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State Approaches to Mitigating Surprise Out-of-Network Billing

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EDITOR'S NOTE

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

Through a grant from the Laura and John Arnold Foundation, Brookings is working to critically evaluate the prevalence, drivers, and policy implications of surprise medical billing, as well as develop potential nonpartisan policy solutions.

STATEMENT OF INDEPENDENCE

Erin Trish is a consultant to a capital management firm on issues related to health care. Outside of this affiliation, the authors did not receive financial support from any firm or person for this article or from any firm or person with a financial or political interest in this article. They are currently not an officer, director, or board member of any organization with an interest in this article.

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Introduction

Surprise out-of-network medical bills occur when patients are treated by providers outside their health plan's contracted network under circumstances that cannot reasonably be avoided. Usually, surprise bills happen when patients are treated by an out-of-network provider that they did not choose. For example, patients undergoing surgery at an in-network hospital performed by an in-network surgeon (of their choosing) may be surprised to learn after the fact that their anesthesiologist (who they did not choose) was out-of-network. This paper focuses on out-of-network bills that arise either from emergency care – including emergency ambulance transport – or from services delivered to patients at in-network facilities¹ by out-of-network specialty physicians or other providers that patients typically have no role in choosing, which commonly include ancillary physicians (anesthesiologists, radiologists, pathologists, assistant surgeons), hospitalists, and neonatologists.

The financial consequences of surprise out-of-network bills can be substantial. Contracted, in-network providers agree to accept health plan payment rates that are substantially discounted from their “list price,” and health plans typically require much lower cost-sharing amounts from their enrollees for in-network services. Patients treated on an out-of-network basis, however, usually are liable for typically higher cost-sharing amounts through their health plan and the difference between the provider's full charges and the insurer-paid amount – a provider practice known as balance billing – which can be extremely large. Patients enrolled in closed-network health plans, such as health maintenance organizations (HMOs), potentially are liable for the full provider charges for out-of-network care.²

The paper begins by exploring how often and why surprise out-of-network billing occurs. The following section then lays out principles for crafting a solution, after which we analyze different policy approaches to mitigate surprise out-of-network billing. We conclude by summarizing our analysis and recommending potential policy approaches.

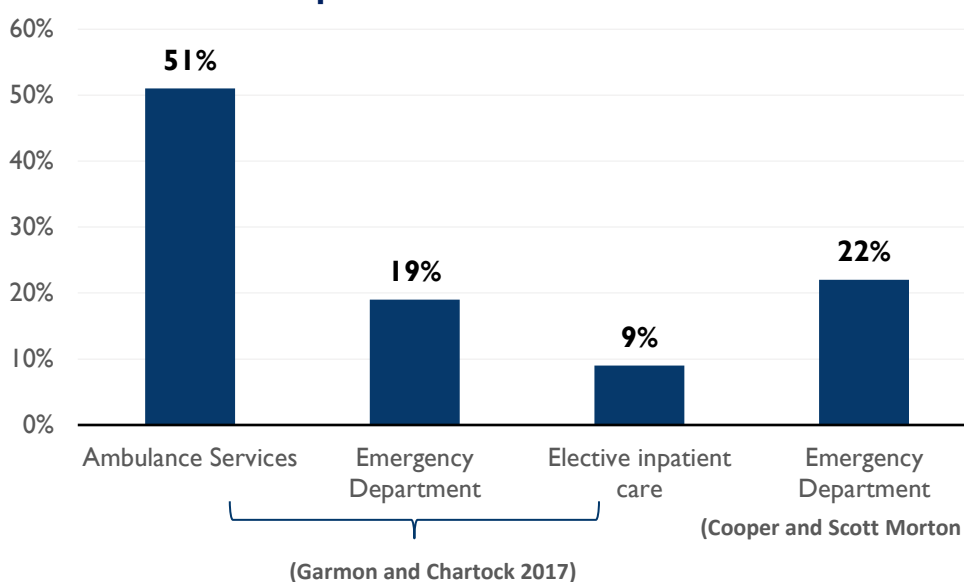
¹ In this paper, we use “facility” to encompass hospitals, ambulatory surgical centers, and freestanding emergency departments.

² For out-of-network emergency services, federal law requires that even closed-network health plans make a minimum payment to the relevant out-of-network providers, as long as the plan includes any coverage of emergency services. However, this amount can be applied to an enrollee's out-of-network deductible, so the patient may still end up owing the out-of-network providers large amounts even before accounting for the amount of the balance bill. See 45 CFR § 147.138(b)(3).

Prevalence and Magnitude of Surprise Out-of-Network Bills

Health care services resulting in a potential surprise out-of-network bill are quite common. Three national studies – one using data from a large, national commercial insurer and two using a large data sample primarily from self-insured employer health plans – all found that roughly 1 in 5 emergency department (ED) visits involved care from an out-of-network provider that could result in a surprise out-of-network bill if not prohibited by state law.^{3,4,5} Further, among people with large employer-sponsored health plans, more than 50 percent of all ambulance cases involved an out-of-network ambulance in 2014, and even for elective inpatient admissions, 9 percent of scheduled hospital stays at in-network facilities led to a potential surprise out-of-network bill.⁶

Figure I. Percentage of Visits Leading to a Potential Surprise Out-of-Network Bill



Source: Garmon and Chartock 2017; Cooper and Scott Morton 2016

Note: For the Garmon/Chartock figures, 19% represents the % of outpatient ED cases, including those to an OON ED, that could result in a potential surprise balance bill.

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³ Cooper, Zack, Fiona Scott Morton. 2016. “Out-of-network emergency-physician bills—an unwelcome surprise.” *N Engl J Med* 2016; 375:1915-1918. <https://www.nejm.org/doi/full/10.1056/NEJMp1608571>.

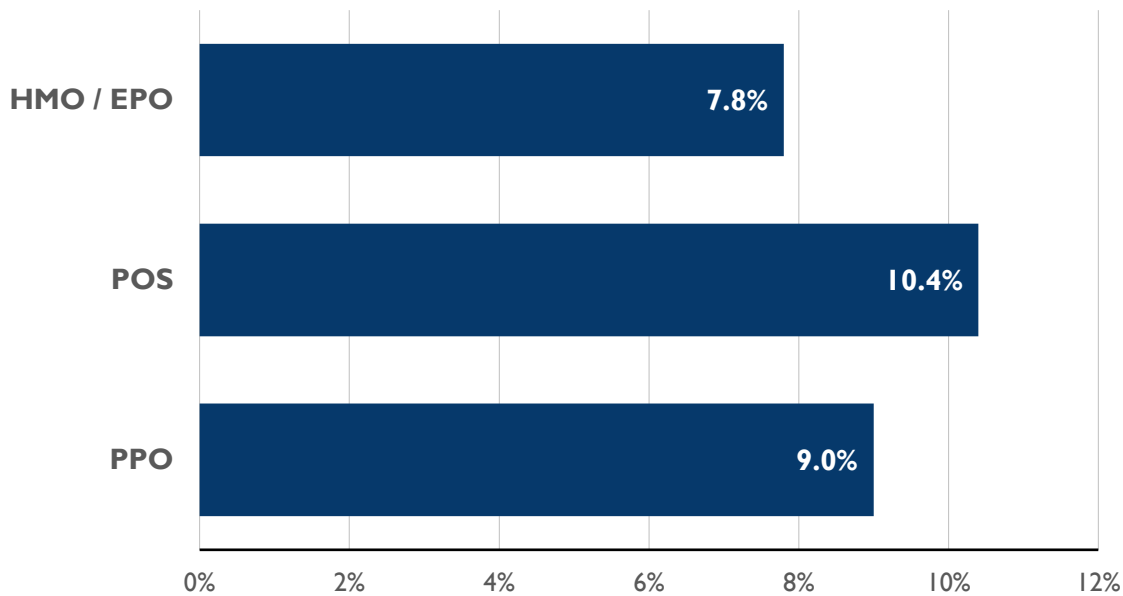
⁴ Garmon, Christopher, Benjamin Chartock. 2017. “One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills.” *Health Affairs*. Vol 36. No. 1 <https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0970>.

⁵ Claxton, Gary, Matthew Rae, Cynthia Cox, Lary Levitt. 2018. “An Analysis of Out-of-Network Claims in Large Employer Health Plans.” *Peterson-Kaiser Health System Tracker*. <https://www.healthsystemtracker.org/brief/an-analysis-of-out-of-network-claims-in-large-employer-health-plans/#item-start>.

⁶ Garmon and Chartock, 2017.

The likelihood that a patient will receive a surprise out-of-network bill varies substantially across hospitals. A study of one large national insurer found that in 15 percent of hospitals, a patient was seen by one or more out-of-network providers in at least 80 percent of emergency cases, while half of hospitals had very few or no such cases.⁷ However, surprise billing is prevalent in almost all areas of the country, for enrollees in both employer and individual market health plans, and across plan types. Some contend that surprise out-of-network billing is largely a byproduct of narrow insurer networks, but its frequency is similar across HMO, preferred provider organization (PPO), and point-of-service plans for large employers and appears to be only marginally higher in individual market plans, which tend to more commonly employ narrow provider networks.^{8,9}

Figure 2. Prevalence of Potential Surprise Out-of-Network Bills from Elective Inpatient Care at In-Network Facilities Across Plan Types



Source: Garmon and Chartock 2017

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⁷ Cooper, Zack, Fiona Scott Morton, Nathan Shekita. 2019. “Surprise! Out-of-Network Billing for Emergency Care in the United States.” *NBER Working Paper* 23623. <https://www.nber.org/papers/w23623.pdf>.

⁸ Garmon and Chartock, 2017.

⁹ Gunja, Munira Z., Sara R. Collins, Michelle M. Doty, Sophie Buetel. 2016. “Americans’ Experiences with ACA Marketplace Coverage: Affordability and Provider Network Satisfaction.” https://www.commonwealthfund.org/sites/default/files/documents/media_files_publications_issue_brief_2016_jul_1883_gunja_americans_experience_aca_marketplace_affordability_v2.pdf.

When they occur, surprise out-of-network bills often are very large. According to a study examining data from a large national insurer, out-of-network emergency physicians charged on average about eight times what Medicare pays for the same service, while in-network rates paid by commercial insurers averaged about three times what Medicare pays. Thus, even if insurers were to pay out-of-network emergency physicians at their average in-network contracted rates, patients could still be liable for a balance bill reflecting substantially higher charges. For an emergency physician visit in this study, the average balance – or the difference between charges and average contracted rates – was \$623.¹⁰ However, many patients face much higher balance bills in the thousands or tens of thousands of dollars, sometimes from claims for multiple services or multiple physicians working in the ED charging many times what Medicare would pay.¹¹ For perspective, roughly one-quarter of multi-person, non-elderly households are estimated to be unable to pay \$1,000 from currently liquid assets.¹²

Why Surprise Out-Of-Network Bills Happen

Normally, negotiations between health plans and physicians are driven by a price-volume trade-off, in which a physician is willing to accept a lower per service price in exchange for the health plan effectively steering more enrollees to that physician by including the physician in its network. Indeed, for most physicians in most geographic areas, it is not possible to maintain a practice without entering some insurer networks because few patients are willing to bear the higher costs associated with seeing an out-of-network physician. However, for some types of physicians, that basic dynamic does not apply.

For ED physicians,¹³ patient volume is driven by patients' choice of hospital¹⁴ and is unlikely to be affected by the whether the physician is in-network or not; hospitalists and neonatologists face a similar dynamic. While patients seeking emergency care usually go to a facility in their insurer's

¹⁰ Cooper and Scott Morton, 2016.

¹¹ Rosenthal, Elisabeth. 2014. "After Surgery, Surprise \$117,000 Medical Bill From Doctor He Didn't Know." *The New York Times*. <http://www.nytimes.com/2014/09/21/us/drive-by-doctoring-surprise-medical-bills.html>.

¹² Rae, Matthew. Gary Claxton, Larry Levitt. 2017. "Do Health Plan Enrollees have Enough Money to Pay Cost Sharing?" *The Kaiser Family Foundation*. <https://www.kff.org/report-section/do-health-plan-enrollees-have-enough-money-to-pay-cost-sharing-issue-brief/>.

¹³ In this paper, we use the term "emergency physician" or "emergency medicine physician" to refer to those specializing in emergency medicine, while the term ED physician is used to refer to all physicians that deliver services in the emergency department, which will include emergency medicine physicians as well as many other specialties who consult on ED cases.

¹⁴ There are also infrequent instances where patients have no choice of hospital (e.g., when unconscious or in urgent need of the closest facility) and may end up at an out-of-network facility.

network,¹⁵ once at the ED, they typically have no choice over the specific physicians treating them. Yet, there is no guarantee that these physicians will be in the same insurer networks as the facility because these physicians generally contract independently with health plans (unless they are salaried by the facility).¹⁶ Since patients have no option to choose an alternative in-network physician in this situation, the physicians' incentive to accept a lower in-network rate is reduced compared to scenarios where patients do have a choice.

Volume is likely to be similarly insensitive to network status for facility-based ancillary physicians such as radiologists, anesthesiologists, pathologists, and assistant surgeons. For elective care, insured patients regularly seek a network facility and primary physician, such as a surgeon, but then have no choice of these ancillary physicians, who similarly contract independently with health plans.¹⁷ A similar dynamic applies for emergency ambulance transport since ambulances tend to be centrally dispatched and patients almost never have a choice of which ambulance company transports them in an emergency.

ED and ancillary physicians, as well as hospitalists,¹⁸ neonatologists, and ambulance companies, therefore, have a potentially lucrative out-of-network billing option that is unavailable to most providers. The amount charged to out-of-network patients faces few market constraints, so it is unsurprising that emergency medicine and ancillary physicians have much higher charges than other specialists relative to Medicare payment levels on average,¹⁹ with extremely high charges at the top end. For example, emergency medicine physicians who billed out-of-network for one large insurer averaged charges of nearly 800 percent of Medicare rates²⁰ and the top 25 percent of anesthesiology

¹⁵ Cooper and Scott Morton, 2016.

¹⁶ Some hospitals directly employ certain hospital-based physicians or utilize faculty at an academic medical center.

¹⁷ Indeed, from discussions with stakeholders, we understand that surgeons sometimes contract with health plans separately for their primary and assistant surgery services, or for their ED coverage, so it is possible for a surgeon to be in-network when acting as the primary surgeon but out-of-network when assisting in elective surgery or on call in the ED, all at the same facility.

¹⁸ While hospitalists face a similar set of incentives as ancillary physicians, discordant network status between hospital and hospitalists appears to be very rare (see Garmon and Chartock 2017). Anecdotally, our stakeholder discussions suggest that one reason for this rarity may be the fact that hospitalist contracts are often structured such that facilities provide additional compensation if the physicians' direct patient billing revenue drops below a threshold. Therefore, the incentive to bill out-of-network may be blunted because doing so would reduce other compensation. However, it is notable that there appears to be recent private equity activity among hospitalist groups, which could potentially augur future out-of-network billing or more aggressive leveraging of the out-of-network billing option to secure high in-network rates.

¹⁹ Bai, Ge, Gerard F. Anderson. 2017. "Variation in the Ratio of Physician Charges to Medicare Payments by Specialty and Region." *JAMA*. 2017;317(3):315-318. <https://jamanetwork.com/journals/jama/fullarticle/2598253>.

²⁰ Cooper and Scott Morton, 2016.

claims billed to Medicare patients had billed charges more than 9 and a half times the Medicare rate (See Figure 3).²¹

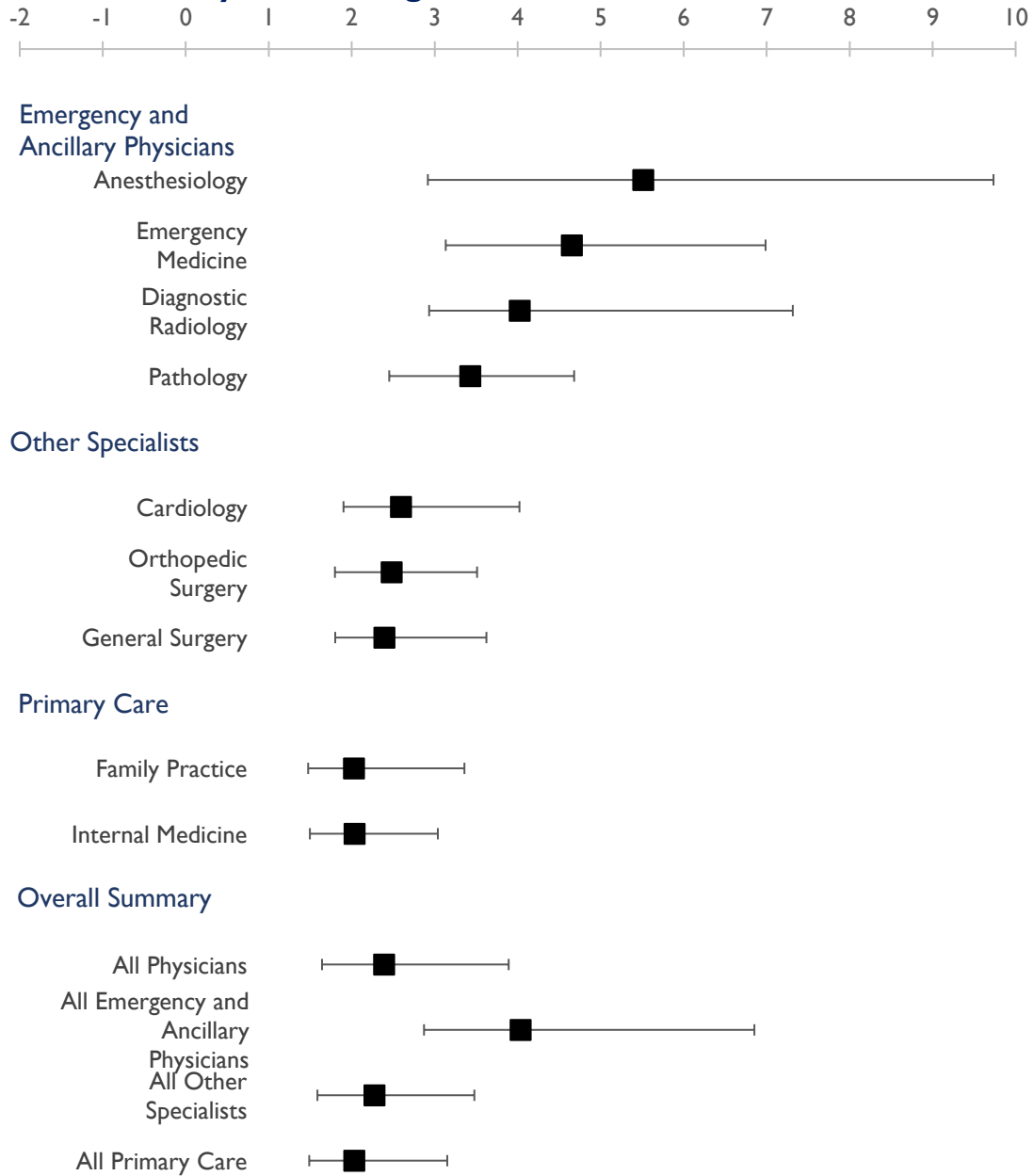
While these charges are high, there also are costs for physicians who rely on out-of-network billing. Collecting from individual patients is more difficult than from an insurer. Out-of-network physicians often settle with patients and/or health plans for payment below their full billed charges and some patient charges are eventually sent to collections, where providers typically receive pennies on the dollar.²² Collecting out-of-network bills also entails administrative and hassle costs, and even the timeliness of the insurer-owed portion of the bill tends to vary by provider network status, with payments often more prompt to in-network providers. The physicians involved also may find sending patients a surprise bill distasteful and be willing to accept less total compensation to avoid doing it. These factors help explain why many ED and ancillary physicians opt to be in health plan networks despite the lack of patient choice.

Physicians are not the only actors whose decisions determine the prevalence of out-of-network billing; decisions by health plans and hospitals play a role as well. Notably, patients *do* generally choose their health plans and hospitals, so both health plans and hospitals have economic – and other – incentives to protect patients from surprise out-of-network billing by persuading ED and ancillary physicians to be in network. However, the availability of the lucrative out-of-network billing option can make it costly for health plans and hospitals to achieve this outcome.

²¹ Authors' analysis of *Medicare Provider Utilization and Payment Data: Physician and Other Supplier* Public Use Files, calendar year 2016. Median and inter-quartile range (IQR) computed across physicians and services, weighting by the number of services rendered.

²² In our stakeholder interviews, we heard multiple times that the industry rule of thumb for emergency physicians billing out-of-network is to expect total collections equal to roughly 35-40 percent of their full billed charges.

Figure 3. Median and Interquartile Range (IQR) Ratios of Physician Charges to Medicare Allowed Rate



Source: Authors' analysis of Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use Files, calendar year 2016.. Provider specialties are included in the data. The primary care specialty includes family practice and internal medicine physicians. Median (IQR) computed across physicians and services, weighting by the number of services rendered.

Most directly, ED and ancillary physicians' ability to engage in out-of-network billing enables these physicians to demand high in-network rates, which makes contracting with these physicians quite costly, and in turn increases insurance premiums. While comprehensive data on commercial payment rates by specialty are not widely available, evidence strongly suggests that the specialties with the

highest rates of surprise out-of-network billing typically get paid significantly higher contracted payment rates – relative to Medicare reimbursement for the same service – than other specialists. Emergency physicians²³ appear to receive average contracted payment from commercial health plans at roughly 250 to 300 percent of Medicare rates,^{24,25,26} radiologists receive about 200 percent of Medicare rates,^{27,28} and in a large survey conducted by the American Society of Anesthesiologists, commercial contracted payments to anesthesiologists averaged nearly 350 percent of Medicare rates in 2018.²⁹ In contrast, studies using claims data show that, across an array of non-emergency services provided by non-ancillary specialists, average mark-ups over Medicare range from approximately 115 percent to near 200 percent.^{30,31} Another study using nationally representative survey data on medical expenditures found that employer-sponsored insurance payments for office visits provided by specialists averaged about 117 percent of Medicare,³² and a Medicare Payment Advisory Commission (MedPAC) analysis of commercial PPO claims from one large national insurer found that contracted payment rates nationwide for all physicians averaged 128 percent of Medicare rates.³³ While Medicare rates are not necessarily a perfect measure of the relative cost of delivering different services, discrepancies this large and consistent across the specialists most commonly involved in surprise out-of-network billing appear difficult to justify.

²³ It is worth noting that ED physicians also must treat any patient who presents at the ED until stabilized regardless of ability to pay as a result of the Emergency Medical Treatment and Labor Act (EMTALA), but their uncompensated care burden does not appear to be large enough to justify pricing disparities this great.

²⁴ Trish, Erin, Paul Ginsburg, Laura Gascue, and Jeffrey Joyce. 2017. “Physician Reimbursement in Medicare Advantage Compared with Traditional Medicare and Commercial Health Insurance.” *JAMA Internal Medicine*. 2017;177(9):1287-1295. <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2643349>.

²⁵ Cooper and Scott Morton 2016.

²⁶ Cooper, Scott Morton, and Shekita, 2019.

²⁷ Trish, Ginsburg, Gascue, and Joyce, 2017.

²⁸ Pelech, Daria. 2018. “An Analysis of Private-Sector Prices for Physicians’ Services.” *Congressional Budget Office Working Paper* 2018-01. <https://www.cbo.gov/system/files/115th-congress-2017-2018/workingpaper/53441-workingpaper.pdf>.

²⁹ Stead, Stanley W., Sharon K. Merrick. 2018. “ASA Survey Results for Commercial Fees Paid for Anesthesia Services—2018.” *ASA Monitor* 10 2018, Vol. 82, 72-79. <http://monitor.pubs.asahq.org/article.aspx?articleid=2705479>.

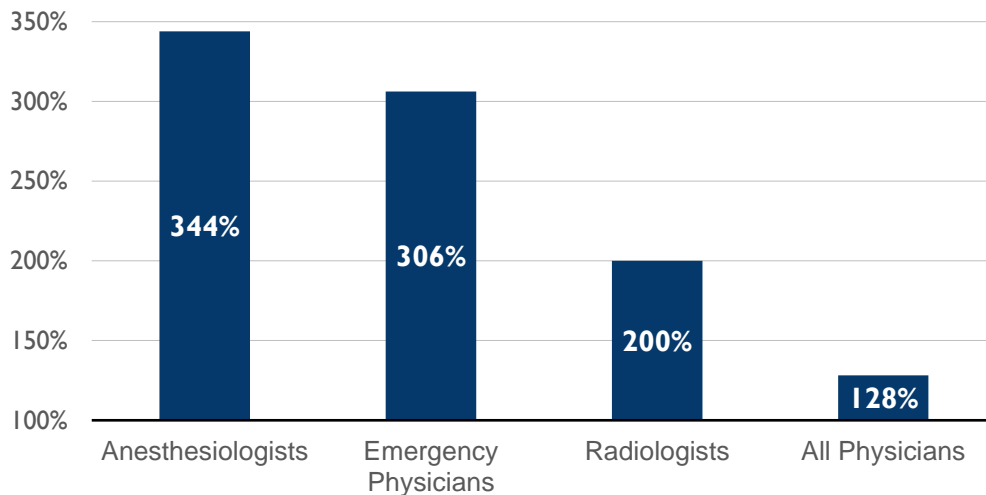
³⁰ Trish, Ginsburg, Gascue, and Joyce, 2017.

³¹ Pelech, 2018.

³² Biener, Adam I., Thomas M. Selden. 2017. “Public and Private Payments for Physician Office Visits.” *Health Affairs*. Vol 36 No. 12. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0749>.

³³ MedPAC. 2017. “Report to the Congress: Medicare Payment Policy.” March 2017. http://medpac.gov/docs/default-source/reports/mar17_entirereport.pdf.

Figure 4. Average Contracted Payment Relative to Medicare Rates for Selected Specialties



Note: Anesthesiologist comparison based on relative mean conversion factors in 2018. Emergency physician comparison based on relative mean payment rates for CPT code 99285 in 2012. For radiologists, 200% represents mean commercial payment for CT Head/Brain scans relative to the Medicare rate (CPT code 70450). All physicians comparison based on data from commercial PPO claims for one large national insurer.

Source: Stead and Merrick 2018; Trish, Ginsburg, Gascue, and Joyce 2017; MedPAC 2017

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Hospitals could seek to limit surprise out-of-network billing by requiring the emergency and ancillary physician groups they contract with to participate in the same health plan networks as the hospital. Unlike health plans, hospitals have leverage over these physicians because they rely on the hospital for patient volume. And, in practice, many hospitals do apply pressure on their emergency and ancillary physicians to sign contracts with the health plans they accept. However, some report that they lack the market leverage necessary to insist on compliance due to a low level of competition among these specialist groups in their areas.³⁴

Indeed, taking such a stance on surprise out-of-network billing would often have costs for the hospital. Economic theory predicts that a hospital that wishes to bar an ED or ancillary physician from billing hospital patients on an out-of-network basis would need to compensate physicians to forgo this lucrative option, particularly since physicians barred from going out-of-network are likely to have limited leverage when negotiating in-network rates.³⁵ For instance, a hospital that wanted to prohibit

³⁴ From discussions with stakeholders, it appears common for hospitals to include a provision in contracts with hospital-based physician groups requiring that they at least negotiate in good faith to join the same health plan networks as the hospital. But hospitals also report that they often lack the power to enforce these provisions.

³⁵ When deciding whether to contract with a health plan, physicians consider the payoff to remaining out of network, which is the amount of money they can collect when billing on an out-of-network basis minus the costs, including both the time and money to collect from patients and any distaste for surprise billing patients. Additionally, physicians must consider the

out-of-network billing by its contracted physicians might have to offer higher stipends, medical director fees, or other forms of direct payment.³⁶ Equivalently, an emergency or ancillary physician group who wanted to bill hospital patients out-of-network – or is able to better leverage the out-of-network billing threat to extract especially high in-network health plan payments – might be willing to accept less in these payment streams.^{37,38}

The fact that it is costly for a hospital to require its ED and ancillary physicians to go in network also makes it costly for insurers to encourage hospitals to take such an approach. In principle, the insurer could offer the hospital higher facility payment rates in exchange for guaranteeing that the hospital's ED and ancillary physicians accept network rate offers or otherwise cover the out-of-network billing costs. However, because this would create such significant costs for the hospital, the increase in payment rates would likely need to be relatively large. Consistent with this, our conversations with stakeholders indicate that insurers often do attempt to apply pressure on network hospitals to encourage their ED and ancillary physicians to accept network payment rate offers, but they report that they often lack the market clout to insist on this, especially if the hospital is one that is essential to have in their network.

Since, as previously noted, patients generally do choose their insurers and hospitals, hospitals or insurers might be willing to pay what would be required to get physicians to forgo surprise out-of-network billing if patients demanded it. In practice, however, consumer demand is unlikely to be strong enough. Few patients even know that network status can differ between the facility and emergency and ancillary clinicians. Additionally, health events that would make this protection valuable are relatively uncommon and hard to anticipate. As a result, exposure to surprise out-of-network billing may not be a particularly salient consideration when consumers are choosing hospitals or insurers, in which case hospitals or insurers that offer this protection may not be able to attract

cost of compensating the hospital for the reputational harm stemming from surprise out-of-network billing occurring at their facility and any distaste the hospital has for surprise billing patients. A similar model is detailed by Cooper, Scott Morton, and Shekita 2019.

³⁶ Stipends, medical director fees, and other forms of direct payment from hospital to physician group are often related to the payer mix of the hospital, services performed that are not reimbursed by insurers, and other factors.

³⁷ For a discussion of this phenomenon occurring, see Bank of America Merrill Lynch. "Physician Staffing: Out-of-network concerns are blown out-of-proportion. EVHC Top Pick." April 2016.

Excerpt: "According to Envision, hospitals are aware of their contracting strategy, and oftentimes it is expressly done to reduce the subsidy that the hospital would otherwise have to pay. Essentially, EVHC [Envision] might say to the hospital, 'I can staff your hospital with a \$300,000 subsidy, or I can go out-of-network with United and the subsidy would be \$0.'"

³⁸ For emergency physician groups, evidence presented in a 2019 working paper from Cooper, Scott Morton, and Shekita suggests that one emergency physician staffing company (EmCare) compensates hospitals by generating higher revenue for the hospital through the ordering of additional imaging tests or admitting more patients.

enough additional customers – or raise their premiums enough – to cover the significant costs they would certainly incur to compensate ED and ancillary physicians for forgoing their lucrative out-of-network billing option. Furthermore, even if consumer pressure were strong enough to squelch surprise out-of-network billing, emergency and ancillary physicians would continue to be able to extract very high levels of in-network payment, which consumers and their employers would bear through higher premiums.

Some argue that aligning the network status of hospitals with emergency and ancillary clinicians is made more difficult by the high levels of market power possessed by some physician groups or staffing companies, particularly for emergency physicians and anesthesiologists, in certain markets. Industry reports suggest there has been considerable consolidation recently within these physician specialties, though we are not aware of comprehensive data on the subject.^{39,40} Additionally, market power is likely exacerbated by staffing companies' use of non-compete clauses in their physician contracts and exclusivity clauses in their contracts with hospitals. Without non-compete clauses, a hospital might be able to create competition with a subset of the staffing company's physicians. And without exclusivity clauses, a hospital might be able to reduce costs by contracting for partial coverage of their emergency or ancillary clinician needs with smaller competitors or by using staffing arrangements. But, the tolerance that antitrust enforcement appears to currently have for these clauses allows them to be in widespread use.

While limited competition in the relevant specialties will lead to higher payment rates, market power on its own is likely not the root cause of surprise out-of-network billing in most instances. Rather, surprise out-of-network billing arises because of the nature of the physician-consumer relationship. As noted earlier, if the potential costs of surprise out-of-network billing were fully salient to consumers, consumers would likely be willing to pay enough for protection against surprise out-of-network billing to induce insurers and hospitals to strike a bargain with physicians to bar out-of-network billing even in an environment of limited competition.⁴¹ However, limited competition in the relevant physician specialties likely does increase the total payment to physicians that would be required to end the practice, thus making it less likely that such an arrangement can be made when the costs of surprise out-of-network billing are only partially salient to consumers.

³⁹ Swearingen, Jeff. 2018. "Market Report: Trends in EM Practice Consolidation." *Emergency Physicians Monthly*. April 2, 2018. <http://epmonthly.com/article/market-report-trends-in-em-practice-consolidation/>.

⁴⁰ Swearingen, Jeff. 2014. "For Anesthesiology Practice Groups, Consolidation is Here." *The Ambulatory M&A Advisor*. March 4, 2014. <http://www.ambulatoryadvisor.com/anesthesiology-consolidation304/>.

⁴¹ A fully rational consumer's willingness to pay to avoid the possibility of a surprise OON bill should be at least as large as what the physician will be able to collect from the patient, while a physician should be willing to accept somewhat less than what could be collected out of network since billing the patient directly is likely to be more administratively burdensome than billing the insurer. This suggests a mutually beneficial bargain could be struck.

It is important to note that out-of-network bills that surprise patients also can result from inaccurate provider directories or inadequate provider networks, but these circumstances are not the focus of this paper and call for different (and additive) policy responses.

Principles for Designing a State-based Solution

Federal legislation to greatly reduce surprise billing has been proposed, but none of these proposals are truly comprehensive, and pending any federal action, many states are eager to address the problem. Accordingly, we set forth a range of approaches that states might take. Before discussing specific policies, it is useful to lay out what features a solution to the surprise out-of-network billing problem should have. In this section, we describe five principles that we believe any state-level solution to surprise out-of-network billing should abide by.

1. Take the patient out of the middle

A key first step is removing the patient from the middle of disputes over surprise out-of-network billing and requiring insurers, providers, and/or regulators to resolve problems. Any solution, therefore, should prevent patients from receiving a surprise out-of-network bill in the first place, making discordant network status between facility and ED or ancillary clinicians invisible to patients. This is in contrast to some current state laws that require patients proactively to file a complaint about surprise out-of-network bills. Patients may be unaware of state legal protections and end up paying an out-of-network bill unnecessarily. Additionally, navigating the complaint process is likely to create significant barriers and costs for patients.

2. Apply protections comprehensively

Protections from surprise out-of-network billing should apply comprehensively across settings – at hospitals, ambulatory surgical centers (ASCs), and freestanding EDs – and not merely in emergency situations. Specifically, protections should apply to services where patients lack meaningful choice of provider, which include:

- All out-of-network emergency care,⁴² whether the facility is in- or out-of-network (including out-of-network facility fees);

⁴² Emergency services should be defined by the “prudent layperson” standard, which is broader than the “stabilization” standard under EMTALA. It covers situations beyond true life-and-limb emergencies, to include circumstances where patients reasonably believe they might have an emergency condition, even if it turns out they do not. See 29 CFR 2590.715-2719A.

- Post-stabilization services at an out-of-network facility (including facility and professional fees);⁴³
- All out-of-network emergency ambulance transport (ground, air,⁴⁴ and water);
- All out-of-network ancillary and hospitalist services delivered through an in-network facility. Ancillary services should be defined as all anesthesiology, radiology, pathology, assistant surgery, and other consulting services, encompassing any tests or imaging performed in addition to the physician professional services.
- Out-of-network neonatology services at an in-network facility immediately following birth until a reasonable option is provided for transfer to an in-network facility with access to an in-network physician.

It may also be appropriate to include some or all out-of-network laboratory services (including pathology) ordered by in-network physicians in the physician office setting. Further, for out-of-network treatment at an in-network facility other than the services described above, protections should apply if the provider does not provide notice of their network status and associated costs and obtain patient consent at least 48 hours before treatment.

3. Minimize reliance on notice and consent exceptions

In an attempt to balance protecting patients and allowing legitimate elective uses of out-of-network care, many state laws and federal proposals allow an exception from prohibitions on balance billing if the medical provider gives notice of network status and an estimate of costs and then obtains advance consent from the patient. Such an exception, however, may allow some providers to thwart surprise billing protections if patients do not fully understand what they are signing or do not realistically have the option to withhold consent, and therefore should be limited if allowed at all. Given the amount of paperwork patients typically must fill out when obtaining medical care and the worry and pain involved with their illness, the notice of potentially high out-of-network billing charges may not be salient enough for patients to take notice. Additionally, the notice might be provided at a point where patients lack realistic alternatives.

Moreover, a notice and consent exception should be unnecessary for the settings and situations detailed in the bulleted list above, as there is no reason to think that patients would ever opt for out-of-network emergency care, ambulance transport, or ancillary services at an in-network facility. A notice and consent exception should be reserved for out-of-network billing protections applied to non-ancillary out-of-network services at an in-network facility, such as a preferred surgeon.

⁴³ Such a protection could apply for the first 24 hours after stabilization, and thereafter if no reasonable option is provided for transfer to an in-network facility.

⁴⁴ States are currently unable to regulate air ambulance services; such regulation is preempted (likely unintentionally) by the Airline Deregulation Act of 1978.

4. Include means of enforcement

An effective policy needs to alter the behavior of health care payers, hospitals, physician groups, and individual clinicians. Regulatory efforts can be frustrated by lack of an efficient enforcement mechanism binding all relevant parties. However, unlike the federal government, states directly license and regulate health care providers, and so can set standards related to out-of-network billing as a condition of a clinician's license or a facility's certification. Enforcement can then be managed through existing processes for managing licensure and certification and resolving patient disputes. Due to preemption under the federal Employee Retirement Income Security Act (ERISA) (discussed below), however, states have more constraints in regulating payers, and will need to design laws that either avoid regulating payers altogether or that rely on voluntary compliance by employers offering self-insured health coverage.

Note, also, that federal policymakers face a somewhat opposite set of constraints – the federal government has fairly wide authority to regulate payers (both fully- and self-insured) and enforce standards against them, but has more limited tools for regulating the conduct of providers and would likely need to link regulation of provider conduct to Conditions of Participation for federal health care programs, which likely would require specifying the link in legislation.

Either way, lawmakers can address this issue without necessarily needing to adopt burdensome enforcement mechanisms for surprise billing protections. Some legal protections fall easily within existing mechanisms for regulating providers and payers. Others that are more novel can be enforced through more general judicial or administrative actions.

5. Be mindful of ERISA preemption

Preemption under ERISA—which bars states from regulating self-insured employer health plans—is likely to be a major consideration for any state considering regulation of surprise out-of-network billing. However, by focusing regulation on health care providers, the policy approaches detailed in the following section are able to largely or entirely protect enrollees in self-insured health plans as well as those in fully-insured plans, while likely surviving any ERISA challenges.

Since the mid-1990s, the Supreme Court has been clear that states can engage in “general health care regulation” – even if the rules affect ERISA plans.⁴⁵ Thus, states are permitted to regulate the conduct of health care providers even when they treat patients covered by self-funded employer plans. For example, the Court has upheld a state law that directed hospitals to bill payers in a very specific way, including imposing a significant surcharge on most ERISA plans; the Court concluded that the state

⁴⁵ *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995).

was regulating hospitals, not employer health plans, and that this was permissible “general health care regulation.”

Regulations of surprise out-of-network billing can be constructed in ways that are clearly regulation of health care providers rather than payers. While regulation will certainly have effects on payers, including self-insured employer plans, rules about the practice of medicine and how providers interact with one another and bill for their services are the kinds of general health care regulations that the Court has allowed. Similarly, billing regulations where the state directly sets a price for certain services or a cap on provider charges, irrespective of type of insurance, do not raise ERISA concerns – indeed, this is nearly identical to state laws that the Court has expressly upheld. However, to the extent a state wants to regulate what payers pay to providers or how payers treat consumer cost-sharing amounts, it should be careful to apply those standards only to fully-insured rather than self-insured plans.

Laws that require providers and the payers to arbitrate billed amounts (described in more detail below) can also avoid an ERISA preemption challenge as long as they are properly limited. The state can compel providers to enter into arbitration as general health care regulation. It can also require health insurers (but not self-funded employer health plans) to engage in arbitration under its authority to regulate insurance, which is clear in the text of ERISA itself.⁴⁶ However, states are unable to impose arbitration on self-insured plans. Nevertheless, there appears to be no obstacle to requiring providers to accept arbitration if a self-insured plan elects that path.

A more detailed discussion of these issues can be found in Appendix A.

Analyzing Potential Policy Approaches

There are two broad policy approaches that states can take to address surprise out-of-network billing in a comprehensive manner. The first, which we term “billing regulation,” relies on capping or setting what out-of-network providers can charge patients and health plans in surprise situations, either by explicitly choosing a rate or determining it through an arbitration process. Additionally, fully-insured health plans would be required to treat such services as in-network for purposes of enrollee cost-sharing. The second approach, which we term “contracting regulation,” effectively makes it impossible for facility-based emergency, ancillary, and similar services to be out-of-network with a health plan when the facility itself is in-network. This second approach can be achieved either through a requirement on ED and ancillary clinicians, hospitalists, and neonatologists to contract with the same health plans as the facility or facilities they practice in, or through a prohibition on these physicians

⁴⁶ “Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.” 29 USC § 1144(b)(2)(A).

contracting with health plans or billing patients directly, effectively making such clinicians reliant on facilities for payment.

In this section, we discuss the pros and cons of each policy option, the anticipated effects, and how states can craft policy solutions that also apply to self-insured coverage. This section assumes that the policies discussed would apply to all the surprise out-of-network situations listed in the previous section.

Billing Regulation

Virtually every state to pass legislation addressing surprise out-of-network billing has taken the billing regulation approach. For states following this policy approach, we recommend combining two key elements:

- Set a cap on the total amount that a provider can charge for a given out-of-network service; and
- Require fully-insured health plans to hold patients harmless beyond their normal in-network cost-sharing amounts – this means that plans must pay the difference between the capped provider charges and the patient’s in-network cost-sharing, and must apply the patient’s cost-sharing amounts to their in-network deductible and out-of-pocket maximum.⁴⁷

States could implement both components of this policy for fully-insured health plans. However, with respect to self-insured health plans, they could only implement the first component since ERISA limits state regulation of self-insured health plans. In this respect, a state approach along these lines would be incomplete compared to a similar federal proposal, which could apply the second component to both fully- and self-insured health plans.

While a state policy following this approach would only constitute a comprehensive solution for patients enrolled in fully-insured plans, even the first component of this approach would, on its own, largely protect patients enrolled in self-insured plans. It would do so in three ways. First, it would directly limit patient liability in cases where they do receive a surprise out-of-network bill. Second, a reasonable limit on what out-of-network providers can charge in surprise situations would reduce the value of remaining out-of-network for ED, ancillary, and similar clinicians, and therefore should

⁴⁷ Under this approach, policymakers would have to decide whether insurers would be required to pay out-of-network providers directly or whether they would instead be permitted to pay the mandated amount to the patient, who would in turn pay the provider. Requiring insurers to pay providers directly would minimize hassle costs for patients. On the other hand, because requiring insurers to pay providers directly would make it easier for out-of-network providers to collect payment (or allow them to do so more quickly), it might reduce these providers’ incentive to join insurers’ networks. In circumstances where the charge limit has been set “too high” (discussed in more detail in the following section), retaining some incentive for providers to join networks at rates below the charge limit would be desirable. Requiring insurers to directly pay providers with whom they lack contractual relationships may also create some operational complexities, although at least some of the states that have taken steps to limit surprise billing appear to have surmounted those problems in practice.

increase the likelihood that they join health plan networks. Third, even when enrollees do unexpectedly encounter a surprise out-of-network provider, with liability now capped at a more reasonable level, many self-insured employers might step in to pay a substantial portion or the entirety of the bill in order to protect their employee.

We note that the approach we describe here of setting a *maximum amount charged* (or, a “charge limit”) is distinct from the policies many states have actually implemented, which instead set a *minimum payment owed* (or, a “payment standard”) from the health plan to the out-of-network provider (either explicitly or through an arbitration process) and prohibit providers from balance billing patients for additional charges above the health plan-paid amount and in-network patient cost-sharing amounts. While these approaches effectively are identical for enrollees in fully-insured health plans (or for the federal government, which is not restricted by ERISA), as noted above, regulating the provider rather than the health plan allows the state to extend some protections to the roughly half of privately-insured Americans enrolled in self-insured group health plans.

A key decision in designing such a policy is determining how to set a reasonable cap on what an out-of-network provider can charge. We next discuss the trade-offs of various approaches to setting such an out-of-network charge limit or payment standard, after which we turn to the discussion of the alternative “contracting regulation” policy approach.

General Considerations in Setting a Charge Limit or Payment Standard

In this section, we discuss how to set the out-of-network charge limit under our recommended approach. (If a state elects to set a minimum payment owed by an insured plan to the provider—the approach typically taken by states to date—broadly similar considerations apply.) Charge limits can be established in one of two ways: directly specifying a limit or specifying an arbitration process. The first approach is both simpler and has the advantage that states can adopt it without having to regulate health plans, thus avoiding ERISA pre-emption concerns, although mandated arbitration may provide more flexibility in payment rates across circumstances. Before discussing each of the specific approaches to setting a charge limit in more detail, however, it is useful to consider the policy implications of setting a limit that is “too high” versus one that is “too low.”

A charge limit for out-of-network ED, ancillary, and similar clinicians that is “too high” would lead to excessive health care spending. Because fully-insured health plans would be required to pay ED, ancillary, and similar physicians the difference between their capped charges and the patient’s in-network cost-sharing, physicians would effectively be guaranteed payment equal to the charge limit. As a result, any charge limit set above current average contracted rates in a market would place upward pressure on those contracted rates, and, above a certain level, those increases could more than offset any reduction in payments to physicians currently billing out of network.

Even setting a charge limit close to the average amounts currently collected by these physicians would likely lead to excessive spending because it would bake in today's inflated costs for ED and ancillary services. As detailed earlier, it appears that emergency and ancillary physicians currently are paid more than they would earn absent the ability to routinely treat and bill patients out-of-network. We will refer to the payment rate that would prevail without the ability to routinely treat and bill patients out-of-network as the "normal market" rate (although we note that to the extent that physician markets are concentrated, even this rate still may be excessive).

On the other hand, setting a charge limit "too low" may be perceived as unfair. It could also raise concerns about physician shortages or reduced access to care if compensation is insufficient to incentivize physicians to train for affected specialties. However, for these particular facility-based clinicians, there are countervailing pressures that would mitigate the impact of a payment standard lower than "normal market" rates. Specifically, these providers by definition practice in facilities, and there are a variety of ways that facilities can compensate for rates that are, in some sense, "too low." Today, facilities make a variety of payments directly to these clinicians (separate from health plan payments for actual services rendered) such as stipends or medical director fees.⁴⁸ Further, hospitals can become involved in the negotiations between clinician groups and health plans. If facility-based ED or ancillary clinician payment rates were capped at too low a level, facilities would be expected to compete to attract ED and ancillary clinicians by using one of these channels to offer additional payment.⁴⁹ Indeed, the facilities are the drivers of these physicians' practice volume, so the more natural negotiation is between the facility and facility-based clinician, rather than between the health plan and clinicians.

There are legal constraints on how much and in what ways facilities can direct funds to clinicians, and there may be some short-term disruption, but we believe these mechanisms would ultimately help augment any rate set "too low" toward the "normal market" rate.⁵⁰ Importantly, we note that there is evidence that the payments from facilities to clinicians for contracted services are today often related

⁴⁸ American Academy of Emergency Medicine. 2005. "The Business of Emergency Medicine—Made Easy!" <https://www.aaem.org/UserFiles/file/thebusinessofem.pdf>.

⁴⁹ However, in most cases, we would not expect facilities to typically compensate emergency and ancillary clinicians for the entire difference between their current contracted rates and the new charge limit because they no longer need to be compensated to forego the now-outlawed lucrative out-of-network billing option.

⁵⁰ While these payment arrangements with facilities would mitigate concerns about setting a rate that is "too low" for ED and ancillary physicians, as well as hospitalists and neonatologists, the same mechanism does not exist for out-of-network emergency facilities (i.e., the facility rather than the physician fee) nor for out-of-network ambulances. Thus, the consequences of setting a payment rate that is "too low" may be more problematic for these particular services, although we do not think there is much risk that a rate in the range of 125 percent of Medicare (our recommendation) would be too low to cover the costs of delivering these services.

to the payer mix of the facility – for example, offering a higher subsidy if a relatively high percentage of a facility’s patients are uninsured or have public insurance with relatively lower reimbursement.⁵¹ That a mechanism already exists through which facilities can provide compensation to ED and ancillary clinicians who expect to earn lower revenue for contracted services provides strong evidence that a similar response could ensue if a payment standard was set below a “normal market” rate. However, the legal considerations are significant and facilities and clinicians will need to take care to document that these fund flows represent fair market transactions to avoid running afoul of state and federal self-referral and anti-kickback laws. Further, as discussed in more detail later in the paper, accommodating changes in applicable state or federal laws may be desirable to allow this mechanism to operate more freely.

In principle, one might be concerned that the need to subsidize these physicians could make delivering these services unprofitable for hospitals and thereby jeopardize access to hospital services. In practice, however, we think this is unlikely to be a concern given that most hospitals’ payment rates from private insurers appear to greatly exceed hospital costs. Moreover, under standard economic models of hospital-insurer bargaining, hospitals should be able to pass increases in their (marginal) cost of delivering services along to insurers. We think that would likely be the case in practice, at least for non-ED services.

Ultimately, we believe that the existence of other mechanisms for compensating these clinicians has important implications for weighing the relative risks of setting a charge limit too low rather than too high. In particular, whereas setting a charge limit that is too high can have harmful outcomes, the concerns related to setting a charge limit too low can be largely mitigated through compensating payments from hospitals to physicians, although federal referral fee laws could be an obstacle to some extent. Despite this legal/contractual complication, where there is uncertainty about the appropriate charge limit, we believe that the availability of hospital “topping off” payments gives policymakers reason to lean toward setting a lower limit rather than a higher limit.

Specific Options for Directly Setting a Charge Limit

We now turn to a specific discussion of three different prices that are commonly considered as the basis for directly setting a charge limit: Medicare rates, billed charges, and contracted rates.

⁵¹ American Academy of Emergency Medicine. 2005. “The Business of Emergency Medicine—Made Easy!” <https://www.aaem.org/UserFiles/file/thebusinessofem.pdf>.

Medicare rates

Medicare rates are reasonable, if imperfect, estimates of the relative cost of providing various services, and are frequently used by commercial health plans to guide rate negotiations with providers.⁵² The Medicare fee schedule for physician services is publicly available, making Medicare rates a transparent and accessible benchmark to operationalize a charge limit. Medicare payments are adjusted by geographic area on the basis of input prices and are accepted as payment-in-full for Medicare patients by nearly all physicians in the United States.

However, Medicare rates are generally lower than negotiated commercial rates for many physician services.^{53,54} Medicare rates are not tied to any market negotiation and can be affected by political and budgetary considerations, so some might fear that these rates will be too low or not vary enough across geographies to reflect market conditions. The first concern can be ameliorated by setting the out-of-network charge limit as a multiple of Medicare rates. For example, Missouri and California have incorporated Medicare rates as a part of their state policies scaled to 120 and 125 percent of Medicare allowed rates, respectively. Commercial rates as a percentage of Medicare do vary by market, and state policymakers could further address geographic variation by scaling the multiple of Medicare rates used for a charge limit based on commercial rates in their state (or in some geographic markets within the state). Another approach, discussed below, would draw on the ratio of contracted rates to Medicare rates for specialists other than emergency medicine and ancillary clinicians.

Billed charges

Physicians' billed charges are another measure available to policymakers, but basing an out-of-network charge limit on billed charges would likely lead to too high a limit and drive up health costs and insurance premiums. Charges (or list prices) face little constraint from market forces and tend to be extremely high relative to objectively reasonable prices. This is particularly true for the specialties most commonly involved in surprise out-of-network billing since, as discussed earlier, physicians in these specialties have particularly strong incentives to set high charges. Emergency medicine physicians and anesthesiologists, the two specialties with the highest prevalence of out-of-network treatment at in-network facilities,⁵⁵ had median charges of 465 percent and 551 percent of Medicare payment rates, respectively, in 2016, based on our analysis of Medicare claims data, compared to an average across all non-emergency medicine or ancillary specialists of 227 percent (See Table 1).

⁵² Clemens, Jeffrey, Joshua D. Gottlieb. 2017. "In the Shadow of a Giant: Medicare's Influence on Private Physician Payments." *Journal of Political Economy*, 2017 Vol 125, No. 11. <https://users.nber.org/~jdgottl/ShadowOfAGiant.pdf>.

⁵³ Trish, Ginsburg, Gascue, and Joyce, 2017.

⁵⁴ Pelech, 2018.

⁵⁵ Garmon and Chartock, 2017.

Table 1. Ratio of Charges to Medicare Rates by Physician Type, CY 2016

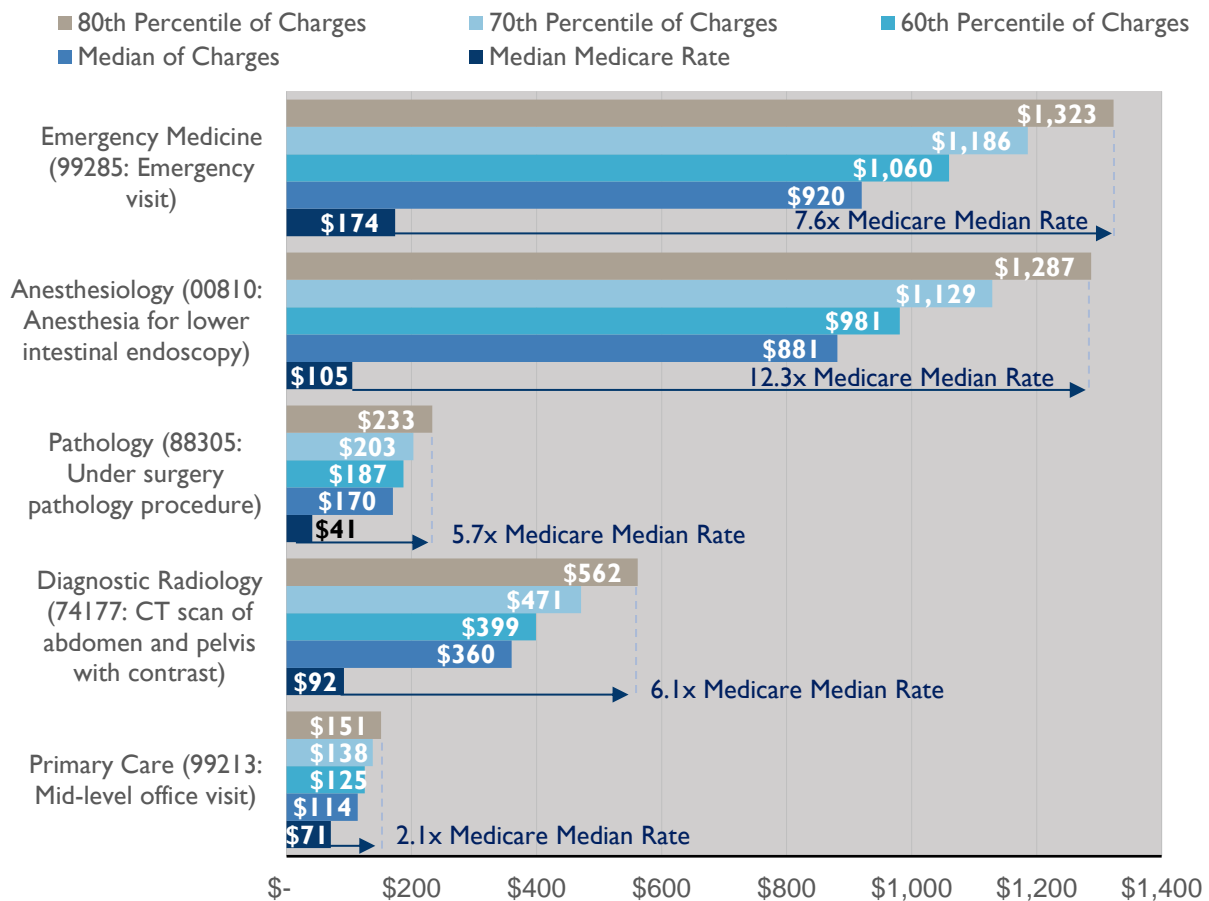
	Median	20 th Percentile	80 th Percentile
Emergency and Ancillary Physicians			
Anesthesiology	5.51	2.52	11.08
Emergency Medicine	4.65	2.79	7.50
Diagnostic Radiology	4.02	2.64	8.03
Pathology	3.43	2.25	5.10
Other Specialists			
Cardiology	2.59	1.73	4.57
Orthopedic Surgery	2.48	1.68	3.91
General Surgery	2.39	1.68	4.13
Primary Care			
Family Practice	2.03	1.38	3.82
Internal Medicine	2.03	1.39	3.45
Summary			
All Physicians	2.39	1.49	4.60
All Emergency and Ancillary Physicians	4.03	2.57	8.00
All Other Specialists (Not Emergency and Ancillary Physicians)	2.27	1.46	4.01
All Primary Care	2.03	1.39	3.54

Source: Authors' analysis of Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use Files, calendar year 2016. All Other Specialists includes all other specialist physicians included in the data, i.e., it is not restricted to only those examples listed under other specialists in the table.

The ratio of charges to Medicare payments is especially large at percentiles of the distribution above the median. Table 1 shows the median, 20th, and 80th percentiles of physician charges for different specialties. Across all provider types, the distribution of charges is skewed such that the distance

between the median and 80th percentile is greater than the distance between the median and 20th percentile. And for anesthesiologists, radiologists, and emergency medicine physicians, in particular, the 80th percentile of charges tends to be extremely high. Operationally, this means that even a small shift in the percentile used to set a payment standard can result in a large leap in absolute payment.

Figure 5. Charges and Median Medicare Rates for Common Physician Services



Source: Authors' analysis of Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use Files, calendar year 2016. Services represent the professional component of common physician services for each specialty presented. Provider specialties are included in the data. The Primary Care specialty includes family practice and internal medicine physicians.

Because charges are not meaningfully market-determined, they often do not vary in logical ways with the underlying cost of delivering different services. At any moment in time, an out-of-network charge limit based on billed charges is likely to overvalue some services relative to others. The absence of market discipline means that billed charges are also likely to change in unpredictable ways over time, potentially causing unexpected and undesirable changes in the level of the out-of-network charge limit.

The latter problem could, in principle, be addressed by benchmarking the charge limit to billed charges at a point in time and then updating the charge limit based on some inflator unrelated to future charges, but it would be preferable to simply take a more sensible approach to setting the charge limit at the outset.

Average contracted rates

At first blush, in-network rates appear to have the benefit of being market-driven and thus more accurately reflecting the relative costs of different services. However, as detailed earlier, contracted rates as a percentage of Medicare rates are considerably higher for emergency and ancillary physicians compared to other specialties because of the lucrative out-of-network billing option available to these physicians. (Unusually high levels of market concentration in these specialties may also play a role.)

Therefore, tying provider payment in cases of surprise out-of-network bills to average contracted rates for that service would cement the currently inflated rates reaped by ancillary and emergency physicians. However, average commercial payment rates (as a percentage of Medicare) for *non-ancillary* specialists with similar training may provide useful insight regarding what reasonable, market-determined payment rates might be.

One promising approach, then, would be for states to employ the average mark-up over Medicare rates among contracted network rates for a group of *non-ancillary* specialists with similar training. In other words, the state would determine by what percentage the weighted-average in-network payment rate for non-ancillary specialist services exceeds Medicare rates, and then set the charge limit for the surprise out-of-network services in relation to that percentage of the relevant Medicare rate in the same region. For instance, if average in-network rates for cardiologists or surgeons (or a blend of appropriate specialties) are 150 percent of Medicare rates, then out-of-network charges for ED, ancillary, and similar services could be capped at 150 percent of Medicare rates for the same services. This method has the potential advantage of adjusting the payment standard to local or state-specific conditions in the commercial market. Alternatively, a state could base their payment standard on *nationwide* or regional average contracted rates for non-ancillary specialists as a percentage of Medicare rates.

While a suboptimal solution (though still preferable to the status quo) that cements today's inflated payment rates, if states instead prefer to tie an out-of-network charge limit to the higher average network rates for emergency medicine and ancillary specialists, policymakers should seek to minimize unintended consequences on future contract negotiations that might lead to lower network participation rates. Specifically, if payment is tied to average contracted rates in the previous year or years, then health plans have an incentive to cancel contracts with higher-than-average rates and physicians may have an incentive to cancel contracts with lower-than-average rates, in order to make

the prescribed payment rate more favorable in the future.⁵⁶ Insurer-specific or provider-specific averages are particularly vulnerable – more so than market or regional averages – to these adverse effects since there is a direct mechanism for individual insurers or providers to influence their own future payment rates. This risk can be avoided by tying the payment rate to an average at a moment in time *prior to* passage of legislation, and then either indexing that amount forward by a measure of inflation or converting it to an equivalent percentage of the Medicare rate and using that ratio thereafter.

Using Arbitration to Determine Payment

Another option to determine provider payment for surprise out-of-network services is to create an arbitration process, which states such as Illinois, New Hampshire, New Jersey, and New York have pursued and has been proposed federally by Sen. Maggie Hassan and Rep. Michelle Lujan Grisham.⁵⁷ Arbitration offers the potential advantage of allowing payment rates to vary more for specific circumstances and potentially adjust more easily over time. The uncertainty in outcome from arbitration might also increase the incentive to contract for both the health plan and provider. Arbitration might also be more politically palatable because it allows lawmakers to avoid explicitly prescribing payment rates. However, it is unclear why an outside arbiter would be better at picking the “appropriate” rate than lawmakers. Nor does this approach completely avoid the need to set rates, as policymakers typically must provide some sort of criteria or guidance to the arbiter about what the appropriate rate is.

An arbitration approach also comes with administrative costs. If those administrative costs are high enough, they could undermine the effectiveness of the policy by leading insurers to simply accede to providers’ demands rather than pursue arbitration. An additional drawback to arbitration for states is the difficulty of protecting self-insured plan enrollees (since ERISA prevents states from compelling self-insured plans to participate in arbitration), which is accomplished by an explicit limit on out-of-network provider charges.

If policymakers choose an arbitration process, they may wish to consider a “baseball-style” or “final offer” structure. In this approach, if the provider and health plan are unable to settle on a payment rate, each submits their best and final offer, and an independent arbiter (typically a neutral party

⁵⁶ See California Regulatory Notice Register. 2018, No. 31-Z. <https://oal.ca.gov/wp-content/uploads/sites/166/2018/08/31z-2018.pdf> for a discussion of this concern in relation to California’s recent surprise billing law, AB 72.

⁵⁷ Adler, Loren, Paul B. Ginsburg, Mark Hall, Erin Trish, Benjamin Chartock. 2018. “Analyzing Senator Hassan’s Binding Arbitration Approach to Preventing Surprise Medical Bills.” *Health Affairs Blog*. October 18, 2018. <https://www.healthaffairs.org/doi/10.1377/hblog20181017.792315/full/>.

chosen by an agency such as the state’s insurance department) chooses which offer they think better represents an appropriate rate. Baseball-style arbitration offers a few potential advantages over other forms of dispute resolution.^{58,59} First, it may prove more efficient to review two competing bids than for an arbiter to directly determine the “correct” number. Second, the possibility of the other party’s bid being chosen creates an incentive to negotiate and settle rather than risk losing outright. And third, because the arbiter must choose either the plan or provider offer, there is an incentive to make a reasonable final offer, which both increases the chances of settlement and potentially provides important information to the arbiter in deciding which offer to choose. Making the arbitration decisions public, as New Jersey’s law does, may additionally make settlement before arbitration more likely as both sides would then know roughly what rate arbiters tend to select. Providing clear guidance to the arbiter about how to select the winning rate offer could have a similar effect.

Rather than providing specific rate guidance, policymakers may wish to specify a floor and ceiling rate to avoid the risk of the arbiter choosing an outlier payment amount. If guidance is provided for the arbitration process, the same discussion applies as above for choosing an appropriate payment standard. Similarly, policymakers are better off “erring” on the low side given that facilities would be expected to compensate facility-based clinicians if the rate chosen is lower than the “normal market” rate. And most importantly, policymakers should exclude any reference to billed charges in their guidance to arbiters because such a reference would likely lead to an excessive payment standard.

To protect at least some self-insured plan enrollees, states should allow employers who self-insure to opt in to any arbitration process, as for example New Jersey recently did, and require providers to accept arbitration if a self-insured employer opts in, which should avoid ERISA preemption issues.

Contracting Regulation

The previous section described “billing regulation” approaches that states can use to address surprise out-of-network billing. We turn now to a different set of solutions, which eliminate the possibility for patients to be seen by an out-of-network ED, ancillary, or similar clinician at an in-network facility, that we call “contracting regulation” approaches.

We consider two main “contracting regulation” approaches, both of which would likely have relatively similar effects on both provider payment and patients’ experiences. Both also have the benefit of protecting all privately-insured state residents because the regulations apply only to providers, avoiding ERISA preemption issues. Notably, though, neither of these contracting regulation approaches would address surprise bills for patients brought to the emergency department at an out-

⁵⁸ Shorter, J. B. 2009. “Final-Offer Arbitration for Health Care Billing Disputes: Analyzing One State’s Proposed Dispute Resolution Process.” *Appalachian Journal of Law*, 9:191-215.

⁵⁹ Monhait, J. 2013. “Baseball Arbitration: An ADR Success.” *Harvard Journal of Sports & Entertainment Law*, 4:105- 43.

of-network hospital or transported in an out-of-network ambulance, so billing regulation would still be necessary to address these instances.

Requiring Clinicians to Contract with All Health Plans Accepted by the Facility

The first approach is to require that any ED, ancillary, or similar clinician who contracts to practice at a facility also contract with all health plans accepted by the facility. This would straightforwardly eliminate the possibility of patients being treated by an out-of-network ED, ancillary, or similar clinician at an in-network facility. However, this approach may prove administratively costly in practice. Requiring a facility-based clinician to join every single health plan network that the facility is in, especially for clinicians practicing in multiple facilities, could prove time-consuming and administratively burdensome.

Some might also object that this requirement shifts too much leverage to insurers in negotiations with facility-based ED and ancillary clinicians, as insurers would know that these clinicians have to accept whatever payment rate they offer to practice at all. However, this concern is not as serious as it might appear for the same reasons that we generally do not worry about setting a charge limit too low. If insurers do indeed use this leverage to pay ED and ancillary clinicians very low rates, then facilities will have good reason to step in to provide additional compensation – or insist that health plans offer reasonable rates as a condition of their contract with the facility – in order to ensure adequate staffing.

Another possible complication, which also applies to a lesser degree to the second contracting regulation approach discussed below, is how to apply this regulation to clinicians who provide some but not all of their facility-based services in the ED or as an ancillary provider. Many different specialists (e.g., various types of surgeons) provide treatment in EDs and separately see other patients as the primary provider in the same facility for nonemergency services. And assistant surgeons who act as ancillary providers almost always also see patients as the primary surgeon in the same facility. To protect consumers broadly against surprise out-of-network bills, this approach would have to require that such specialists contract with all the facility's payers specifically for at least the ED and ancillary services they provide, which might require contracting and billing under two different national provider identifiers (NPIs). Anecdotally, we understand that some specialists in this situation already contract and bill under separate NPIs, so this may be a surmountable hurdle.

A weaker form of this approach might simply require facility-based ED, ancillary, and similar clinicians to “negotiate in good faith” to join the networks of all the health plans that the facility accepts. In this case, a dispute resolution mechanism would have to be included, such as arbitration, to resolve any disputes over what constitutes reasonable versus unreasonable rate negotiation.

The second contracting regulation approach would prohibit facility-based ED and ancillary clinician services from being billed individually to health plans or patients at all.⁶⁰ Under this approach, facilities would incorporate all ED and ancillary clinician services into the facility fees they negotiate with health plans and these facility-based clinicians would have to obtain their full payment from the facility for the services they provide. This approach can alternatively be thought of as requiring facilities to contract with health plans over a “bundled” package of services that includes any associated ED or ancillary clinician services. This bundling approach may appear radical, but it is not dramatically different than how nursing services are billed and nurses are paid today. Note that it may make it more attractive for these clinicians to become facility staff in some cases, but would not require that outcome as these providers could continue to deliver services as independent physician groups and contract with the facility for payment.

Facility-based physicians who both provide services in the ED or as an ancillary provider and separately as the primary physician in nonemergency situations would still be allowed to contract with health plans or bill patients for this latter set of services, but not the former. Neonatology services provided in the 24 hours after a new birth up until a reasonable option for transfer is provided and those provided by hospitalists would also be incorporated in the services that cannot be billed to health plans or patients, in line with their incorporation under billing regulation approaches.

Requiring physician compensation for facility-based ED and ancillary services to come entirely from facilities would mark a significant change, but this solution has the benefit of maintaining price competition for ED and ancillary providers while simultaneously protecting patients. As detailed earlier, the more natural market negotiation exists between ED and ancillary clinicians and the facility they practice at, rather than with the health plan where no price-volume tradeoff exists. Facilities would need to offer sufficient compensation to attract ED and ancillary clinicians and those clinicians would compete to contract with facilities based on price, quality, and the services they provide. Facilities would then negotiate with health plans on reimbursement for this bundled service including these related physician services.

Physicians may view becoming reliant on a facility (typically a hospital) for payment – and the associated loss of independence – as a drawback of this approach. However, they need not become hospital employees. Instead, they could still maintain an independent contractual arrangement similar

⁶⁰ Yale University professors Zack Cooper and Fiona Scott Morton have proposed an approach along these lines specific to emergency services. See “Out of Network Emergency-Physician Bills—An Unwelcome Surprise.” *N Engl J Med* 2016;1915-1918.

to what typically exists today. Still, the level of contractual disruption this policy approach would entail may present a practical challenge.

Note that the ultimate outcomes under this contracting regulation approach would be similar in most relevant respects to the outcomes under a billing regulation approach with a relatively low level out-of-network charge limit. (Indeed, this contracting option can be thought of as a billing regulation approach with an out-of-network charge limit set to zero.) In either case, facilities would now play the primary role in compensating ED and ancillary physicians for their services.

Legal Issues

Stark and Anti-Kickback Laws

As states pursue legislation in this area, especially solutions that may expand or create new fund flows from hospitals to other clinicians, providers may raise concerns about their obligations under state and federal “referral fee” laws that govern financial arrangements between physicians and hospitals or other providers. In general, these laws, known federally as the Stark Law and the Anti-Kickback Statute, limit what payments can flow between physicians and facilities that refer patients to one another. If a state law were to require certain specific forms of billing or contracting (like requiring all billing be conducted by the hospital), that should clearly override any conflicting implication from a more general law designed to proscribe inappropriate financial arrangements.

However, as noted previously, there could be legitimate concern about how these referral laws would apply to more indirect changes in contracting and payments between facilities and providers. Thus, if a low payment rate for emergency and ancillary physicians were to induce hospitals to compensate these physicians directly through stipends or other fund flows, careful legal counsel and documentation would be needed to ensure that the additional payments were legally structured. In particular, documenting that transactions are based on fair market value for the relevant services and avoiding payments that are based on the volume or value of services would be important.

Other State Law Issues

We briefly consider other issues of state law that may be relevant for states as they design policies to address surprise out-of-network bills. Each state has its own accumulated body of insurance law and standards regarding the practice of medicine. Legislatures in each state will need to consider how their specific legal environment may impact how they approach these policies, and whether they need to make conforming changes.

Perhaps the most significant legal consequence impacting contracting regulation solutions could be exposing hospitals to greater liability risk for medical errors committed by ancillary specialist physicians. Under standard legal principles, hospitals are not automatically liable for medical malpractice committed by independent physicians. Courts, however, recognize an exception that holds

hospitals liable for physicians who are, or appear to be, their agents. One factor courts consider is whether or not physicians bill independently.⁶¹ State law varies on this question, but in states where this might be a serious concern, policymakers could consider including in any contracting-based legislation or regulation a provision declaring that consolidated billing arrangements mandated by statute should not, by themselves, impose hospital liability for physicians' negligence.

In addition, many states have a body of state law regarding the corporate practice of medicine. The general principle is that medicine may only be practiced by a licensed professional whose ethical standards are not compromised by loyalty to a non-professional. Therefore, where such laws exist and are enforced, a company cannot employ a physician directly (unless the company itself is owned by physicians) – because supervising physicians as an employer would constitute practicing medicine. Some states make exceptions for hospitals or other health care facilities, but others do not.⁶² Further, while some states have enacted corporate practice of medicine statutes, in other cases the restriction has emerged from state courts or attorneys general interpreting the general medical licensing requirement, or simply the opinions of the licensing board.

Similarly, states also have enacted laws regulating the contracts between health care providers and insurers. These “provider protections” are often intended to restrain insurers from using anti-competitive clauses in their contracts, to guarantee patient choice of provider, or to create procedural rights for providers in their interactions with insurers. These laws may prohibit issuers from offering more favorable terms to some providers than others, and so-called “any willing provider” laws may require insurers to enter into contracts with all providers willing to accept certain terms.

If not addressed, these types of state laws could frustrate approaches to address surprise out-of-network billing. Corporate practice of medicine doctrines may limit the extent to which a facility can negotiate a payment that covers physician services, a necessary component of certain contracting regulation approaches. “Provider protections” may guarantee that a provider could negotiate separately with an insurer (even if the state intended to bring all billing under the hospital) or could give broad groups of providers the ability to contract at a rate resulting from a single arbitration. Thus, a state legislature should consider whether it needs to make conforming changes in state law or enact statutes to narrow or overrule common law doctrines to ensure a statutory scheme functions as intended.

⁶¹ Hall, Mark A., David Orentlicher, Mary Anne Bobinski, Nicholas Bagley, I. Glenn Cohen. 2018. “Medical Liability and Treatment Relationships.” *Wolters-Kluwer*, 4th ed., 2018).

⁶² Michal, Mary H., Meg S.L. Pekarske, Matthew K. McManus. 2006. “Corporate Practice of Medicine Doctrine 50 State Survey.” *The Hospice and Palliative Care Practice Group of Reinhart Boerner Van Deuren s.c.* <https://www.nhpco.org/sites/default/files/public/palliativecare/corporate-practice-of-medicine-50-state-summary.pdf>.

Surprise Ambulance Bill Protections

Ambulance services are frequently overlooked in laws that address surprise billing, but increasingly they are a source of concern for out-of-network billing. Not too long ago, most ambulance service was provided either by local government or by hospitals for amounts close to what Medicare pays. Recent years, however, have seen a proliferation of for-profit ambulance companies that charge a good deal more than Medicare. Prices for government and hospital-based ambulance services also have increased substantially, to help cover cost deficits and to make up for volume lost to newer competitors.⁶³

Because much ambulance transport is done on a scheduled basis (e.g., transferring patients), health plans usually include ambulance service in their contracted networks, but some ambulance companies, especially for-profit ones, are unwilling to agree to rates offered by insurers, preferring instead to remain out of network by relying on their ability to balance bill for emergency transport (mainly by responding to 911 dispatchers).

As described earlier, one analysis of 2014 commercial claims from primarily large employers reported that more than half of all ambulance cases involved an out-of-network ambulance.⁶⁴ Anecdotal reports suggest that ambulance balance-billed amounts may be increasing.⁶⁵ Most egregious are air ambulance bills, which often amount to several tens of thousands of dollars. States are prohibited, however, by federal aviation law from regulating air ambulance rates.⁶⁶ For ground ambulance service, balance bills in the past typically had been several hundred dollars, but the market developments just described have, more recently, resulted in balance bills of \$1,000 or substantially more, which is several times higher than amounts Medicare pays.^{67,68}

Out-of-network ambulance bills should be addressed in the same manner as out-of-network emergency services, through a limit on out-of-network billed charges based on a multiple of Medicare rates combined with a hold harmless requirement on health plans to limit enrollee costs to in-network

⁶³ U.S. Government Accountability Office. 2012. “Ambulance Providers: Costs and Medicare Margins Varied Widely.” GAO-13-6, Oct 1, 2012. <https://www.gao.gov/products/GAO-13-6>.

⁶⁴ Garmon and Chartock, 2017. See Supplemental Appendix Exhibit A1.

⁶⁵ Nation, George. 2017. “Taking Advantage of Patients in an Emergency: Addressing Exorbitant and Unexpected Ambulance Bills.” *Villanova Law Rev.* 62(4): 747-85 (2017). <https://digitalcommons.law.villanova.edu/cgi/viewcontent.cgi?article=3357&context=vlr>.

⁶⁶ This state pre-emption is an unanticipated effect of the Airline Deregulation Act of 1978. Recent Congressional proposals to lift this pre-emption have been stalled. Instead, the FAA Reauthorization Act of 2018 calls for further study of issue.

⁶⁷ James, Sha’Ron. 2018. “Emergency Medical Transportation Costs in Florida.” *Florida Insurance Consumer Advocate*. <https://www.myfloridacfo.com/Division/ICA/EMTWhitePaper.pdf>.

⁶⁸ Consumer Reports. 2016. “\$164 Per Mile: Surprise Ambulance Bills Are A Growing Problem & Difficult To Avoid.” Feb. 22, 2016. <https://www.consumerreports.org/consumerist/164-per-mile-surprise-ambulance-bills-are-a-growing-problem-difficult-to-avoid/>.

cost-sharing amounts. To apply such a solution to air ambulance bills, however, federal legislation would be necessary.

Recommendations for Action

In crafting a solution to surprise out-of-network billing, our chief objectives are to protect patients in a comprehensive manner and to restore more normal market dynamics to contracting for emergency department and ancillary clinicians, which should in turn reduce health care spending. Below, we describe two approaches to achieving these objectives, which we believe would have similar effects in practice.

Option #1: Billing Regulation Only

The first option is a pure billing regulation approach. Under this approach, states would:

- Set a limit on out-of-network charges equal to a multiple of the relevant Medicare rate in line with what non-emergency or ancillary specialists with similar training are paid by commercial payers. Given existing national data and the limited risks to setting the charge limit below “normal market” rates, we believe that 125 percent of the relevant Medicare rate would constitute a reasonable limit. States could modify the multiple, either statewide or by market area, to reflect local market conditions.
- Require fully-insured health plans to hold enrollees harmless for any cost-sharing beyond normal in-network cost-sharing amounts for these out-of-network services (and count such cost-sharing toward in-network deductibles and out-of-pocket limits).
- Apply these requirements to: (1) out-of-network emergency services (including ambulance transport but excluding services delivered after transfer to an in-network facility is offered); and (2) out-of-network ancillary clinician, hospitalist, and neonatology services delivered at an in-network facility (where a facility is defined as a hospital, ambulatory surgical center, or freestanding emergency department).

Option #2: Hybrid of Billing and Contracting Regulation

The second option is a hybrid billing regulation/contracting regulation approach. For out-of-network ambulance services and emergency services delivered at an out-of-network facility, states would implement the billing regulation approach described under option #1. For the other services enumerated in the third bullet above—emergency, ancillary clinician, hospitalist, and neonatology services delivered at an in-network facility—states would bar independent billing, thereby implicitly requiring that insurers pay for these services entirely through payments to the facility at which they practice. (Facilities would then compensate clinicians delivering these services directly.)

By enacting either of these approaches, states could largely protect all privately-insured state residents from surprise out-of-network bills, regardless of whether they are enrolled in a fully- or self-insured health plan. And by eliminating the lucrative out-of-network billing option for ED and ancillary physicians, these approaches could also reduce health care spending and insurance premiums (although for option #1, this reduction would likely only occur if policymakers set a charge limit sufficiently far below the inflated amounts currently paid for these services). States can enforce these regulations on providers as a condition of provider licensure or facility certification, and on fully-insured health plans through existing insurance regulatory processes.

These two options could also serve as a blueprint for action at the federal level, with a few modifications. If pursuing option #1, the federal government could require self-insured (in addition to fully-insured) health plans to hold enrollees harmless for any costs beyond normal in-network cost-sharing amounts associated with surprise out-of-network services. The federal government could also extend the billing regulation approach we recommend for ground ambulance and out-of-network emergency services to air ambulance services (which states are prohibited from doing). If enacting a federal solution, Congress would also have to decide whether to supersede existing state reforms, which range widely in their comprehensiveness and effectiveness.⁶⁹

⁶⁹ Hoadley, Jack, Kevin Lucia, Maanasa Kona. 2019. "State Efforts to Protect Consumers from Balance Billing." *The Commonwealth Fund*. <https://www.commonwealthfund.org/blog/2019/state-efforts-protect-consumers-balance-billing>.

Appendix A: ERISA Preemption Considerations

In 1974, Congress enacted the Employee Retirement Income Security Act (ERISA) to guarantee sound financial management and basic consumer protections in workers' pension and health care benefits. To ensure uniformity, ERISA included one of the broadest provisions preempting state laws that Congress has ever enacted – declaring preempted “any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.”⁷⁰ Since then, avoiding ERISA preemption has been an important design consideration in any state policy that affects employer-sponsored health care benefits. While ERISA jurisprudence is famously murky, the types of state policies described in this paper can be designed to avoid ERISA preemption.

We first provide an overview of the relevant ERISA preemption doctrine, then consider how that impacts billing regulation and contracting regulation.

ERISA Overview

As noted previously, ERISA's preemption clause specifies that federal law shall supersede any state law that “relate[s] to” a benefit plan covered by ERISA, including employer-sponsored health coverage.⁷¹ This “relates to” clause potentially has an extraordinarily broad sweep since, in a complex field like health policy with so many interconnected aspects, almost anything can be said to “relate to” anything else. Read broadly, ERISA could preempt any state law that impacted the delivery of or payment for health care services, because any such laws would have some effect on employers' health benefits. But, importantly, there are two relevant ways in which this broad preemption clause is limited.⁷²

The first is straightforward: the statute contains a “savings clause,” which specifies that ERISA shall not preempt state laws regulating “insurance, banking, or securities.”⁷³ The insurance component of the savings clause has generally been interpreted to mean that a state law that regulates health insurers will be permissible. This is true even when the state law affects insurers' conduct in the market for group health insurance, where the customers are all, by definition, ERISA-regulated employer health plans. To determine whether a state law “regulates insurance,” the court uses a two-part test: it first considers a “common sense view of the matter,”⁷⁴ and then applies a more mechanical test to see if the

⁷⁰ 29 U.S.C. § 1144(a).

⁷¹ 29 U.S.C. § 1144(a).

⁷² Beyond the issues discussed here, ERISA's preemption clause contains a variety of other exceptions that are not relevant in this context. *See* 29 U.S.C. § 1144(b).

⁷³ 29 U.S.C. §1144(b)(2)(A).

⁷⁴ *Metro. Life Ins. Co. v. Massachusetts*, 471 U. S. 724, 740 (1985).

law would be considered insurance regulation under the McCarran-Ferguson Act.⁷⁵ For example, in upholding a state law mandating mental health benefits in group insurance, the Supreme Court noted that state law had long regulated the “substantive terms of group health insurance contracts” and these substantive standards are permitted under ERISA’s savings clause.⁷⁶ This same case also noted that an identical substantive standard could not be applied to self-insured plans, as there would be no insurer to regulate.⁷⁷ Put another way, ERISA prevents a state from telling employers what they must (or must not) do in their benefit plan, but it does allow a state to tell insurers what *they* must (or must not) do with respect to the policies they sell to employers.

The second important limiting principle was introduced by the Supreme Court in a line of cases starting in the mid-1990s and has tended to save from preemption state laws related to “general health care regulation,” and specifically state laws that act on health care providers. Prior to this decision, the Court had interpreted the phrase “relate to” rather broadly to mean that any state law that had “a connection with or reference to” an ERISA plan would be preempted.⁷⁸ These early ERISA cases rendered preemption nearly automatic for any law that was not expressly covered by a statutory exemption. However, in the 1995 case *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.* (commonly referred to as *Travelers*), the Court criticized the “uncritical literalism” of prior jurisprudence and directed courts to consider the “objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.”⁷⁹ In analyzing whether ERISA should preempt a state law regarding hospital payments, the Court concluded that “nothing in [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation” and therefore state law in this area should survive.⁸⁰

Indeed, the actual facts of *Travelers* are particularly relevant here. New York State had enacted a law that required all hospitals in the state to bill in a particular way. Hospitals were required to use a specific fee structure and were also required to impose surcharges above the standard rate to help cover uncompensated care. This surcharge varied depending on the payer. Medicaid and Blue Cross Blue Shield were charged one rate, and other commercial payers (including ERISA plans) were

⁷⁵ This, in turn, requires examining whether the law regulates a practice that “(1) has the effect of transferring or spreading a policyholder’s risk, (2) is an integral part of the policy relationship between the insurer and the insured, and (3) is limited to entities within the insurance industry.” *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 359 (1999).

⁷⁶ *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 729 (1985).

⁷⁷ *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985).

⁷⁸ *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983). Why the Court thought that instructing stakeholders to look for “connection with” an ERISA plan was a helpful modifier to the statute’s “relate to” phrasing puzzles scholars to this day.

⁷⁹ *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995).

⁸⁰ *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 662 (1995).

charged a rate that was up to 24 percent higher. The Court concluded that states have traditionally regulated hospitals, there was no evidence ERISA was intended to disrupt this area of state law, and therefore the New York law – which acts on hospitals – should survive. Two years later, the Supreme Court underscored states’ ability to regulate health care providers, holding in *De Buono v. NYSA-ILA Medical and Clinical Services Fund* that a state could charge a tax to health care clinics, even when those clinics were directly operated by a self-funded ERISA plan.⁸¹

So, while ERISA’s scope remains broad, states have been generally able to write laws that act directly on insurers or on health care providers, while avoiding laws that directly regulate employers. With this background, we examine how a court is likely to view ERISA preemption of billing and contracting regulation of out-of-network surprise billing.

ERISA Preemption and Billing Regulation Approaches

Billing regulation approaches limit surprise out-of-network billing by a) capping or setting an out-of-network price for the relevant service, either directly or through arbitration, and b) requiring the payer to pay the full charge (minus in-network patient cost-sharing amounts) and treat the cost as in-network for purposes of the consumer’s cost-sharing. We consider each component of the policy in turn.

Arriving at a Price: If the state adopts a methodology to directly set a price for the service or a limit on the out-of-network charge, there is no basis for a court to find that preempted. Indeed, the facts of *Travelers* involved an even more expansive pricing scheme that told hospitals what they must charge to each particular payer, and the Supreme Court expressly concluded that the rate regulation was permissible even though it affected the “costs and charges” paid by ERISA plans.⁸²

Arbitration-based approaches raise more questions, but also can be designed to survive an ERISA challenge. Requiring the *provider* to enter into arbitration is uncomplicated. But, of course, a payer must sit on the other side of that arbitration. That is, this approach does involve some active conduct by the payer, who may be an ERISA plan or an entity acting on behalf of an ERISA plan. Nonetheless, as applied to insurers selling insured products in the group market, this is almost certainly permissible – it is at the core of the regulation of insurance contemplated by the statutory savings clause. The state is regulating the contract between the insurer and providers (not the contract between the insurer and the ERISA plan) – and therefore the law is even less closely tied to the ERISA plan than the benefit mandates that have been expressly upheld by the Court. On the other hand, requiring self-insured

⁸¹ 520 U.S. 806 (1997).

⁸² *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995). The Court is using “charges” in its more colloquial sense, not to distinguish between charges and paid rates.

plans to enter into this sort of arbitration is likely not permissible, since ERISA does not permit states to regulate employers as if they were insurers.⁸³

However, a state law that allows self-insured employers to voluntarily opt in to an arbitration scheme, and requires providers to accept the results of such arbitration, should avoid an ERISA challenge, as it does not compel any action by the employer. Another factor the Supreme Court has considered in ERISA cases is whether the state law "alters the incentives," rather than "dictat[ing] the choices" of ERISA plans – upholding state laws that create incentives for employers without requiring action.⁸⁴ Here, where the state law merely creates an option for employers to avail themselves of arbitration, the law could not be found to "dictate the choices" made by an employer plan. In addition, we note that state laws that simply require providers to engage in good faith negotiations are unlikely to implicate ERISA. Here, again, the law directly acts upon the provider and so it is permitted under *Travelers*.

We also note that the Supreme Court has suggested that state laws that "regulate insurance" within the meaning of ERISA's savings clause may still be preempted if they involve "alternative causes of action and alternative remedies" (including arbitration)⁸⁵ – but that line of cases is not implicated in this context. Specifically, the Court has noted that a state law allowing beneficiaries to use a state cause of action to recover benefits from their insurer, even if construed as regulating insurance, is still preempted by ERISA. The Court has reasoned that, because the federal statute lays out detailed standards and processes for "civil enforcement" of plan terms by plan enrollees,⁸⁶ those are intended to be the "exclusive remedy" for enrollees.⁸⁷ As a result, state law creating alternative remedies is preempted, even if it regulates insurance. However, these cases do not address all forms of dispute resolution related to health coverage; instead, they address only dispute resolution *between the plan and its enrollees*. The Court has created an exception to the "regulates insurance" safe harbor based on the specific fact that ERISA includes a very detailed set of standards for dispute resolution between the plan and its "participants and beneficiaries" (i.e., enrollees). These ERISA-specified procedures do not relate at all to disputes between the plan and providers. Therefore, states' latitude to regulate

⁸³ As noted above, the Court has noted that state law cannot require employers to offer certain benefits because that would constitute substantive regulation of the ERISA plan itself. Requiring that payment for a specific service be negotiated in particular way is a similar restraint on the conduct of the ERISA plan, and therefore cannot be sustained. This conclusion is buttressed by the Supreme Court's recent decision in *Gobeille v. Liberty Mutual Insurance Co.* that states may not require data collection from ERISA plans. *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. ____ (2016).

⁸⁴ *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*, 519 U.S. 316, 334 (1997).

⁸⁵ *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 381 (2002).

⁸⁶ 29 U.S.C. § 502.

⁸⁷ *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

insurance is not affected simply because regulation happens to contain a dispute-resolution mechanism, as long as the mechanism does not involve enrollees directly.

Requiring Payment and Regulating Consumer Cost-Sharing: To fully protect consumers, policymakers may want to ensure that the payer does in fact pay the provider's full charge and treats the settled price as in-network for purposes of consumer cost-sharing. States should face no obstacle in applying these standards to insured plans, but almost certainly may not impose them on self-insured plans. As with benefit mandates, this is the sort of "substantive term[]" in a benefit contract that can be required in the group insurance market, but cannot apply directly to a self-insured employer.

Taking these various points together, states wishing to pursue a billing regulation approach can design a law that is not preempted by ERISA. To do so, they will need to refrain from regulating how self-insured plans pay the charged amount or how they treat consumer cost-sharing, and exercise caution in how they regulate prices. Simply setting a price or out-of-network charge limit is the safest policy from the perspective of ERISA preemption, but arbitration approaches will likely survive as long as they are not mandatory for self-insured payers.

ERISA Preemption and Contracting Regulation Approaches

For the same reasons described above, states likely have wide latitude to develop contracting regulation solutions. Contracting regulation approaches that dictate the terms under which health care providers are licensed to practice in the state are clearly regulation of health care providers and thus do not implicate ERISA. Even though such a rule may affect the ultimate prices paid by ERISA plans or the specific way in which payment bundles are constructed, that sort of tangential effect does not render a law preempted under the *Travelers* precedent. Similarly, state laws that limit how or whom a provider can bill for a service escape preemption – indeed, that is exactly what the New York law did that *Travelers* upheld.

It is worth noting that a state pursuing this approach could indirectly impact the way in which an employer plan complies with various requirements imposed by ERISA itself, especially with regard to consumer cost-sharing. For example, consider a state law that has the effect of making anesthesiologist services "part" of the hospital's bill to the payer, rather than a separate bill for anesthesia services. If the hospital is in-network, then the anesthesia services would automatically be treated as in-network for purposes of ERISA's requirement that plans impose a maximum out-of-pocket limit on in-network services, without the state independently imposing that requirement. This sort of indirect effect should not affect the preemption analysis – indeed, it is much more tangential than the direct surcharge imposed by New York in *Travelers*. That said, under a somewhat peculiar line of cases dating back to the 1980s, state legislatures may wish to avoid focusing on these sorts of ERISA-related impacts in their deliberations. In one of the earliest ERISA preemption cases, the Supreme Court emphasized

that state laws that have a “reference to” ERISA plans will be preempted.⁸⁸ That has led some lower courts to examine state legislative history as a component of their preemption analysis, and to find preemption in situations where state deliberations seemed premised on ERISA impacts.⁸⁹

Future ERISA Developments

Finally, we reflect on whether changes in ERISA jurisprudence might alter our analysis in the future. Naturally, forecasting new legal developments is speculative, but one useful guide over past developments has been to observe whether employers are likely to see particular state regulations as a burden. While ERISA preemption jurisprudence can be unpredictable, it is unlikely that new frontiers in the doctrine will be crafted in an area where state law simplifies administration and lowers costs for payers. The state laws discussed in this paper can be fit comfortably within the existing *Travelers* framework, and that should be sufficient comfort for states to move forward.

⁸⁸ See, e.g., *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983).

⁸⁹ For example, two courts have struck down state or local laws that imposed an employer mandate designed in such a way that it would only impact Walmart stores, and both courts considered legislators’ statements that treated the mandate as “requiring” the employer to offer health insurance. While these cases invoke different components of the ERISA preemption framework, the experience may still be relevant. *Retail Indus. Leaders Ass’n v. Suffolk County*, 497 F. Supp. 2d 403, 407-407 (E.D.N.Y. 2007) (discussing legislators’ desire to force retailers to offer health insurance); *Retail Indus. Leaders Ass’n v. Fielder*, 475 F.3d 180, 194 (4th Cir. 2007) (noting that legislators “understood the [Maryland Fair Share] Act as requiring Walmart to increase its healthcare spending”).

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