

What I'm going to leave you with are just simply five observations that maybe will provoke some thought and discussion and questions as we move forward. It is really to describe how we as constituents in this process either introduce intended or in some cases unintended consequences that are contributing to or exacerbating this problem of surprise bills.

I will start with the one that I began with, and by the way, these are not in any particular order, so don't think the first is most important. I think they all are of equal concern.

The first here is physicians. I mentioned at the very beginning that there is a subset of providers that are really seeking to exploit the system, and there are multiple ways they might do that. They do that through federal laws or emergency laws. They might do that through local or state laws that require certain payments for non-participating providers. They might do that through health plan policies around how they do or do not pay for non-participating services. That is observation one.

Observation two, regulators. I want to be clear. I believe a regulatory solution is an important part of this problem, but with the best of intentions, some of our existing regulatory solutions could actually serve as contributors or exacerbators to this problem, and that is if they require payment of billed charges in all circumstances, or even in emergency circumstances, without a reasonable cap or a reasonable way to set what those rates should be.

The one that I don't think has really been addressed in this room, and it's not one that is immediately self-evident, although I think the Professor addressed this idea of self-funded employers. If you're not familiar with that term, that means about 50 percent or more of the health care insurance that exists today are rendered by employers who are responsible for that payment, not health plans. The risk of the medical expense

resides with those employers.

Because those employers, particularly the large jumbo accounts or the national accounts in some cases have the best interest of their employees, the best interest of their dependents at heart, they are saying we need to pull them out of the equation. That is a good thing. Let me be very clear, that is a good thing.

In doing so, what they are saying to the health plans is we want you to pay billed charges. What does that do? It creates this unintended incentive for those providers who are non-participating to say wow, if 1 out of every 5 or 1 out of every 10 times I see somebody, I get paid billed charges.

They may not exactly why they are getting paid those billed charges, but it's like winning the lottery. Not only is it like winning the lottery, they get to set the amount they win, and if they don't like the amount they are winning or the frequency by which they are winning, they simply increase their charges. There are unintended consequences there.

Certainly, I think you have to look at the health plans and say in our efforts to make health care affordable, in our efforts to narrow networks and to optimize care, one could say have we gone too far, are we setting rates that are not sustainable, that are too aggressive. It's the tug of war that was described.

Lastly, the hospital component to this. It is clearly prudent for hospitals to issue contracts for certain hospital based services. It's efficient to do so. They typically will bid those in some process and typically award a single contract to an anesthesia group, so that group will supply all anesthesia services at a hospital, or that group might supply all ER services or all radiology services.

It makes good sense to do so, but in doing that, you then create sort of a monopoly provider who can say well, I'm the only access point you have for anesthesia at this hospital, or I'm the only access point you have for pathology. That problem is not new but what is also occurring, and one of the speakers alluded to this, is that the

hospital based groups are also coming together.

Even if you were made aware that at hospital A, the emergency room group was non-contracted, you think, well, send me to hospital B, it's now possible that hospital B is also staffed by that same emergency room group or that same pathology group, and so the consumer finds themselves stuck in the middle in terms of you have statewide or regional monopolies of hospital based providers that are complicating that problem.

I will stop there because I know our time is tight. So, thank you.

MR. GOLDMAN: We'd love to hear from a provider. Jeff?

MR. PLAGENHOEF: Thank you. So, I'm the physician on the panel, and the provider. This is going to be interesting. I am heartened to see that we do agree on several things, but the provider's viewpoint is what has been missing from a lot of dialogue in this regard, and even in the creation of the white paper, I don't think I saw a provider as part of the team. We are going to shed a slightly light on it, and we look forward to the questions and answers afterwards.

I am the incoming President of the American Society of Anesthesiologists. We are about a 52,000 member health care association. For those of you not familiar with physician anesthesiologists, we are the highly trained medical experts who evaluate, monitor, and deliver vital care to patients before, during, and after surgery.

So, as a physician, my training is in medicine, not medical insurance. Unfortunately, in this new era of increasingly confusing insurance products, we're caught in the middle with our patients who are forced to purchase complex insurance policies. Regardless, these are our patients, and helping them in any way that we can is part of our DNA.

This is a multi-factorial, multi-faceted problem that really is not understood by many at all. Proposed solutions just addressing symptoms instead of the

root cause are flawed approaches similar to just treating symptoms of disease instead of focusing on patient wellness and prevention of disease.

We believe balance bills are symptoms of the issue, the cause is gaps in insurance coverage. We appreciate that the media has brought this issue to the public's attention and we will look forward to working with other stakeholders here and believe that the most successful solutions can only be formulated by working altogether as a team.

Our primary goal is ensuring access for patients to care inclusive of all services that they or their family may need. This is not the situation for many unsuspecting patients right now. What we have learned is the problem is not really the surprise bills as much as the problem is surprises in what insurance covers and doesn't cover.

Specifically, insurance companies are failing to create adequate and readily accessible networks. There are multitudes of reports of insurance companies narrowing networks as a strategy to limit their costs and to shift those costs to patients and other stakeholders. By tiering and progressively narrowing the networks that they create, insurance companies are only exacerbating the problem that originated from changes in health insurance that were introduced by them in the first place.

Unfortunately, patients learn the hard way about gaps in insurance coverage. Not when they purchase their insurance, but when they hope to be covered by it. All is good when patients are healthy and not needing reliable insurance coverage.

Monthly premiums are affordable and network adequacy isn't on their radar, but then a need arises for health care services, possibly in an urgent or emergent scenario. Then the surprises pop up. Unaffordable co-pays, high deductibles, and payment denials front-loaded in amounts that can be devastating, all as a result of the deliberate cost shifting.

As if narrow networks were not complicated enough, tiering makes it

even worse. Providers can be in network with a carrier in one tier, say for example, the gold tier, and out of network with the same carrier in another tier, for instance, the bronze tier.

When transparency about insurance coverage is proposed as a solution, it is incredibly important to understand that only the insurance companies know day to day who is in and who is out of networks they construct. We don't even know at times.

Maintaining accessible networks with adequate numbers of all providers and all services as well as a mechanism for fair out of network payment are the keys to solving the problem.

Agents work hard for their insurance policies. With the complex design of all these products, it is incredibly difficult to discern what policies truly provide consumers. Physician organizations across the country are now working together to promote the rights of patients to have well defined, effectively communicated, easily understood, and fair minimum standard benefits.

Again, legislation that would solve these issues must include preventative strategies attacking the cause of the problem and not just the symptoms.

My family fell victim to this problem, too. Now, listen carefully because our story epitomizes what has happened to insurance coverage in this country. Not only am I deeply involved in insurance coverage in this country, but my wife, current President of the Texas Society of Anesthesiologists, has been working for over a decade advocating for patients struggling with insurance that fails them in times of need.

We learned firsthand of the gaps, complexities, surprises, and frustrations with our family's insurance, with a mammogram. She needed a biopsy. After communicating with the hospital and our health insurance representatives, we were very disappointed to learn the procedure had to be performed at a competing hospital, the only one in network, if we wanted to avoid thousands of dollars of cost to our family.

We spent considerable time and effort, and I mean considerable, asking

detailed questions on both the payer and provider side of this equation. We did our homework. We were assured that this was a women's preventative health service which therefore, was said to be well covered, and we were really excited when both sides said all we would have to pay was $150. Thought great.

After her procedure, we received both good and bad news. Benign, thank God, but bad news followed six months later when we received a bill for $1,800, in spite of arguably being the experts on this subject, and doing all of our homework, we still received an unexpected big bill. After all our work to be aware, responsible, and informed patients to safeguard against some surprise, we learned firsthand of the gaps in our coverage. Once again, we got a bill 12 times what we were told to expect.

Regarding the white paper, I applaud the Professor and his team. There are a number of components and recommendations that we agree with. I'd like to note, however, the white paper is based on the assumption that patients are billed by out of network providers even though the patients did all they could to remain in network.

With my personal experience I just shared, I'm quite sympathetic to that scenario. However, it should be strongly understood that the vast majority of physicians want to be in network, as my friend said. With networks narrowing and tiering, the frequency of surprise bills is increasing. The truth is there are very few physician outliers sending exorbitant bills. That has been shown.

The insurance lobby is claiming the contrary and inaccurately and yet persuasively portraying few examples out there as the rule rather than the exception. In a free market capitalistic economy, there will always be a few charging higher rates for whatever they sell, and in medicine, the emphasis should be on a few, a small minority of physicians send these huge bills.

The vast majority of physicians report they want to be and try to be in network, and are met with we don't need any more physicians, we're full. We want the patient volume that comes with being in network. We want the stability that comes from

being in network. Our practice administrators really want us to be in network so they know what to bill and what they can expect we will be paid.

So, their narrative is not true. It is not that we won't come to the table to negotiate, which I've seen printed in the press in multiple places. We aren't being allowed at the insurance company controlled tables in many instances.

To summarize, physicians want patients to have ready access to physician networks capable of providing the care and services that they need. The best solutions will maintain incentives for insurance companies to appropriately negotiate in good faith with physicians for adequate, complete, and comprehensive networks.

We worked on solutions to this, and we propose a BBIG solution where "BBIG" stands for ban big insurance gaps, because they are the cause of balance billing and the surprises that come with them.

We have also learned through our studies that patients want and expect physicians to help them with this, and we see that physician perspectives are missed by many, including many proposing solutions.

We are, too, looking for just the right porridge. Thank you.

MR. GOLDMAN: Thank you. I'd like to ask all of you a few questions. Colin, you spoke about providers trying to exploit the system. Jeff has set out an alternative view here, and we saw some data from Mark suggesting the networks in Texas are inadequate, so the result of this is people don't have access to some providers that they obviously need.

How do you respond to that?

MR. DROZDOWSKI: I would first respond by saying I think that is a situational issue, but in general, if you look at what provider types, what specialties, tend to be at the core of these surprise bills, I would dare say certainly Anthem and most insurance companies do all that they can to have them in all their networks.

I agree that narrowing, that I think you made reference to, is certainly

part of what we are looking to do, but when we as health plans think of narrowing networks, it does not immediately mean we want to narrow radiology, we want to narrow emergency room, we want to narrow pathology. That is not where we are going. It is in the broader areas where we see greater variation in care, we see greater variation in costs, where there is increased competition among those particular specialties.

While I appreciate his comments, the data would say that where the balance bills are coming from are in those specialties that we certainly are not looking to narrow.

MR. GOLDMAN: Tom, you set this up in a way that the hospital is a neutral party watching in some sense the insurance companies duke it out with the professionals. In some sense, it's not that case, or maybe I have misinterpreted your position. What role does the hospital play here, and how can they solve this?

MR. PRISELAC: If I gave anyone the impression that hospitals are neutral parties in this, I want to correct that impression completely, because that is not what I was trying to say at all. What I was trying to say in part is first at a minimum, there are what I will call the typical community hospitals, which among other things has the hospital based specialists, anesthesiology, pathology, imaging, emergency services, and for those hospitals, they are not responsible for the professional services, but they experience the consequences of how this matter plays out with their patients.

Those hospitals are very much in the middle of it. I think those hospitals are trying to do what they can given the nature of the relationship that exists between what I will call the typical community hospital and their medical staff, which is largely frankly a matter of trying to influence and convince people to willingly go along with a particular outcome. You get the variation that this conversation is based on.

There are other organizations, my own and others, where we do have the kind of relationship with physicians because we are a health care services organization providing hospital and physician services, where in the course of

establishing those relationships, as was mentioned by our first speaker, there is the opportunity in that context to have the conversation to make it a matter of a contractual relationship or other vehicles that can be used, because you have aligned economic incentives.

Those aligned economic incentives in today's world are very much oriented towards meeting consumer needs. That is the difference.

MR. GOLDMAN: Let me come back to the specific thing. Suppose there is an anesthesiology group out there, to take one example, and they are really dedicated to patient service, and they are a little frustrated with the dealings with the plans that are predominant in the market. So, they're not contracting with the two plans for which those are most of your patients.

What is the response of the hospital in that case? Jeff, I will give you a chance as well. You could kick them out of your hospital or you could go to the plan and say you need to have these people in.

MR. PRISELAC: I won't go into all the details, but I think people generally, I hope, can appreciate the benefit that can accrue to the patient in terms of both quality and efficiency of operation when there is a contract with a single anesthesia group to provide those services, as opposed to frankly -- I've been in the business almost 40 years. I've seen hospitals where it is individual and it is chaos, frankly, it's chaos.

There is a very good patient interest question for why having a contract with a group. Once that is in place, I do think the hospital, either through its contracting, has a responsibility to try to secure either agreement from the anesthesiologist, that they either participate in the plans that the hospital is a part of, or if they are not, because there can be reasonable disagreements that exist, effectively, the anesthesia group would agree to a mechanism whereby patients who are treated under those plans aren't going to experience these surprise bill phenomena. There are ways to deal with it.

MR. GOLDMAN: I'm going to give Jeff a chance to respond, and then I

want to bring it back to Betsy.

MR. PLAGENHOEF: I'll give you some real experience that relates to this so you can get the picture. Again, the clinician or physician side of this is often missed.

For background, I was the president of my group. I had all the interaction with the administrators, but more importantly, I was the payer liaison for all 400 plus anesthesiologists in the State of Alabama for about 12 or 13 years, and I dealt with the largest insurer in Alabama, most of you probably know who that is, on a very regular basis, as well as the Medicare agency.

Very sensitive to the issues of the payers, and we were actually told that we had the most constructive relationship with the largest payer of any specialty they had ever dealt with. That is kind of the background.

We were not in network with all big payers, we were with the largest. Why? We were a group that was rock solid top to bottom, very good professional citizens, involved at all levels, doing good work, having good outcomes, et cetera, and the one particular large payer that we would never contract with only brought to the table offers that only somebody desperately in need of business would take.

If you look at data at our institution, it might draw some conclusions about the anesthesiologists not being willing to sit down at the table and negotiate when in fact the opposite was true. I sat down and talked to them about it all the time.

Before I left and moved to Texas, I was real close to having something, but that was after working for a decade. I can share stories of my colleagues in Texas that tell me the same. They are trying but when competitive pricing isn't offered, you have to remember all physicians are private businesses as well. In our specialty, it is crucial that we negotiate those commercial contracts well, because of how poorly the government pays anesthesiologists.

The Government Accounting Office shows that anesthesiologists are

paid lower than any specialist by Medicare, $.30 on the dollar. Medicaid in Alabama, to use that as an example, we were the fifth lowest. We were paid, I think, $10.72 for every 15-minute unit.

If your government funded patient population is in the 45 percent range and then you accept commercial contracts that are well below average market prices, you will be out of business. You won't be able to recruit and retain.

If the prices that are paid for our services are not directly related to real market value rather than artificially created values by Medicare and Medicaid, and we can get into that, RUC does work, but they start with a budget. Medicare/Medicaid prices are budget driven. They are not market driven, so there is strong argument for not using them.

Again, when we are paid that low, you have to negotiate right. Some people commonly say, we hear this from the insurance lobby, oh, they commonly bill 300 percent higher than they should. Well, that is because you have to increase Medicare rates 300 percent to come up to commercial rates.

There is a reason why billed charges are often times higher. It is because physicians throw a bill out there not having any idea sometimes what it is going to be cut to. We don't know. We can't predict what we are going to be paid. We can bill what we want to and there doesn't seem to be a predictable consistent amount that we will get paid in return.

There is a lot of confusion there. Lots and lots of confusion. That is what we would like changed. Things need to be simpler.

I may be the dumbest anesthesiologist in the country, but I ought to be able to figure out my estimation of benefits document that I receive six months later. I often times can't. It took me forever to try to figure out what insurance product to buy. I thought I bought the best one, but obviously I didn't. We still got surprises.

MR. GOLDMAN: Betsy, there are clearly market power issues here.

There is virtually unanimity among everyone that the patient shouldn't be held responsible, which I think is good news. On the other hand, there are questions that the policy reforms might set up, for example, setting rates, as Jeff has argued, low rates could create problems of access.

On the other hand, as Colin has pointed out, high rates could limit the ability of insurers to get discounts.

At Consumers Union, are you worried about access issues as a result of legislation, and how do you monitor those types of issues?

MS. IMHOLZ: We're not so worried about the access issues although, of course, we will be watching it, because back in California, as Tom referred to, in 2009, we resolved the emergency room issue, reimbursement issue, and didn't find there was an access problem created. We don't have a reason to really believe there is going to be access problems. The marketplace is dynamic, so of course, we will be watching it closely.

MR. GOLDMAN: I can tell everyone here that you can get an ambulance in Los Angeles. I know that is not a worry.

MS. IMHOLZ: We didn't even talk about air ambulances, a whole other issue, that I know Blue Cross is looking at. Again, whatever the market will bear prices, not in network. We're talking $100,000.

If I may just comment on another thing that Jeff said.

MR. GOLDMAN: Yes.

MS. IMHOLZ: Some points we agree on, which is about the complexity of the system for the doctors, for the patients, the tiering adds an extra layer of confusion, nearly impossible for anyone to figure out their insurance. That is true.

The other point was he said there were just a few providers billing at these huge rates. We're not just worried about the $30,000 example that I started off with. We're talking about $100, $500, $1,300 bills, and it is all relative, what is a big bill

when you're scraping by, trying to make the rent and put food on the table, $100 is a lot of money, too.

As people are paying their premiums, which we all know are going up all the time, we want to make sure they are getting value for their dollar, and even $100 more is not going to be easy for a lot of people.

MR. GOLDMAN: Sure. I think that is right. As I noted at the introduction and one question is sometimes we want to use co-pays and deductibles, and there are places where they are appropriate. For example, we want to steer people to providers, I think, when they have a choice and when they can make an informed decision.

I think the challenge here is what happens obviously when it is thrust upon them by the vagaries of health care.

MS. IMHOLZ: That is the topic today, when it is not their choice, it's not an informed decision.

MR. GOLDMAN: We're going to open it up to the audience for questions. We have about 15 minutes. If you could state your affiliation and ask it in the form of a question rather than a soliloquy, we would appreciate it.

MS. SALTZMAN: Good morning. Karen Saltzman with AFL-CIO. Our affiliates bargain health claims. Sometimes they jointly administer them with employers. I was sort of confused about some of the descriptions about self-funded plans, and allowing states to do regulation. Could somebody explain more about that?

MR. GOLDMAN: I think the confusion is over ERISA and who is subject to state regulation. I don't know if Colin or Betsy wants to comment.

MS. IMHOLZ: The Department of Labor is charged with, as I'm sure you know --

MS. SALTZMAN: I'm an expert.

MS. IMHOLZ: You're an expert, I know.

MS. SALTZMAN: (Inaudible)

MR. GOLDMAN: That is not actually a question. I'm going to invite Mark up. We're going to make it a question.

MR. HALL: I think we need to think more about what solutions could work legally. One is just to have new Federal legislation that takes over the whole field, but we don't see that very often, and we have seen it with respect to mental health and preventive care, so it's not impossible.

Short of that, what could be done? One thing that ERISA does allow is for states to regulate provider rates. If they are not regulating plan payments, but provider rates, there might be some sort of regulatory vein that could be pursued.

New York has a process where for uninsured and for those with self-funded plans, usually we keep the patient out of it, with respect to self-funded plans or uninsured patients, but they allow a process where the patient assigns their claim to somebody who resolves it with the provider, and that apparently could be done under ERISA.

MR. GOLDMAN: Thank you. I think we want to take some more questions.

MS. CASSIL: Thanks. Alwyn Cassil with Policy Translation. I have a question but I have a clarification that I'd like to make first. I know we are talking about surprise medical bills, the anesthesiologists, the pathologists, that I have no idea that I'm going to go out of network on.

I think there is an upstream problem that you're not talking about that is related, and that is you are assuming that me as a consumer, I as a consumer, in a PPO, can make an informed choice to go out of network, and I would say no, I can't, because I can't get Mr. Drozdowski to tell me what his out of network payment rates are based on. So, I can't make an informed choice.

I'm covered by Anthem through a Fortune 50 employer, and have had the experience of going out of network knowingly, to find that when I get the bill for that

service, the out of network allowed amount is less than Medicare, less than what Shared Health allows, and then when I try to get an answer from Anthem about how do you base your out of network payments, they say, oh, well, you'll have to call --

MR. GOLDMAN: Okay, the question is clear. Colin?

MR. DROZDOWSKI: (Inaudible)

MR. GOLDMAN: Do you want me to summarize? She wants to know how much you pay for pathology. I like your question better, but that is not what I heard.

MR. DROSDOWSKI: First of all, let me acknowledge that all health plans need to do a better job at informing consumers, not going to shy away from that point, ma'am. It is a valid point.

There are complexities that make it nearly impossible. We can tell what we will allow in a non-emergency out of network situation. What we cannot tell you is what will you then be balance billed on top of that. That becomes an issue between you and the rendering provider because by definition, they are not in network. They can say well, I need X amount of money for this, and Anthem will say we will allow Y, and you can have that negotiation.

Depending on the service, we have that ability today, but we also don't know in advance exactly what it is the provider will be billing. So, when they have the specifics of the bill, it is then easier to say this is how much we're going to allow, but it's not as easy as saying well, you're going to have your knee replaced. Well, what exactly is going to occur in that episode is a challenge.

I'm not defending the fact that we need to provide more information because we do. We need to have better tools as an industry. It also is dependent on knowing exactly what it is you are going to have and what that provider will bill.

MS. CASSIL: Can I follow up?

MR. GOLDMAN: No, I'm actually going to let Jeff follow up. I'm sorry.

MR. PLAGENHOEF: I might actually help you. I love your question

because I've been in that position. I'll defend the insurance companies a little bit because one of the problems is just human factor science.

A lot of people, even if the information was there, don't look for it, they back shelf it, they don't need it, life is busy, everything is going on fast, and then all of a sudden they need it, they're going in an urgent situation. They can't get the information for one reason or another or there is not time to, so that's one thing.

I get that. It is really, really hard, and I think it is really impractical to think that the average person, again, my wife and I are pretty savvy consumers, especially as it relates to this, we couldn't get the information we wanted. The information we got was grossly inadequate.

I have a hard time finding out what the allowable is. If you look at the right-hand corner of the graph in the white paper, bottom right-hand corner, really, the right-hand margin, you think about a PPO where patients are agreeing to pay more money, they have more flexibility to go out of network to choose their institution, their providers, and look at the numbers.

Right off the bat, the $10,000 is discounted 60 percent to $4,000. I don't know how that happens, why it happens, who decides. I think it's random -- not random, but it is unilaterally decided by the insurance company, but I don't have a say so. The patient doesn't have a say so.

If you look at the worst case scenario, the amount of money that patient knowingly paid more insurance for is really in the end costing them an exorbitant amount of money.

The complexity is at the root of the problem. Surprise bills are coming because the products are so complex and confusing, the average person can't figure it out.

If you look in California, yes, there was a huge complaint brought by the payers and the consumer advocates that 30 percent of people were getting surprise bills.

It's super important to analyze what "surprise" means.

The California legislature sought a solution, and they commissioned their own study. Of all those cases they looked at, the 30 percent, guess how many were truly caused by being out of network by the providers? 2 to 3 percent. All the rest of them were surprises because of the big deductibles, co-pays, allowables, denied care, et cetera. They're paying insurance, but I just got care and I have a bill that I have to pay that is thousands of dollars. That's the problem.

MR. GOLDMAN: I think there is a broader question of price transparency that we could debate, what we have seen from Neeraj Sood's work on this topic, that some consumers are able to do this type of price shopping, but for most consumers who are sick, getting care for the first time, it's hard to do that type of shopping.

I'm going to go with Norm Pace here in the front, and then we will come over here.

MR. PACE: Norm Pace, and I have multiple categories as a person, practicing doc, was in the health plan industry, et cetera.

Dana, this may be a question for you. There is an analytical aspect, and also perhaps for Professor Hall. Has there been any scoring as a percentage of premium in these different subcategories with surprise bill non-par, delta between par and non-par, delta between allowable, et cetera, or AB 72 comes into California, scoring that Anthem and other insurers would have, and then also the scoring of how that is going to affect the tilt between ERISA and non-ERISA, will this encourage more ERISA plans to go fully insured because they're going to tilt in where they have a ceiling on non-par.

MR. GOLDMAN: The physician is asking about the analytics, and the answer is none of us thought to do it until just now. It is a very good question.

QUESTIONER: (Inaudible) I'm a physician from Texas. I'm actually an anesthesiologist. Dr. Plagenhoef, you talked a little bit about solving the problem through

network adequacy and increased transparency and through fair payment.

Can you describe a little bit exactly who and how would figure out exactly what a fair payment is?

MR. PLAGENHOEF: Sure, that's a great question. I think the New York legislation gives you an example of how you can have fair payment determined. You have to understand or think about the history of what happened in New York.

There was a big lawsuit, the Ingenix lawsuit, and a large well-known payer was found to be doing their calculation of UCR internally, non-transparently, and they were found to be manipulating the data for their own financial benefit.

The results of that lawsuit was they had to pay $95 million to create an unbiased market related database of billed charges, real data, what people are billing. It is called FAIR Health.

The way that we could comprehensively fix this, whether it is at the state level or the Federal level, is to agree to pay out of network providers a percentile of FAIR Health. One of the other speakers said, actually I think the Professor said, 75 percent, 85 percent. Some people are advocating for 80 percent of FAIR Health.

Payers say oh, those are not related to meaningful data, and that will just drive up costs. In California, they looked at that and they studied that, and they found that the 80th percentile of billed charges actually correlated with somewhere between 5 to 10 percent higher than in network rates.

So, ask yourself, what would prevent insurance companies and physicians from being in this scenario? If insurance companies had to pay slightly more for people to be out of network, they wouldn't want people to be out of network because the more that are in network, the more money they would save.

The beauty of using the 80th percentile of FAIR Health or an agreed upon percentile would be that not only is there a guarantee that physicians will be paid for their services in a meaningful fair market value supported way that won't negatively impact

access, the beauty is when you're talking about the outliers, if the payment for the out of network physician who might have billed exorbitantly is based on 80th percentile of billed charges in a particular geo-zone where people provide the same care, then that would be a way of nipping that in the bud as well. It would play well on both ends.

MR. GOLDMAN: I would like to make just a couple of quick comments about that. We are very supportive of working with regulators, working with providers for a solution, but to index it in any manner purely to charges is not logical and with all due respect, a few minutes earlier you sat here and said I don't know what I charge, I just sort of put it out there.

MR. PLAGENHOEF: I know what I charge.

MR. GOLDMAN: That is what you said, you said I throw it out there. Charges are not reflective of costs. As the Professor noted, it is very common for providers to bill three/four/five times what they regularly accept as payment in full and what is exponentially more than what they accept from Medicare.

I would respectfully submit that if you're advocating for something that is a function of a charge structure that is not well understood and that can be increased simply by every year increasing your charges, if you hold at 80 percent, a provider increases charges by 10 percent per year, 80 percent goes up by 10 percent, and there is nothing that can be done about it.

Betsy?

MS. IMHOLZ: This is a point on which we agree with the plans completely, and I would say California did study it, and it is a sticking point, not just in California, but in every state about what is the fair and reasonable reimbursement going to be for out of network providers.

After studying it and looking at FAIR Health, California landed in a different place, which is the greater of the average contracted rate or Medicare plus 125 percent of Medicare. We do want to get that Goldilocks' point at which we are

encouraging providers to contract, and it's a balancing act. Not every state lands in the same place. We did study it and looked at FAIR Health and decided not to go that way.

MR. GOLDMAN: Mark?

MR. HALL: Two points I forgot to make about this very debate. One is we might conceivably, and to the complexity, unfortunately, adding more complexity, arrive at different balancing points in different areas. The extent of the relationship between charges and contracted rates and Medicare might reflect a certain average in one geography but that average might vary widely from one specialty to another in other geographies, which makes it that much trickier and scares off regulators, but it is the reality.

The other point is whatever you start with, we very much believe it needs to continue to monitor, and we have a couple of good examples in Maryland and Colorado where they started with something but they said we don't know if it's going to be too hot or too cold or just right. Every two years, we go back in and look, what is the effect on network composition, what are we hearing about the provider negotiations, what is the impact on access, and what have you.

Absolutely, whatever we do needs sort of continuing evaluation and fine tuning.

MR. GOLDMAN: We can't get it right out of the gate. This is going to be our last question, Mike Ryan.

MR. RYAN: Mike Ryan, BMS. First of all, I'd like to compliment Brookings and the Schaeffer Center for taking this subject matter on. It really is important for the nation.

I would say the following, my question is the following. It is really, Dana, for you and Professor Hall. What we hear when we survey patients and talk to patients is more and more what we are seeing, patients who are deciding to delay procedures, not undergo required services and other things because they are frightened of their

insurance. The high deductibles, they don't understand the tiering, they don't understand this issue of out of network as well, so they are trending to use their insurance more and more as catastrophic insurance.

I guess my question is from an academic perspective, has anyone bothered to really study what the health care burden of that is over time, with people electing not to get the care they need?

MR. GOLDMAN: I'll start just by pointing out that I really want to thank the audience for pointing out things we don't answer rather than things we answer, much appreciated.

MS. IMHOLZ: There is some work on this. RAND, years ago, studied high deductible plans, and did find as you are saying, people are delaying care, they're not getting the preventive care. I'm not sure that actually went as far as getting to the health impact.

MR. GOLDMAN: Good example. Neeraj Sood is here, and he will comment in a minute. When you look at high deductible plans, when we studied them, a lot of them have carve-outs for preventive services, but what you find is people don't use those services even though they are free, so the point is they don't really understand the plans.

Neeraj, do you have a different view since you have written on high deductible plans? Why don't you come up as well, and then I'll invite all the audience to come up afterwards? Everyone gets the mike here at Brookings.

MR. SOOD: We have analyzed data for 40 or 50 large employers to look at the effects of high deductible plans, and what we find is that over a three-year period, they do save costs, but people save costs primarily by just cutting down on use of both needed and unneeded care.

We see declines in use of medications for chronic illness, so rather than go for the generic, they just stop taking their meds. We see people getting mammograms

in December when they know they are going to be in a high deductible plan in January. Even though in January, the mammogram is going to be free for them, they don't realize that, so you see this spike up in preventive care prior to joining.

In some sense, consumers are smart, but in some sense, health insurance is just too complicated for them, so they are trying to make smart decisions, but it's difficult for them to make smart decisions.

MR. GOLDMAN: Thank you, Neeraj. I want to give each of you a minute to make a last concluding remark on this topic. Betsy, we will start with you.

MS. IMHOLZ: This has been a lovely discussion, I really appreciate it. I think you have gotten a flavor of the complexity of all this. We need policy solutions in this area and legislation is the other possible. We are going to aim high, but we may have to take this step by step, and I hope we will in the coming year.

MR. GOLDMAN: Thank you. Tom?

MR. PRISELAC: Well, the die is cast to a certain degree in California with AB 72, but like someone just made the comment, people tend to think that once legislation is done, the process ends. It just begins. Look at the Affordable Care Act as maybe the poster child for that.

I think everybody needs to keep their eye on what the implications of this are, study it, understand it, and be open to making the adjustments that otherwise ultimately look to be indicated. That may be the biggest challenge.

MR. GOLDMAN: Colin?

MR. DROZDOWSKI: I would simply say that forums like this and open and honest communications are necessary. I think if you have heard and learned nothing from this, this is complicated, and clearly the best solution will come from collaborative dialogue with the parties, the providers, the members, the consumers, the employers.

We're committed to that, and I think it is essential to get to a sustainable solution to this issue.

MR. GOLDMAN: Jeff?

MR. PLAGENHOEF: Thanks. We physicians are committed to being at the table, and we admit that we actually haven't been or haven't done that well organized, but that is changing right now this year. We are coming together to stand up and fight for solutions that make sense.

You can't base what was done in some states, necessarily the argument that it was the best thing, what we have seen in the states, and everybody in D.C. certainly knows how lobbying impacts what gets done, unions and things.

In California, for instance, a lot of influence was weighed in at the end by the labor unions, had a lot of influence on what got done.

Heretofore a lot of money has been spent in the state houses deciding what to do. Physicians haven't showed up in big numbers. There are states where one doctor shows up to give the other side.

Hearing from everybody is important. We want to be at the table. We are here to protect patient rights. We want people to have good insurance, good health care, and we want it to make sense. We want it to be affordable.

I'm going to make one more plug for FAIR Health. I think the numbers that were stated had more to do with Medicare than commercial insurance. Again, you should expect large multiples of billed charges as compared to Medicare because Medicare and Medicaid are based on government budgets, not on market values. If you limit payment based on government budgets, you will negatively impact access to care.

Realize that just because California didn't use FAIR Health and they used a multiple of Medicare, it doesn't mean it was smart or that FAIR Health is bad. I will argue there is a correlation, the facts show, that the analysis in California and in Texas, those numbers were meaningful.

The insurance lobby continues to say that they are un-meaningful and 400, 500, 600 percent above what it should be. That is compared to Medicare.

You have to be a savvy consumer, and we need everybody at the table aware of all these details. Right now there are examples of states where decisions have been made because of one-sided lobbying, quite frankly. So, let's be smart about this for the American people.

MR. GOLDMAN: Okay. Great. Thank you very much. Thank you, all.

PANEL #2: ADDRESSING THE GROWING PROBLEM OF SURPRISE MEDICAL BILLS: POLICYMAKER AND POLICY THINKER PERSPECTIVES

MR. GINSBURG: Appreciate it if people could take their seats. We'd like to get this panel started. This is the second panel to talk about policy.

This is the second panel. It is going to focus on policy, and this panel is a combination of policymakers and policy thinkers, and actually, everyone on the panel is a mix of policymakers and policy thinkers.

Here is what we are going to do. Jack Hoadley from Georgetown University is going to speak about state policy in this area. He's going to really be reflecting how state policymakers approach this issue, what are they attempting to do, what do they find feasible to do, what more would they like to do, but are finding it very difficult.

Matt Fiedler, who is on the Council of Economic Advisers, is going to talk about federal policy, both some of the proposals that the Obama Administration has put forward recently and other ideas where the federal government can do things.

Zack Cooper and Neeraj Sood, who are both economists, they are both going to present additional ideas for policy to address this issue of surprise medical billing.

Jack, could you begin?

MR. HOADLEY: Okay. Thank you for the opportunity to be here today, and I think it is really helpful to have this session on a very important issue of surprise

billing.

In 2015, my Georgetown colleagues, Kevin Lucia and Sandy Ahn and I looked at what protections some states are offering to consumers in surprise billing situations, and this was funded by the Robert Wood Johnson Foundation, and in turn, built on a 2009 study we did for the California Health Care Foundation.

In looking at these issues, we looked at a variety of scenarios for balance billing that you have already heard about this morning, and really found that for the most part states are focusing on two of those scenarios.

Either the billing that occurs in emergency situations or the surprise billing, usually the situations where people are in network hospitals but are getting some portion of their care from an out of network physician or other provider, and whether they have managed to schedule the surgeon who is in network but the anesthesiologist or the radiologist or some other consulting physician or an assistant surgeon turns out to be out of network.

Or whether it is some other type of care situation where again we all know if you have been in the hospital, there are a variety of doctors who come in just to visit you and check up on what you're doing, and you really don't know why they are there, who they are, and some of them turn out to be out of network.

Legislation for the most part does not deal with scenarios where you are intentionally picking an out of network obstetrician to deliver your child or other situations like that, where hopefully you are well informed, although some of the transparency issues will deal with that, or we don't mostly talk here about some of the issues around some of the gaps in networks or transportation, lab services, or some of the other issues that do also come up.

Mostly, what we have seen are state efforts to look at those two scenarios. About three-quarters of the states really have no specific statutory consumer protections, although some may have related policies such as disclosure rules or

transparency, but don't sort of deal with the core of the issue as we have been talking about it here.

For the 12 or so states that do have some kind of legislative solution that's relatively comprehensive, most of them have various of the elements that we have heard talked about already this morning, the disclosure and transparency requirements that are often viewed, as Paul said in his paper, necessary but not sufficient for dealing with this issue.

They also have elements in most cases of some kind of prohibition on balance billing aimed at the providers, aimed at sort of protecting the consumer by not allowing bills to be sent.

Some of the states have elements of hold harmless to require the insurers to make sure that no bill comes to the consumer, and I'll come back and talk about sort of the balancing of those two things.

Most of them have some provision around adequate payment kinds of issues that we have been talking about a fair amount already this morning. Some way to get the payment right, whether it is some sort of rate setting, using one of those standards around Medicare, FAIR Health, other kinds of UCR standards, or some type of mediation or dispute resolution provisions.

What I will mostly talk about is some of the political considerations that have come up as states have tried to deal with these things, and really helps in part to explain why 12 states or so have done something, but three-quarters of the states have not.

I think it was very well illustrated in the previous panel where there are competing incentives. Often with broad agreement from all parties, and again we heard that this morning, the consumer should be kept out of the picture, but the problem is unless you create the mechanism to do that, it is hard to get to that point.

You have the insurers who don't want to see a sort of hold harmless

approach. They don't want to be left holding the bag and paying whatever the charges are. We have the providers who want to sort of maintain their rate structure that they have set for good reasons and not want to be subject to what in some instances has been very low UCR kind of rates, usual and customary rates, set by insurers.

That creates sort of the tension that we are operating under in the competing incentives. None of them want to be the bad guy. None of them want to look like the person who is causing the consumer to be left holding the bag.

What states have to do in these situations depends a lot on the market and the political environments in which they operate. I think of some of the things we have seen as we have talked to legislators, stakeholders, legislators in the different states where we have looked at these things, and often it is the concentration of the provider or the insurance industry or both.

In a state where you have one large dominant insurer, the environment is going to play out differently than if you have a large array of competing insurers. It is going to affect the underlying negotiations with providers that is going to set the framework in which the rate situation exists, or concentration on the provider side, if you have dominant provider groups, we know there are some states where all the members of a particular specialty may be affiliated with one provider group, and they exercise leverage that affects things.

All of those things come into the situation where the political environment, the policymakers, have to have a recognition that any solution they do operates in the context of those provider and insurer market situations, and can potentially affect network negotiations and the other kinds of relationships between those things.

You do something to set a particular provision to protect the consumer in the balance billing situation, you're going to influence potentially all the kinds of negotiations that exist out there between providers and insurers.

The political influence of the stakeholders matters a lot, too. You have states where traditionally in the lobbying process, maybe the medical association is really viewed as that one powerful lobby you don't want to get on the wrong side of, or the health plan, or the one large health plan if it's a concentrated kind of thing.

Again, they operate in a unique political environment that is different than what we sometimes see here in Washington and maybe different from the state across the border. Obviously, there are differences also in recognition of consumer interest in this, how much they are active, the consumer groups are active, and media attention.

I think you will find that a lot of states that have dealt with these things have dealt with it because there has been media attention, perhaps just one dramatic case, perhaps to a series of cases, but often that kind of puts the issue up on the agenda.

Going beyond that, we have to think about the role of political leadership and how that plays in and the different ways that operates in states.

Recently, in Florida, where I had a chance to be down there for a little bit of their process, it was interesting because it was the Office of the Insurance Consumer Advocate, a state office, a state official, that kind of took it upon herself to play a role in trying to get something done on this.

She developed some of the case studies that were out there. She convened a couple of hearings to try to bring some attention to the issue. She helped to work with some of the stakeholders to try to do some kind of model legislation that could go towards the legislature.

This is an office that not a lot of people necessarily are aware of, but at least in Florida, this was a particular part of the state administration that came out and tried to play a role, and then it was a member of the majority party, the Republicans in Florida, that decided to try to champion this bill.

As somebody said this morning, this isn't necessarily a red or a blue or purple issue. Here was a case in Florida where it was a Republican legislature who sort

of took the leadership role, a very powerful Republican legislature in a state where it is a majority Republican legislature, and he really tried to play the role of trying to lead this coalition.

The first year, in 2015, when they tried to do this, it failed. They ran into some significant push back from some of the provider groups in Florida, and that grinded the process to a halt.

They came back, and that is where the consumer advocate and the insurance consumer advocate came back and tried to reignite the issue for 2016, get things started again, the same legislator was willing to pick up the mantle and move forward, and what they did was they found some adjustments to make from the bill that was traveling in 2015, which ended up being just enough to get past the political opposition that had been raised the first year.

It is this kind of circumstance that plays out, again, you are all here in Washington, you are people who watch the political and policy process. None of this is any great surprise. Part of it is how it plays out in particular situations and in particular states at a given moment.

California went through a two-year cycle as well, 2015, unsuccessful, 2016, successful. Again, there were adjustments made to the legislation. There was compromise. Betsy talked this morning about things that start out looking for one way, and as I understand it, and I haven't followed California as much, in the end, some of the lead provider groups and some of the lead insurance groups stayed at least neutral in terms of their public positions, and that allowed the legislative process to go forward.

New Jersey failed, large push back from a major provider group in the state, and again, I don't know the specific political dynamics that were playing out there, but they were successful in stopping that effort in New Jersey.

In New York, it seems like it was much more of a process driven by some of the political leadership, who then convened stakeholders from across the

spectrum, convened the insurers, the providers, the consumers, the different categories within those groups, and tried to figure out what elements could come together and form the basis for a compromise.

Again, political leadership finding a way to come to some neutral position, and what they did was to provide some things that helped different groups. Connecticut, I think, had a similar process to what went on in New York.

We also took a look at one state in particular, New Mexico, where there is no legislation. What is interesting there is the environment was different. We were told by folks in New Mexico that there were relatively few providers, it's a relatively small state. Health plans typically had contracts with most providers that practiced medicine in the state.

That meant there were few opportunities for balance billing, surprise billing, to exist. Problems were infrequent. Also, there was a spirit of when a problem does arise, let's see if we can come up with an informal arrangement and people can talk.

We heard that from the folks we talked to in New York in terms of the history there. The history had been the provider and the insurer, they get together, they see each other on the golf course or at some reception. They say, you know, we have a problem, let's get on the phone tomorrow and see if we can work it out. It got worked out.

I think what we are starting to see is those sort -- in New Mexico, that was sort of the basis for we don't really need legislation because there isn't much of a problem, and when there is, we can work it out.

I think what we are seeing is that environment is what is changing. The politics is changing in the sense that we are seeing more of narrow network kinds of arrangements. That means there is more opportunities for surprise billing if there are more frequent situations where you go into the hospital and there will be a physician you meet who is not in the plan's network.

We have more consolidation of insurers and providers, both sides. That means they have more economic, market pressure to bear in those negotiations, and I think more generally negotiations over networks and rates in this environment have gotten more difficult.

Whether in fact we see more total balance billing, I think, is hard to measure, but we are seeing some of the conditions that can lend itself to these problems.

I will just wrap up with one last thought, which is I think it is still very early to judge the success. New York has only been in effect a couple of years. Obviously, California is not even in effect yet, it has just been passed.

I think it will be important to monitor, and as somebody said this morning, to make the possible adjustments, and one of the things we have seen in the dozen or so states that have these laws on the books, they have gone back. Florida had a law that covered some situations, but they came back to cover more. California had some situations covered, they came back to cover more or to fix things.

So, it is an evolving process, and I think that is kind of where things sit.

MR. GINSBURG: Thanks, Jack. You had mentioned how consolidated the providers and insurers are having an effect, but you didn't say what the effect is. If it's consolidated, you are likely to see more of a concern about surprise billing, and also the likelihood of addressing it.

MR. HOADLEY: Yes, I think it is both of those factors. I think as you see consolidated providers, they are going to be tougher in negotiations, maybe more situations where networks aren't as inclusive as we heard about in New Mexico. If they got sort of that economic power, that is often going to translate to political power that says do it our way or no way. I think it has both sort of the market effects and creating the situations but also sometimes making solutions more challenging.

MR. GINSBURG: Thank you. Matt Fiedler.

MR. FIEDLER: Thank you for having me. It has been an interesting

conversation so far. I look forward to seeing the rest of it.

I am going to open with sort of a quick CEA view on what the economic case is or policy intervention in this area. I think there is a pretty strong economic case that patients just shouldn't be in the middle here.

Cost sharing has a real role to play in health insurance by encouraging consumers to be cost conscious when they seek medical care, and that includes sort of the choice between a lower cost in network provider and a higher cost out of network provider.

We also know from the sort of standard economic analysis of insurance that cost sharing has a down side. It means the patient is exposed to a portion of the financial risk associated with getting sick and needing care, so that cost sharing should really be focused on the circumstances where that financial incentive can encourage a more efficient or cost conscious decision.

The circumstances we are talking about today are just not one of those circumstances for the most part, cases where the patient sort of is in a poor position to influence whether they end up with, in the emergency case certainly, very little influence at all, and in the sort of out of network specialists or facility, sort of fairly limited influence.

When you are talking about one of these situations where not a lot is in the patient's control, the sort of economic case for why an insurance product should include cost sharing in these cases is fairly limited.

That creates a little bit, if you're an economist, of a puzzle as to sort of why do we see all these contracts out in the world that don't provide this protection, and I think these sort of discussions so far have touched on a few different things, but I want to pull out what I think are probably the two sort of key components.

I think the one which came up in the first panel, choosing among insurance products is complex. Even sort of choosing among the basics of the cost sharing and network designs of different plans is a difficult decision for consumers in and

of itself.

The sort of third order question of okay, what is going to happen if I am at an in network facility and there is an out of network physician is probably just realistically not something that is ever going to make the consumer checklist when choosing among insurance plans.

Even if we were in a situation where that was on the consumer checklist, I think verifying that prospectively is likely to be pretty hard.

That means we are in a situation where the sort of market signal from the consumer to the plan in terms of what the plan design should look like is going to be fairly weak, and maybe not surprising that the sort of marketplace has not solved this problem.

I think there is a sort of other important component here which also came up in the first panel, which is that the plans are legitimately in a difficult position here, vis-à-vis the providers. If they are simply told they need to cover these costs, their bargaining position in terms of what that rate ultimately looks like is fairly limited, and it ultimately is going to have consequences for the consumers at the end of the day because they are going to bear that cost in the form of higher premiums.

It is sort of an indication for the need to be thoughtful in how we craft solutions here.

Turning to solutions a little bit, there have been a lot of ideas put forward, and I think this discussion is a really helpful one because as people have said, this is a complex issue, and I think there is additional thinking that needs to be done.

I want to provide a quick overview of sort of what the Administration has already done in this area, and then what the sort of natural next steps look like from the Administration's perspective.

With respect to plans offered through the health insurance marketplace, individual market plans, we have some tools that allow us to make progress administratively. I think one of the important ones is starting last year, marketplace plans

in the Healthcare.gov states have been required to provide sort of public information, detailed searchable information on their provider networks, which makes it easier for consumers to actually figure out who is in network and who is out of network.

I think there are circumstances where that solves the problem. I think most of the circumstances we are talking about today, probably that is not the most relevant solution, but it does in cases where there is some element of choice but there was no information to facilitate that choice before make things somewhat easier.

I think the second thing that the Administration has done, and this will take effect for the 2018 plan year, is as many people probably know, the Affordable Care Act requires all private insurance plans to place a limit on annual out-of-pocket spending. Generally speaking, that limit on annual out-of-pocket spending only applies to in network services, which in these circumstances, we really want to make sure people do have protection against catastrophic costs. It's one of the sort of core functions of health insurance even in these out of network scenarios.

Starting in 2018, that limit, again, for marketplace plans, is going to also apply to out of network charges associated with care at in network facilities in instances where the patient wasn't prospectively notified that there was a risk of an out of network charge in that circumstance.

We think these are both important steps forward, but I think we agree with the conversation on the earlier panel that there is a need for sort of more comprehensive steps in this area. These are regulatory tools that only affect the individual markets, so there probably is need for legislative action here that will sweep in the employer market.

But also I think to one of the rationales in the earlier panel, the rationale for Federal action here, that will not only affect the state regulated sort of small group and large group markets, but also sweep in self-insured plans as well.

The President's fiscal year 2017 budget included a proposal along these

lines, targeted specifically at the circumstance of again the sort of in network facility/out of network physician case. It would have sort of approached the problem in two ways.

First, it provided a requirement that in network facilities take reasonable steps to match patients with in network physicians. We know from data presented earlier there are some cases where there is no in network physician at a facility, but in many cases, there are, and it is important and in the interest of the consumer in those circumstances that people be thinking about that matching process in a sensible way.

There are going to be cases where that matching process is not successful for some reason, so the second prong of the proposal will require physicians who regularly practice at a facility to accept an in network rate for the services provided, ensuring that even in the cases where the matching wasn't successful, consumers aren't going to bear that out of network cost in those situations, whether it is directly as cost sharing or balance billing, or indirectly through higher premiums that they are paying down the line because the plan has been stuck with the bill.

The goal, the fundamental principle, I think, is there has been a lot of agreement on making sure consumers are protected.

That is sort of where the Administration is at this point, and I look forward to the rest of the discussion.

MR. GINSBURG: Matt, any comments on the proposals of the Administration? Any comments on how they have been received, interest in Congress?

MR. FIEDLER: Obviously, I think this event and what we see out in the press, there is a lot of interest in this issue. I think in terms of what the near term prospects are, I don't have a great sense of the Hill dynamics on this one.

MR. GINSBURG: Have you seen the non-partisan attitude that Jack reported in the states at the federal level?

MR. FIEDLER: I think we have gotten the sense that this is an issue that is hopefully disconnected, at least to some degree, from the sort of more acrimonious

discussions over the ACA, and that it is a problem that certainly people understand has existed for a long time, and we can hopefully work together to find a solution.

MR. GINSBURG: Thank you. Zack?

MR. COOPER: Thanks, and thanks, everyone, for coming. It is a topic I care a lot about. We're doing a fair bit of research on it, and what we are starting to see is that surprise out of network billing happens, I think, way more frequently than we expect, and the cost to consumers is pretty bid. I am hoping the research will be out in the short term here.

I think talking about surprise out of network billing makes me sort of one part angry and four parts pretty optimistic. I think the anger is just that this exists. I think we need to keep in mind that there is pretty good data from the Federal Reserve that basically half the folks in the U.S. can't afford a $400 surprise expense without taking on debt, selling assets, or really getting into financial distress.

You have these people out there who are facing real financial harm, and the sort of stakeholders, you have doctors on the one hand who are the highest paid professionals in the U.S., you have hospitals who are doing pretty darn well, and you have big insurance companies. I think this is just one of those things that just frustrates people, to hear these consumers are really struggling, and all these interest groups are saying it's a big problem, but it's really complicated. I think we fundamentally just need to fix it.

I think the optimism comes in in that there are a lot of things in health care that are very tough to solve, and maybe darn near impossible. I think this is one where it is a solvable issue, and I think where economics can come in by saying why does it happen, why does it persist, and then what do we do.

I think fundamentally out of network billing comes up because for certain aspects of health care, emergency services or anesthesiology, for example, the patient is buying a package that includes the physician and the facility. They are not buying these

two services separately.

Yet the way we contract is those two parts apart, and that is fundamentally the issue. What ends up happening is normally in most markets in health care, the physician faces a choice about whether or not to join a network, and if they join a network, they might face lower rates, but they are going to get more volume.

The challenge is when we think about out of network billing where the patient doesn't have choice, these physicians that you can't plan for, you can't avoid, what ends up happening is the physician in that case can basically charge whatever they want. They don't have to participate in a network and if they don't participate in a network, there is no consequence on their volume.

The same competition that applies to almost every other physician group out there doesn't apply in these cases. The question is how do we bring the market discipline to bear on this space.

Why does it persist? Why does this keep happening? I think fundamentally what we have is this sort of multiple equilibrium problem where nobody wants to act first. If you're a hospital and you're the first one to crack down, you're basically going to lose your physicians. If you're an insurer and you go out and you say this is terrible, we're going to crack down on the hospitals, you're going to lose your hospitals. Nobody wants to move first. I think that in particular is why we need to see both state and federal action.

When we think about policy, I think we all agree it should protect consumers, and that is frankly what most of the states have been doing. To steal Colin's language, it's addressing a symptom. Whenever you have these policies that focus on protecting the consumer, it is sort of after the fact, and then you get into this debate about how you set the rates.

You have sort of three options. One is the hold harmless view where you just force the insurers to pay it. That doesn't make a whole lot of sense because

then no physician ever has an incentive to join a network, and then the insurers ultimately pass the higher rates on to the consumers.

You can go the sort of Maryland approach and set some rate as a percentage of Medicare, and you worry about supply issues, maybe you set the reimbursement too low, or you go the New York route and you have mediation or baseball rules, whatever you want to call it.

The challenge is that is like clunky and cumbersome, so what is the solution? I think what it fundamentally needs to be is addressing the problem. I think what we need to say, for example, hospitals, you're required to sell a bundle. If you're going to be providing anesthesia, if you're going to be providing emergency services, you have to sell a package, and that package has to include physicians in facility services.

We can't have this world where we have some element that is chosen that includes two things we are contracting over separately. I think the really nice thing about that sort of package idea, first of all, it gets you around this issue of separately going after fully insured and self-insured products. You don't have that division any more, you are regulating at the unit.

The second is it preserves competition. The hospitals are still going to compete over price and quality to get patients and to join networks. Hospitals are also going to compete to attract physicians, same way they compete now over the wages they give to nurses. Physicians are going to still have to compete in order to get jobs working in hospitals or contracting. We can figure out different ways for that engagement to happen.

If Cedars and Tom want to employ physicians, they can do it. If they want to contract, they can do that, too. Physicians will compete. At the end of the day, insurers will compete over the breadth of their networks, the quality of their products, and their premiums.

You end up seeing competition preserved at each of these levels. I think

again the fundamental issue here is the nature of the service just looks different. Unless we sort of target that and bring in competition, we're going to keep sort of playing second best. We hold the patient harmless, but we end up seeing what we saw in the first panel, like this perpetual debate over what the level of the prices should be.

MR. GINSBURG: Zack, you're talking about why this world that you sketched hasn't happened, and the virtues of it happening, what steps would have to be taken to bring it about?

MR. COOPER: This is where economists have an advantage. I work with where the rubber meets the sky. I think fundamentally it is states, in my view, regulating the package of what gets sold. Basically saying I would start with emergency services, and if I were in a state house, I'd go out and say look, the deal is if you're a hospital and you are going to sell emergency services, what you are selling is a package, and it's just that simple.

The hospitals can decide how they build the package. Again, they can salary the physicians, they can contract with physicians to provide it. We're going to get out of this sort of crazy world where we have physicians billing you and hospitals billing you for a unit that you are not split over.

If I took somebody here out to dinner and I went to a nice restaurant in town, spent $100. Guy brings me bread, we eat the bread. About a month later, I get a $10,000 bill from the bread guy. I didn't choose it, it just sort of showed up. He threatened to send it to collections if I didn't pay. That is just a ludicrous way to buy food.

In a sense, we have institutionalized that in health care. The question is what we should be really paying for is the unit, not the individual components. I think again it should not be an issue about debating the hold harmless and how the rates get paid. It should be debating about how we create a unit and how we price that unit in the marketplace.

MR. GINSBURG: Thanks. Now, we will go to Neeraj Sood.

MR. SOOD: I have the privilege of being the fourth economist to talk on this topic. I'm going to tell you a lot of new things. Just a disclaimer that unlike some of the other panelists, I really started thinking about this specific issue -- I've done a lot of research on health insurance more broadly -- but about this specific issue about three weeks ago when Paul asked me to be on this panel.

The way I approached it as a Professor was first why does this occur. In some sense, if you want to craft a solution to a problem, you need to understand why it happened. I came up with four reasons why it might be happening.

The first is it is just an administrative hassle, what economists call "transaction costs." There is a provider. There are 100 different health plans. I just don't have the capacity to contract with all the 100 different health plans. I'm going to contract with five or six big plans, and the others, they are going to be surprised by my bills.

The second reason could be the health plan has market power. Basically, the health plan is telling providers work for us at the cheap rate, and the providers are like no way, I can't accept this rate, I'll go out of business. The problem is in some sense the market power at the health plan level which makes the network inadequate because they are not offering a competitive or fair price to providers. That could be a potential reason.

The third reason could be it is the other way around. It's the providers who have the market power, and the health plan is offering a reasonable rate, but the providers have a monopoly in the market, and they know they control, patients really want to go to them because they control say a large concentration of providers in a certain market. So, basically they are not going to come to the negotiation table, they are not going to accept fair rates. They are going to hold out until the time they get their kind of high monopoly rates.

In some sense, to figure out which solution works -- and I guess the fourth option could be providers or physicians like to give surprises. I have a solution for

that. I'll talk about it later.

I think the key thing is if it is an administrative hassle, the solution is fairly easy, you can reduce the transaction costs. The first time you see a patient from a new health plan, maybe you get UCR or a rate, but now you need to go and have a contract with this new health plan.

I think if it is just administrative costs, the solutions are fairly easy. If it is either market power on the provider side or market power on the health plan side, the solutions are more difficult.

As one of the speakers said, this might vary market to market, so maybe in a rural market, a provider has a lot of market power, and in an urban market, maybe the health plan has a lot of market power. This might vary depending on how many health plans are competing in that marketplace and how the providers are organized, are they solo practices or do they have a joint kind of set up.

If you take the case where providers have market power, what would be the solution? I guess the first solution is it might depend on whether the service is urgent or not urgent. If the service is urgent, then in some sense the patient has no opportunity to shop, and you should just have the government step in and say this is the price you will pay, and you can decide whatever is the fair price for that service.

If the service is not urgent or is potentially shop-able, then in some sense you want to keep the consumer in this marketplace, because that is how you discipline provider market power.

You want to basically give consumers enough disclosure and enough opportunity to shop around. Not only say this is the estimate for the service, but here are a bunch of other providers who might be providing this service at a cheaper price, or here are a bunch of other providers who are in network and therefore, your out-of-pocket costs would be lower.

But ultimately, you need to have the consumer make the decision

whether they want to go with the higher cost that may be better quality provider, or whether they want to stay in network with lower cost but maybe lower quality provider, and so on. Ultimately, then you have to let the consumers decide what they want to do.

If it the health plan's market power, then you basically want to go with whatever Jeff says, right. It is basically have new laws which mandate that health plans have to have an adequate network. You are kind of now tilting the balance or bargaining power in favor of the providers, and you are basically telling health plans if you don't contract with 50 percent of the providers, then you are liable for any out of network bills, or if you don't contract with a fair share of the providers in the market, then you are liable for this.

I agree with Zack that one way to kind of keep the consumers in this is to make it easier for them, and one way to make it easier is when I shop for a surgeon, I don't think about a surgeon, an anesthesiologist, and an assistant surgeon as separate things. I'm just trying to figure out which hospital or which surgeon is going to operate on me.

The prices I see should be for that bundle. It could be for the bundled surgery, maybe it could be for the entire hospital stay. It depends. The bundle might change the risks for the hospital or the surgeon. If you have a narrower bundle, you just tell the surgeon when you quote a price, you just can't say these are my charges, you have to quote the price for the entire surgery, then there is less risk for the surgeon, or you could say no, it is just not for the surgery, but whatever happens in the hospital post-surgery and so on, and then that would be a bigger risk for the surgeon. What that is maybe it is open for debate, and you can decide.

One last thing. How do we figure out what is the right price or who has more market power? In economics, there is a concept called "opportunity costs." What we should be paying providers is what they would have earned in their next best job. If they want an anesthesiologist, what would they be, and what would be their earnings.

That concept makes sense in theory, in my classroom, but it's very difficult to figure out what that is. I don't know what Jeff would do if he wasn't an anesthesiologist.

As a lay person, I would want to know what are providers making, what is the annual salary and how does it compare to something else. I was sitting here and I Googled it, and it said looking at the average anesthesiologist salary would make you light headed. I stopped there.

That's it. Thanks.

MR. GINSBURG: Thank you, Neeraj. I'd like to give the panelists an opportunity to comment on other panelists.

MR. FIEDLER: If I could jump in on sort of the discussion of bundled payments here, which I think is an interesting approach to this problem to think about. I think probably most people in this room are aware that the Administration is sort of very enthusiastic about bundled payments as an approach to sort of more efficient and higher quality health care delivery, and the Center for Medicare and Medicaid Innovation has a number of tests underway testing those approaches in Medicare that we are very excited about.

We often think about that as sort of changing structured care delivery. I think the point that Zack and others have made is it also has potential effects on sort of making bills more predictable and understandable for consumers, that is important and an important one to think about, given the fact that our cost sharing systems sort of follow the underlying contours of our fee for service payment system.

I think this is an important point and actually sort of an underappreciated benefit of some of the efforts to rationalize the payment system, and will have benefits both in the surprise bill context but more broadly.

The one caution I would have is to the extent we're just shifting the sort of bargaining power problem from the insurer down to whoever is holding the bundle,

whether that be the facility or someone else, if that is the case, then I'm not sure we have fully solved this problem. We have maybe helped on the sort of complexity, consumer choice complexity dimension, but we may not have solved the bargaining power issue.

MR. SOOD: The way I think about bundled payments is that you are basically now asking the surgeon or the hospital to be the agent of the consumer, basically recognizing that the consumer is going to find it difficult to shop around service by service, but the consumer might find it easier to shop around for a bundle.

Whoever is the owner of the bundle is now acting as an agent of the consumer and doing bargaining on behalf of the consumer. There is evidence of this, for example, in the alternate quality contract in Massachusetts where they tried incentivizing physicians, and basically what they found was that physicians, when they had an incentive to save health care costs, they didn't say by reducing use of care, the majority of the savings came by figuring out which facility offered the cheapest MRI and sending the patient to that facility.

In some sense, I feel like some other entity who is incentivized to shop around for the patient might be a better shopper for the patient rather than putting the entire onus on the patient.

MR. FIEDLER: Again, we have to get back to this fundamental issue, which is that for certain specialties in medicine, the physician is going to see the same number of patients whether their price is $1,000, $10,000, or $100,000. They are just not chosen. As a result, it lets them set a price that is more or less out of thin air.

One approach is the bundled approach. I think the other in a very, very different direction, sort of consumer protection, where the Federal Trade Commission would say in some form, insurance companies can't say a hospital is in network if you're going to go there and get an out of network bill. Then what you have basically done is you have put the onus on the insurer, where they can't say something is in network unless the entire package is in network.

I think you need to really go in one of these two directions. We have to stop treating this indivisible unit as two separate items, the physician and the facility, at least in the case of anesthesiology or assistant surgeons or emergency physicians. Those just come together.

Whether you have the sort of consumer protection assurance route or the payment route, again, it is really about treating these as one single unit.

MR. HOADLEY: Sitting here as the one political scientist on a panel surrounded by economists, I really go back in a way to Paul's question to Zack. How do you get from a concept that is very interesting and has a lot of potential to how you would make that happen in reality, and particularly how you make that happen in sort of the political reality.

If a state decided they wanted to go with that approach, you can imagine in a state where one insurer has a very, very large percentage of all market, how do you go about setting up that kind of bundling situation or where the anesthesiology group or radiology group has sort of a statewide presence, and they can still say no, and how do you end up sort of giving the tools to either the health plan or the surgeon, and sort of that surgery bundle, and then the unexpected kinds of things.

When you're in a hospital, you go in for one particular surgery, but then something happens, your heart starts to do something funny, so suddenly the cardiologist, the convenient cardiologist is called in that wasn't anticipated.

Again, particularly if it is a state policy kind of thing, and we are not just redesigning the whole health care system in sort of one big swoop, how would it be possible for a state to sort of start that process to occur.

SPEAKER: It is a great question, and I think the answer is one bite at a time. I think you start with some of the units that are more sensible than others, so I think you start with emergency care, where if you just pick one unit that really isn't debatable and you say for hospital based emergency care, this is what it is going to look like.

Jeff is going to come running at me and tell me it was a bad idea. He's lurching.

You say this is where I am going to start, and hopefully it works. It might not, it might not get through, but you start one bite at a time. You take this example that is incredibly egregious and if it works, you keep on expanding it out.

I think particularly with this one, I think admiring the problem just like isn't the long term solution.

MR. SOOD: I think maybe another solution here is to kind of have health plans more accountable for the narrower networks, so you could come up with a health plan index saying what fraction of their beneficiaries in the last year faced a surprise bill or how many of their beneficiaries went out of network.

I think that is kind of a summary piece of information which if I had on every health plan, it would make it easier for me to shop around. Right now when I see a health plan name or if I go on the exchange websites, I really don't know, in terms that a consumer can understand. In some sense, I want to know like what are the chances I'll face a surprise bill, and maybe that will give me some pause. I might pay a higher premium for a plan with a broad enough network where surprise billing is lower.

I think in some sense this will again empower consumers to make choices, ultimate choices. Some consumers might be happy with taking the risk of a surprise bill and having a lower premium, but other consumers might want to minimize that risk and pay a higher premium.

MR. GINSBURG: I just want to make an observation, as I have been listening to this panel, particularly the discussion on bundling, the fact that there is so much focus on the consumer is going to be more important in medical care than has traditionally been the case, and there are a lot of things that probably have to change in order to facilitate that.

Our medical care system grew up as a fragmented cottage industry

where relationships were developed for the convenience and efficiency of the providers. Of course, they were just thinking about their own specialty and niche.

I think people are much more serious about the term “consumer empowerment” and really thinking about how to enable consumers to be more active and more in control of their medical care.

SPEAKER: I think some of the challenges of that -- I think that as a principle makes a lot of sense, again, I think the challenge comes in the reality. There are two parts to that. There is empowering the consumer who is sitting with a particular insurance policy and is now making provider choices, and I guarantee you we have all tried to go through the exercise of I’m about to have a medical procedure, is that particular provider really in the network.

Part of the consequence is how do we improve those tools. We had a situation in our own family very recently, needed a lab test, and it seemed like the lab that was available through where the primary care doctor was located wasn’t in the network. That means now I have to go somewhere else, this family member needs to go somewhere else to go after and seek out that lab test, and even that, do we know for sure that other lab is in the network.

We have those issues, let alone the emergency kind of environment, and then at the point of the health plan, I think there is a question of what are the tools we really need to make those -- whoever just said having that kind of data point on how much out of network costs, if we could come up with a good way to measure that and capture that, that would be great to have as a measure, but of course, it is going to be sitting there as one of many different measures, and we are still asking people to make choices in a very complex insurance environment.

MR. GINSBURG: I think it would be a good time to go to the audience for questions.

MR. LIEBERMAN: Hi, I’m Steve Lieberman, and I’m a Nonresident

Fellow at Brookings. Thank you to the panel.

I want to go back broadly, although, Zack, I think specifically your idea about creating bundles. I think uniform weights and measures improve markets, but they don't solve fundamental issues of economic powers.

My question has to do with equilibrium pricing. I think this is close to what Mark was talking about earlier, about the potential solution of having the hospital be required to have all the professionals practicing at the hospital be in network.

The question is how does having package pricing, which I am not opposed to, I think it is a good innovation, how is that fundamentally different in terms of the bargaining power of hospitals versus professionals versus insurers? How does that differ? That strikes me in the short term, what is the equilibrium pricing is the question.

MR. COOPER: Yes, I think it is a great question. I think the first thing we know is that hospitals have considerably more bargaining leverage than physicians and physician groups.

I think one safe thing to assume here is if you took my sort of version of this, you might actually see prices go up a little bit, in the sense that the hospital is going to be able to negotiate a higher price than the physician will independently.

I think what it is going to do is lower the variance. By putting this unit in place, you are going to absolutely make the hospitals a little bit more powerful, and there is a whole host of antitrust issues related to hospitals that we could talk about ad nauseam, but I think what it does do is it gets rid of this particular issue.

Again, there are a lot of issues in health care, and I think we just have to start one at a time. The more you bring some rationality into the payment system, the more you can talk about the market power issues because you have separated having to talk about physicians and facilities independently.

MR. SOOD: The bundled payment does reduce costs for the patient, so given the number of providers in the market, provider prices have to fall. The idea is if I

just go to the first provider I see and that is the only provider I go to, that is going to influence providers, and they are going to have high prices.

Now, if you tell me prices of five different bundles for five different providers, and if I shop around, the higher priced provider is going to lose market share, so he is going to drop his prices. In some sense, there is this kind of consumers by shopping around will influence provider market power. If there is only one provider, then it doesn't matter, bundled or unbundled, that one provider is going to dictate the price because there is no opportunity to shop.

MS. McANDREW: Thanks so much. I'm Claire McAndrew with Families USA. This is a really key issue that we and other consumer advocates have been working on.

Taking it back to the conversation about addressing this issue at the federal level, like you mentioned about the need for legislation, I do want to mention that Representative Doggett had introduced an act to end surprise billing last year, no Republican co-sponsors yet.

A question, in the Notice of Benefit and Payment parameters, the Administration did ask for comments on what more they could do beyond I guess what I would call largely symbolic measures to count cost sharing towards the out-of-pocket maximum. I agree it is helpful, but it doesn't actually take on the surprise bill part of it. It just gets to the cost sharing.

Do you think there is anything more they could do at the administrative level, or do you think it actually takes legislative authority under the Affordable Care Act? I didn't know if there was anything they could really do.

MR. FIEDLER: I think we are sort of absolutely looking for additional things we could do. I don't honestly know how far the administrative authorities ultimately go here, and my suspicion is particularly outside of the individual market, the sort of ability to do things here administratively are more limited, not to say that if people have

ideas, we are seeking comments on these questions and we would love to hear them, things that are feasible certainly would be things we would be interested in.

I think a sort of comprehensive solution here probably is legislative.

SPEAKER: States have found that sometimes because the state has the purview over regulating insurance that they can do certain things with regulatory authority as long as it is something that they can impose as a requirement on insurance. They don't have the same regulatory authority on the provider side.

Again, there is a limit at the state level of what you can do through regulation and often to get to these more comprehensive solutions, to make sure it is not mostly insurance focused, they found the need to go to legislative solutions.

MR. SLACKMAN: Thank you very much. I'm Joel Slackman with Blue Cross Blue Shield Association. I'd like to take this back to a more basic question. In the report, there is a statement, "There is no serious dispute among observers that surprise medical billing happens to a significant extent." Then it goes on to refer to anecdotes, and a few studies.

What strikes me is there is really a dearth of evidence about the scope of the problem, the sectors, where the problem occurs. My question to you and Zack in particular, since you referred to research, is do you think more work needs to be done systematically to understand the extent of surprise out of network, the types of services, emergency, not emergency, self-funded, fully insured?

It seems to me that any solution should be tailored to the problem, and the problem at least as I see from the evidence cited to date has yet to be explicated very vigorously or comprehensively.

MR. COOPER: I couldn't agree more, it's hard to tackle a problem if you don't quite know what the problem looks like. I think it gets to a broader issue, which is the availability of insurance claims data. You are from the Blue's, so we will beg on you for data. We have a lot of data on Medicare, we don't have a lot of data on the privately

insured.

I'm doing a fair bit with claims data and trying to use it. We do have some research coming out that I hope will put some parameters around it and be able to give us a sense of how often this occurs.

I think what you have asked and what you raised is really the need for a national claims database, so we can take the Blue's data, for example, and say how often does this happen to your policyholders, and more data out there on folks with private insurance coverage, they are about 60 percent of the folks in the U.S. It is just very, very hard to look into it.

MR. HALL: The challenge is more complicated in the sense that even in insurance claims data, that doesn't get you to the full nature of the problem because if the issue is whether the provider sends that balance bill after the claim is adjudicated, that's not going to be known on the insurance claim, because that is an extra transaction.

People can report on it, but then we have the challenge of people don't necessarily understand whether the bill they got is a balance bill or some other kind of bill that is surprising to them, but not what we would define narrowly here as a surprise bill.

We don't know how often, where there is the potential for a balance bill, that the physicians go out and actually request payment on that balance bill, reach a settlement amount, opt not to charge, whether somebody else intervenes and covers it.

It really is a challenge, and I think you pointed to an important issue. We would like to know that more, but we could get part of the way with a more comprehensive insurance claims database, but even that won't get us to really what we are talking about here.

MR. SOOD: I think just understanding the causes is probably as important, does this happen more in markets where providers are consolidated or does it happen more in markets where insurers are consolidated. That would really help us figure out what the solution should be.

MR. GINSBURG: This may be an example of where because of the problems in the data, policy will move forward based on anecdotes for better or for worse.

MR. ZAFFREN: Thanks. Shreve Zaffren from Texas. I just want you guys to help me understand one thing. When we talk about economics, it goes back to what the actual market price is. We are talking around government set rates, this rate, that rate, whatever somebody else decides the rate is, as opposed to looking at actual claims data, which to my understanding FAIR Health, which was created for that very reason as a non-profit organization, has out there.

Why is in a context where you have designed networks that are narrow by design, which means people are going to be out of network, or tiered networks where I'm going to be in network with one tier and out of network in another tier, regardless of what kind of bundle you put in a hospital, to benchmark it back to an actual market rate, which if it is paid fairly, eliminates the whole surprise billing problem.

I'm just having a hard time understanding that part of it.

MR. FIEDLER: If I could just jump in for a moment, I think the point you have raised here is one of the reasons that the Administration's proposal was trying to tie it to a sort of existing in network rate at the same hospital, in order to try to get to some sort of -- there are sort of pro's and con's of various approaches here.

That said, I think there are a variety of different approaches here, and each of them have pro's and con's.

SPEAKER: Yes, I think the fundamental issue is the in network rates have some meaning, the charges really don't. There is basically a 30 percent correlation between the charge and the negotiated transaction price.

The question is when you have one price that is market determined through bilateral negotiations and you have this charge that is sort of pulled out in different ways at different organizations, how do you set the price. I think it ends up being a quite challenging issue.

MR. SOOD: Again, it depends on who has the market power. If the health plan has a lot of market power, the in network rate is going to be inadequate because it is going to be too low. They are controlling the price. Similarly, if the providers have the market power, the in network rate might be high.

I think just saying it is a market price and we should pay that is not the correct approach. In some sense, you should be paying the market price in a competitive market where both providers and insurers have roughly more or less the same market power. Then that price is kind of optimal from a societal perspective.

SPEAKER: The state solutions have tried to be reached in the context of the particular political environment that both reflects the market status in the state and some of the other political forces, and that has led in the case of New York to the arbitration as part of it, the backdrop.

They can encourage certain things and set certain parameters, but ultimately the protection is that baseball style arbitration process where each side gets to make its offer and the arbitrator picks one or the other.

What they really hope happens is the fact that one or the other may be picked, and this is exactly the experience in major league baseball, in most cases, the two parties will come together on a number.

If a physician suggests their charge rate as their bid into the arbitration or maybe it is 80 percent of their charge or 90 percent of their charge, they are making a strategic decision, if the plan uses its UCR rate or says okay, we should come up a little bit because we don't want to encourage that the arbitrator pick the other side, that is hopefully a process where the two bids will come in closer, and either they will reach a deal or the arbitrator will pick one.

That is a way to sort of get around from these standards. Other states have seen that we can take Medicare as a starting point and then use a multiplier to get to a point that sort of works politically in that environment.

MR. GINSBURG: I think we have run out of time, and I need to close the meeting. I'd like to thank the staff of the Brookings Center for Health Policy, and the USC Schaeffer Center for all the hard work they have done behind the scenes to bring this conference about.

Thank you to the audience for coming and for your great questions.

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