

Testimony of Christen Linke Young, J.D.
Fellow, USC-Brookings Schaeffer Initiative on Health Policy

U.S. House of Representatives
Committee on Education & Labor
Subcommittee on Health, Employment, Labor, and Pensions
Hearing on “Examining Surprise Billing: Protecting Patients from Financial Pain”

April 2, 2019

Chairwoman Wilson, Ranking Member Walberg, members of the subcommittee, thank you for the opportunity to testify today. I am Christen Linke Young, a Fellow with the USC-Brookings Schaeffer Initiative for Health Policy. My research focuses on private insurance, access to coverage, and the intersection between state and federal policy making. I am honored to have the opportunity to speak with you today about surprise out-of-network billing.

A group of scholars affiliated with the USC-Brookings Schaeffer Initiative for Health Policy – Loren Adler, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Erin L. Duffy, and me – recently published an analysis of out-of-network billing and associated policy solutions.¹ The material that follows is lightly adapted from that publication, which reflects the work of this diverse and thoughtful group of coauthors. Further, this testimony reflects my personal views and should not be attributed to the staff, officers, or trustees of the Brookings Institution.

Executive Summary

Surprise out-of-network bills arise when a consumer receives care from an out-of-network provider in situations they cannot reasonably control. One common example is when a patient sees out-of-network anesthesiologist for a procedure at an in-network hospital, but these sorts of bills can arise with respect to many types of services – emergency department, radiology, pathology, and even neonatology and hospitalist care.

Situations like these – where a patient is receiving care from an out-of-network provider that she did not choose – are fairly common. Studies suggest that about 20 percent of emergency department visits and 10 percent of elective inpatient care stays involve at least one out-of-network provider, and about half of ground ambulance rides are out-of-network. The bills patients receive under these circumstances can be quite large.

The existence of these surprise out-of-network bills and their large sizes reflect a market failure. For most types of physicians in most geographic areas, joining insurance company networks is standard because many patients are not willing to bear higher out-of-network costs. But for

¹ Adler, Loren, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Christen Linke Young, Erin L. Duffy. 2019. “State Approaches to Mitigating Surprise Out-of-Network Billing.” *USC-Brookings Schaeffer Initiative on Health Policy*. <https://www.brookings.edu/research/state-approaches-to-mitigating-surprise-out-of-network-billing/>

The views expressed in this piece are those of the author and should not be attributed to the staff, officers, or trustees of the Brookings Institution.

types of physicians that patients do not choose, this logic does not apply. Emergency physicians, anesthesiologists, and other ancillary physicians receive a flow of patients based on individuals receiving care at the hospital in which they practice, and that volume will be largely the same regardless of whether they join an insurance company network.

Because volume does not depend on the prices set by providers in these kinds of specialties, going out-of-network frees them to bill patients at essentially any rate they choose. And, as would be expected, we see that physician specialties that are able to bill out-of-network have high charges compared to other doctors. For example, for most physician types, median charges are about double what Medicare pays for the same service. But for anesthesiologists and emergency medicine physicians, charges are about five times greater than the equivalent Medicare payment.

To be sure, many of these providers do still choose to join insurance company networks. That may be because they find it distasteful to bill patients directly or because they prefer the ease of collecting from insurers rather than patients. But when they do go in network, they appear to receive some of the highest in-network payment rates in the health care industry. Whereas the in-network payment rate across many similar specialties averages around 125 percent of the Medicare rate for the service, the available data suggest that the average in-network rate for anesthesiologists is roughly 350 percent the Medicare rate. For emergency medicine physicians it is roughly 300 percent the Medicare rate.

One way to understand these very high in-network rates is that these physician types exploit the fact that they could remain out-of-network to demand very high payment rates when they do go in-network – payment rates more than double what their peer physicians who cannot realistically plan to stay out-of-network receive.

Further, the impact is felt broadly by consumers of health care. Sometimes, an out-of-network care episode generates an eye-popping surprise balance bill that ends up in the news, but in many other cases, the insurer agrees to pay the very high charge, and this, along with high in-network rates, drives up premiums for everyone.

Policymakers who want to solve this problem need to correct the market failure and create an environment where these providers face a more typical set of incentives. There are two basic ways to approach the solution.

The first is to establish an amount that these physicians will be paid when they deliver care out-of-network. Policymakers should establish the out-of-network price for the relevant service, either directly or through arbitration; prohibit balance billing above this amount; and require the insurer treat this amount as in-network. The goal is not to establish the exactly “correct” commercial payment rate, but rather to establish conditions that diminish the attractiveness of the out-of-network option and lead these providers to go in-network or work with hospitals to get paid a normal rate. While there are a number of methodologies that can be used to establish this out-of-network price, it is critical that it not be set at a rate that is “too high” (either higher

than now or that locks in the current distorted rate), since that would drive up costs and frustrate the basic goal of restoring a market for these services.

The second approach is to get these types of providers out of the business of billing directly to patients or insurers, at all. Instead, they would be paid by the hospital or other facility in which they practice. Hospitals would negotiate with insurance companies for a rate that includes the services, and the hospitals would pay the anesthesiologists and other-facility based providers. An alternative version would require that facility-based providers establish contracts with all insurers that are in-network for the facility at which they practice.

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 analysis 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 facilities² 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.

Prevalence and Magnitude of Surprise Out-of-Network Bills

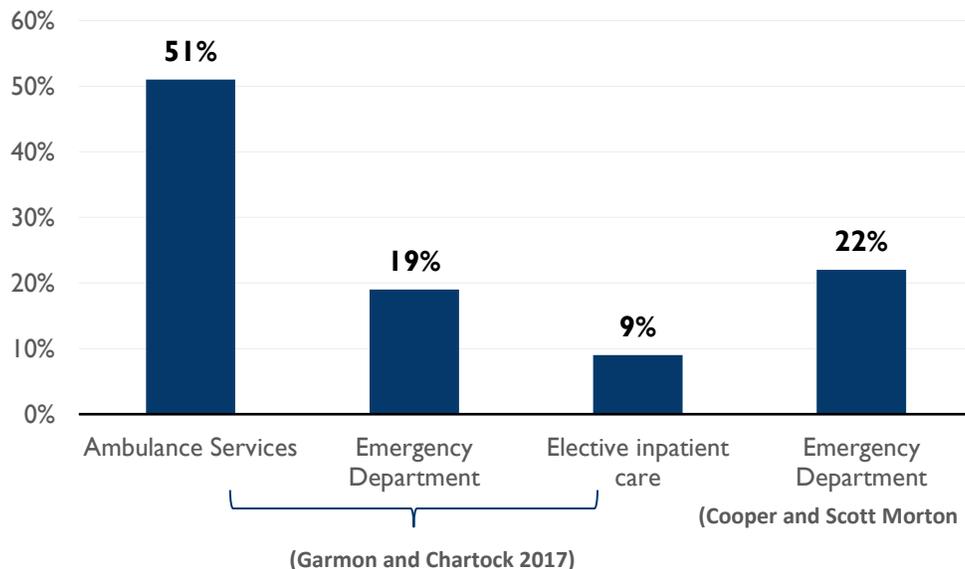
Health care services resulting in a potential surprise out-of-network bill are quite common. Three national studies all found that roughly 1 in 5 emergency department (ED) visits involved care from an out-of-network provider that could result in a surprise out-of-network bill if not

² The term “facility” encompasses hospitals, ambulatory surgical centers, and freestanding emergency departments.

The views expressed in this piece are those of the author and should not be attributed to the staff, officers, or trustees of the Brookings Institution.

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.^{6,7} 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.^{8,9}

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.

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.

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>.

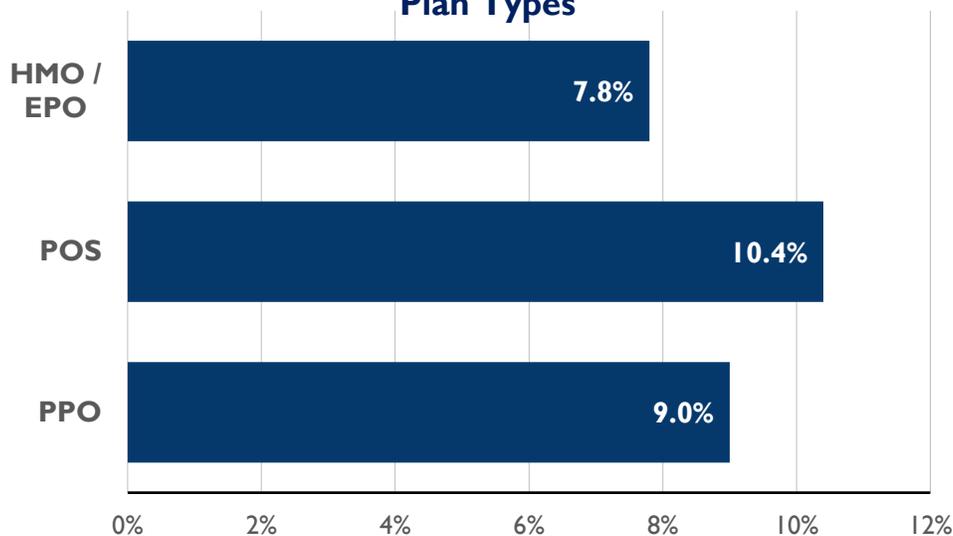
⁸ Garmon and Chartock, 2017.

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.

The views expressed in this piece are those of the author and should not be attributed to the staff, officers, or trustees of the Brookings Institution.

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

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

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/>.

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 whether the physician is in-network or not. While patients seeking emergency care usually go to a facility in their insurer's 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.

These providers, therefore, have a potentially lucrative out-of-network billing option that is unavailable to others. 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.¹⁸ For example, emergency medicine physicians who billed out-of-network for one large insurer averaged charges of nearly 800 percent of Medicare rates¹⁹ and the top 25 percent of anesthesiology claims billed to Medicare patients had billed charges more than 9 and a half times the Medicare rate (See Figure 3).²⁰

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.

¹⁵ Cooper and Scott Morton, 2016.

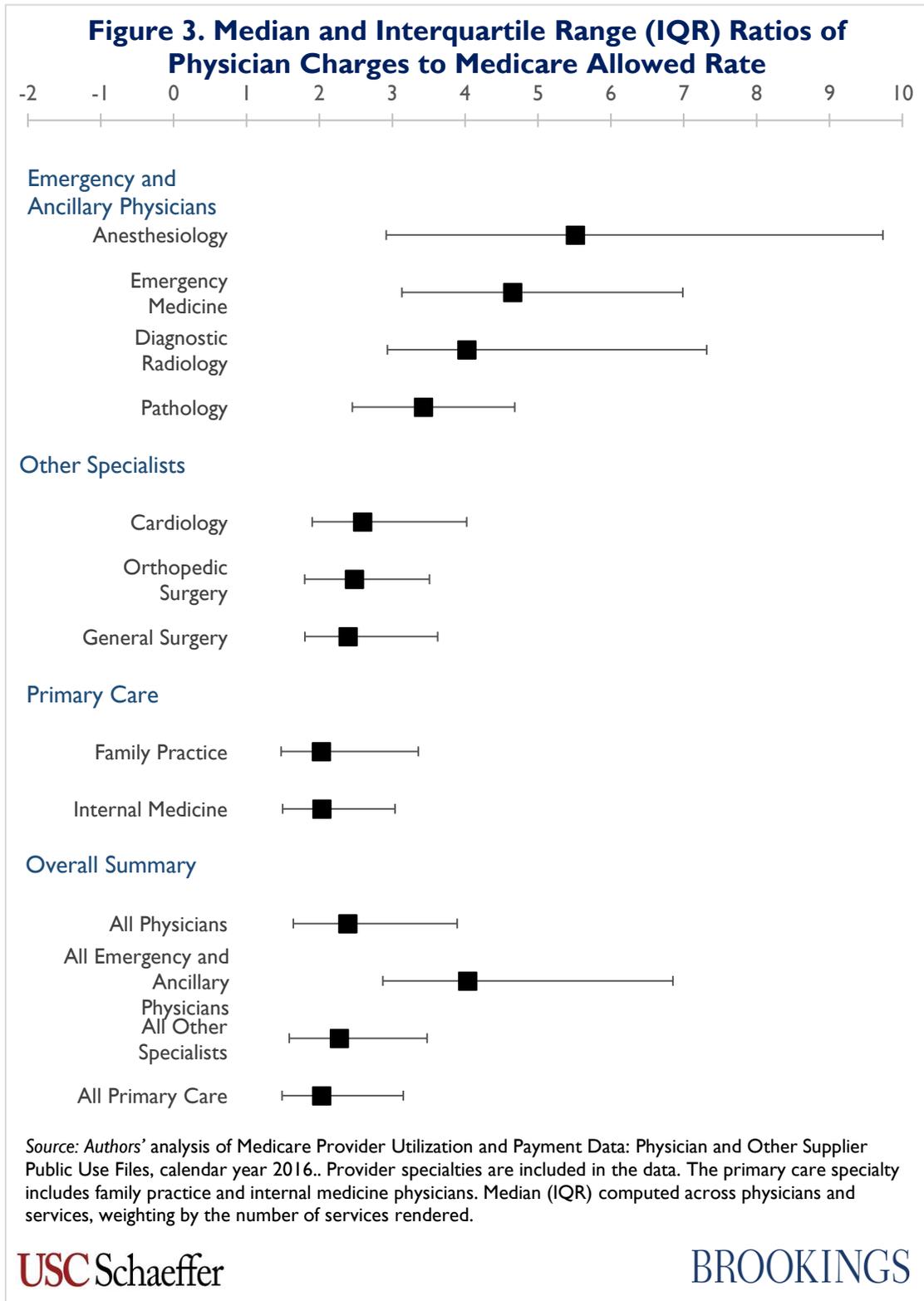
¹⁶ Some hospitals directly employ certain hospital-based physicians or utilize faculty at an academic medical center.

¹⁷ Indeed, in conversations with Schaeffer Initiative researchers, stakeholders indicated 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 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>.

¹⁹ Cooper and Scott Morton, 2016.

²⁰ Schaeffer Initiative researchers 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.



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. 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.

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 physicians²¹ appear to receive average contracted payment from commercial health plans at roughly 250 to 300 percent of Medicare rates,^{22,23,24} radiologists receive about 200 percent of Medicare rates,^{25,26} 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 2018.²⁷ 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.^{28,29} Another study using nationally representative survey data on medical expenditures found that employer-sponsored insurance payments for office visits provided by

²¹ 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.

²² 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>.

²³ Cooper and Scott Morton 2016.

²⁴ Cooper, Scott Morton, and Shekita, 2019.

²⁵ Trish, Ginsburg, Gascue, and Joyce, 2017.

²⁶ 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>.

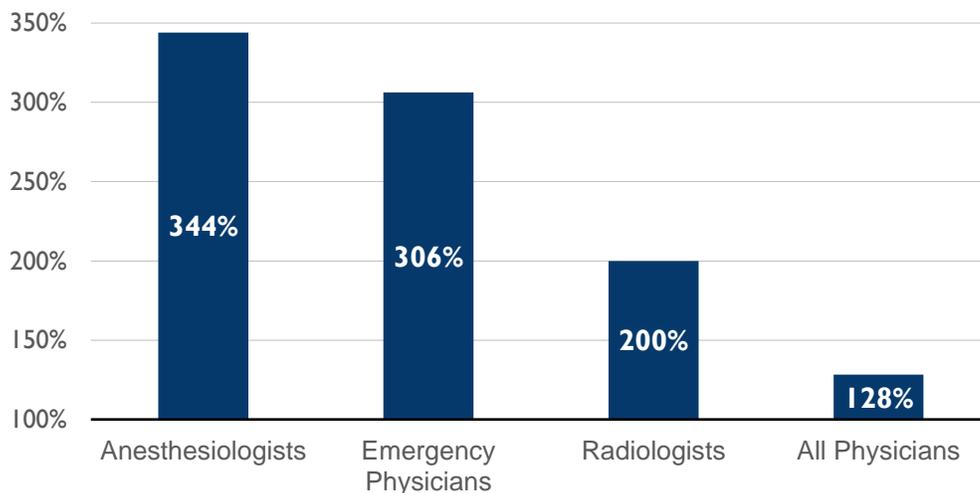
²⁷ Stead, Stanley W., Sharon K. Merrick. 2018. "ASA Survey Results for Commercial Fees Paid for Anesthesia Services—2018." *ASA Monitor* 10 2018, Vol. 82, 72-79. <http://monitor.pubs.asahq.org/article.aspx?articleid=2705479>.

²⁸ Trish, Ginsburg, Gascue, and Joyce, 2017.

²⁹ Pelech, 2018.

specialists averaged about 117 percent of Medicare,³⁰ 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.³¹ 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.

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

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, they may lack the market leverage necessary to insist on compliance.

³⁰ 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>.

³¹ MedPAC. 2017. "Report to the Congress: Medicare Payment Policy." March 2017. http://medpac.gov/docs/default-source/reports/mar17_entirereport.pdf.

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.³² For instance, a hospital that wanted to prohibit out-of-network billing by its contracted physicians might have to offer higher stipends, medical director fees, or other forms of direct payment.³³ 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.³⁴

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. However, because this would create such significant costs for the hospital, the increase in payment rates would likely need to be relatively large.

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 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.

³² 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 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.

³³ 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.

³⁴ 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.'"

The views expressed in this piece are those of the author and should not be attributed to the staff, officers, or trustees of the Brookings Institution.

Principles for Designing a Solution

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 four principles for a solution to surprise out-of-network billing.

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 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. A comprehensive approach would include:

- All out-of-network emergency care,³⁵ whether the facility is in- or out-of-network (including out-of-network facility fees);
- Post-stabilization services at an out-of-network facility (including facility and professional fees);³⁶
- All out-of-network emergency ambulance transport;
- 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

³⁵ 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.

³⁶ 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.

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 proposals create an exception from prohibitions on balance billing if the medical provider gives notice. 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 many settings, as there is no reason to think that patients would ever opt for out-of-network care when they are not otherwise choosing their provider. 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.

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. Attention should be paid to how any new standards will be enforced.

Analyzing Potential Policy Approaches

There are two broad policy approaches that can address surprise out-of-network billing in a comprehensive manner. The first, termed “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, plans would be required to treat such services as in-network for purposes of enrollee cost-sharing. The second approach, termed “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 contracting with health plans or billing patients directly.

Billing Regulation

Billing regulation combines two key elements:

The views expressed in this piece are those of the author and should not be attributed to the staff, officers, or trustees of the Brookings Institution.

- Limit the amount that a provider can receive for delivering a given out-of-network service; and
- Require 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.³⁷

The first step – limiting provider payment for out-of-network services – can be accomplished as either a limit on the amount the provider can charge when care is delivered out-of-network (a maximum amount charged or charge limit), or as a requirement that the health plan pay a minimum amount combined with a prohibition on provider balance billing (a minimum payment owed or payment standard) These approaches are functionally equivalent; this analysis will refer to charge limits.

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, which is described in some detail below.

General Considerations in Setting a Charge Limit or Payment Standard

Charge limits can be established in one of two ways: directly specifying a limit or specifying an arbitration process. The first approach is simpler and more transparent, although 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

³⁷ 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.

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. This analysis 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 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.³⁸ Further, hospitals can become involved in the negotiations between clinician groups and health plans. If facility-based ED or ancillary clinician out-of-network 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.³⁹ 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 these mechanisms should ultimately help augment any rate set “too low” toward the “normal market” rate.⁴⁰ Importantly, there is evidence that the payments from facilities to clinicians for contracted services are today often related 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.⁴¹ 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

³⁸ American Academy of Emergency Medicine. 2005. “The Business of Emergency Medicine—Made Easy!” <https://www.aaem.org/UserFiles/file/thebusinessofem.pdf>.

³⁹ 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.

⁴⁰ 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.

⁴¹ American Academy of Emergency Medicine. 2005. “The Business of Emergency Medicine—Made Easy!” <https://www.aaem.org/UserFiles/file/thebusinessofem.pdf>.

fair market transactions to avoid running afoul of state and federal self-referral and anti-kickback laws.

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, this is unlikely to be a concern. 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.

Ultimately, 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 referral fee laws could be an obstacle to some extent. Despite this legal/contractual complication, where there is uncertainty about the appropriate charge limit, the availability of hospital “topping off” payments or negotiating on behalf of physician groups in establishing in-network contracts gives policymakers reason to lean toward setting a lower limit rather than a higher limit.

Specific Options for Directly Setting a Charge Limit

It is now useful to consider three different prices that are commonly considered as the basis for directly setting a charge limit: Medicare rates, billed charges, and contracted rates.

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.⁴² 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.^{43,44} 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

⁴² 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>.

⁴³ Trish, Ginsburg, Gascue, and Joyce, 2017.

⁴⁴ Pelech, 2018.

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,⁴⁵ had median charges of 465 percent and 551 percent of Medicare payment rates, respectively, in 2016, based on a USC-Brookings Schaeffer Initiative analysis of Medicare claims data, compared to an average across all non-emergency medicine or ancillary specialists of 227 percent (See Table 1).

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.

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.

⁴⁵ 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.

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

The views expressed in this piece are those of the author and should not be attributed to the staff, officers, or trustees of the Brookings Institution.

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 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, policymakers 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 charge limit could be based 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 policymakers 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.⁴⁶ 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

⁴⁶ 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.

have pursued and has been proposed federally by Sen. Maggie Hassan and Rep. Michelle Lujan Grisham.⁴⁷ 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.

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 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.^{48,49} 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.

⁴⁷ 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/>.

⁴⁸ 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.

⁴⁹ Monhait, J. 2013. “Baseball Arbitration: An ADR Success.” *Harvard Journal of Sports & Entertainment Law*, 4:105- 43.

Contracting Regulation

The material above described “billing regulation” approaches that can be used to address surprise out-of-network billing. It is useful to consider 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, termed “contracting regulation” approaches.

There are two main “contracting regulation” approaches, both of which would likely have relatively similar effects on both provider payment and patients’ experiences. Notably, though, neither of these contracting regulation approaches would address surprise bills for patients brought to the emergency department at an out-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).

The views expressed in this piece are those of the author and should not be attributed to the staff, officers, or trustees of the Brookings Institution.

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.

Prohibiting Independent Facility-Based ED and Ancillary Clinician Billing

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.⁵⁰ 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.

⁵⁰ 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.

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 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.

Stark and Anti-Kickback Laws

Some of the policy solutions described above may expand or create new fund flows from hospitals to other clinicians, and so 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 new legislation 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. Policymakers may also wish to consider whether modifications to these federal laws are necessary.

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.⁵¹

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.⁵² Anecdotal reports suggest that ambulance balance-billed amounts may be increasing.⁵³ Most egregious are air ambulance bills, which often amount to several tens of thousands of dollars. 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.^{54,55}

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 cost-sharing amounts.

Considerations for States

A number of states have enacted legislation that targets surprise out-of-network billing, generally using some version of the billing regulation approaches described above. Several specific considerations apply to state policymaking in this area.

First, preemption under ERISA—which bars states from regulating self-insured employer health plans—will be a major consideration for any state considering regulation of surprise out-of-network billing. 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.⁵⁶ Thus, states are permitted to regulate the conduct of health care providers even when they treat patients covered

⁵¹ 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>.

⁵² Garmon and Chartock, 2017. See Supplemental Appendix Exhibit A1.

⁵³ 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>.

⁵⁴ James, Sha’Ron. 2018. “Emergency Medical Transportation Costs in Florida.” *Florida Insurance Consumer Advocate*. <https://www.myfloridacfo.com/Division/ICA/EMTWhitePaper.pdf>.

⁵⁵ 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/>.

⁵⁶ *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995).

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

Some 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. However, to the extent a state wants to regulate what payers pay to providers or how payers treat consumer cost-sharing amounts, it must be careful to apply those standards only to fully-insured rather than self-insured plans.

State can take steps to limit the extent to which their regulation targets plans, rather than providers, and can thereby extend some meaningful protections to residents in self-insured plans. Specifically, billing regulation approaches that limit the amount a provider can charge (rather than establishing a minimum amount a plan must pay) are a particularly promising way for a state to design around ERISA preemption. To date states have not explored this option. State can also consider approaches that allow self-insured plans to opt in to a state regulatory scheme, and some enacted state laws contain this feature. That said, ERISA does still constrain state flexibility to enact comprehensive solutions.

A second consideration is the state’s own accumulated body of insurance law and standards regarding the practice of medicine. State limitations regarding the corporate practice of medicine and insurance “provider protections” that govern the relationship between health plans and physicians could frustrate the state’s surprise billing policy if not addressed. Finally, an evolving challenge for states is how to address situations where their residents receive care at an out-of-state facility, which can occur frequently in some regions.

Recommendations for Action

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

Option #1: Billing Regulation Only

The first option is a pure billing regulation approach. Under this approach, policymakers 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, 125 percent of the relevant Medicare rate could

constitute a reasonable limit. Policymakers could modify the multiple, either nationwide or by state or market area, to reflect local market conditions.

- Require 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, policymakers 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—the policy 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 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).