A Targeted Approach to
Surprise Medical Billing

By Doug Badger and Brian Blase

December 2019

GALEN INSTITUTE

P.O. Box 130

Paeonian Springs, VA 20129

www.galen.org

(703) 687-4665

galen@galen.org

https://galen.org/assets/A_Targeted_Approach_To_Surprise_Medical_Billing.pdf

December 2019

A Targeted Approach to Surprise Medical Billing

By Doug Badger and Brian Blase

EXECUTIVE SUMMARY

Surprise medical bills are a source of frustration for many Americans. There are several circumstances in which patients are exposed to such "surprises." The first occurs when people receive treatment at a network facility and subsequently receive a balance bill for treatment in that facility from a non-network provider. A second occurs when people receive a large bill after receiving scheduled treatment without having been provided an estimate before they received the care.

In this essay, we lay out a truth-in-advertising requirement to address the first surprise and a good faith price estimate in advance of receiving scheduled care to address the second surprise.

Truth-in-advertising protections combined with a good faith estimate requirement leaves one scenario in which patients need protection from surprise medical bills—emergency services at out-of-network facilities. Patients should be protected from balance billing in this situation, and Congress should apply existing federal regulations to determine the rate that insurers compensate providers.

Congress should not enact an arbitration model, which has a host of problems, including imposing contractual terms on parties that have not entered into a contract. It should reserve rate-setting to the circumstance in which a patient receives emergency care at a non-network hospital.

In sum, we propose that government protect patients from surprise bills primarily by preventing insurers and providers from giving false and misleading information to consumers and by requiring that consumers be informed of prices before they receive scheduled care.

Background on surprise bills

Surprise bills most commonly arise in connection with emergency care, whether or not the hospital is in network, although they also can occur in connection with scheduled medical care at network facilities. In both cases, a non-network physician—an emergency department doctor with privileges at a network emergency facility, for example—issues an unexpected bill to a patient after the insurer has generally paid a portion. Patients unexpectedly subjected to this practice, known as "balance billing," can face large bills, which, in rare cases, can amount to tens or even hundreds of thousands of dollars.[1]

The extent of this practice is difficult to measure. A 2017 study suggested that balance billing for emergency care appeared to be limited to a relatively small number of hospitals. Specifically, it found that half of hospitals issued surprise bills less than 2% of the time. However, according to this study, at 15% of hospitals, surprise bills were issued at least 80% of the time.[2] It's unclear whether surprise billing has become more widespread over the past few years.

Status of congressional efforts to curb surprise medical bills

Congress and numerous state legislatures have rightly sought to curb the practice of surprise bills. Several key congressional committees have spent time this year pursuing solutions to the problem of surprise medical bills.[3] Legislation appeared to be on a fast track early in the year but has since slowed. The delay is primarily due to a stand-off between the two powerful interest groups that often benefit from surprise medical bills: providers and insurers. Each has advanced a proposal that favors its interests at the expense of the other. Each has lobbied aggressively enough to confound congressional action thus far. Of note, large employers are often seeking a solution to surprise bills and have generally sided with insurers.

[1] A case in which a privately insured patient received a bill for nearly $109,000 after being treated at a non-network emergency department is just one example of this practice. https://www.npr.org/sections/health-shots/2018/08/31/643342598/his-109k-heart-attack-bill-is-now-down-to-332-after-npr-told-his-story

[2] Zack Cooper, Fiona Scott Morton, and Nathan Shekita, "Surprise! Out-of-Network Billing for Emergency Care in the United States," NBER Working Paper 23623, July 2017, revised January 2018, pp. 19, 20 and 52 (Figure 1). https://www.nber.org/papers/w23623.

[3] The House Energy and Commerce Committee favorably reported HR 2328 on July 17, 2019. https://www.congress.gov/116/bills/hr2328/BILLS-116hr2328ih.pdf. The Senate HELP Committee favorably reported S 1895 on July 8, 2019. https://www.congress.gov/116/bills/s1895/BILLS-116s1895rs.pdf

GALEN INSTITUTE

Complicating the political calculus, Congress has its own interests. Laws authorizing some politically popular programs require renewal, and lawmakers need to identify provisions that the Congressional Budget Office (CBO) believes will save enough money to "pay for" extending these programs. CBO has estimated that both the House and Senate surprise billing measures would finance reauthorization of these expiring programs.[4] That provides Congress a rare opportunity to pay for extending politically-popular programs by tackling the politically-unpopular practice of surprise billing. Members are loath to pass up that opportunity. A solution to the surprise billing problem that protects patients and minimizes unintended consequences would be a win for Congress. While Congress should generally look for savings from federal programs, the surprise billing proposals should be evaluated on their own merits and not whether they provide offsetting savings for Congress to spend on other priorities.

Median network rate—The insurers' preferred solution

One proposal generally favored by insurers is for the government to set a maximum rate for out-of-network care, such as using the median in-network rate. Included with this approach, non-network providers could not balance bill patients for emergency services; nor could they balance bill for non-emergency services that they provide in network facilities.

Providers would instead be required to accept an insurer's median network rate (along with the patient's in-network cost-sharing amounts) as payment in full. Put another way, a doctor who *does not have a contract* with an insurance company must accept a rate that is less than what that same insurer pays half the doctors with whom it *does have a contract*.[5]

S. 1895, which was favorably reported by the Senate HELP Committee in July 2019, takes this approach to surprise medical bills. CBO estimates that this

[4] Using savings deriving largely from its surprise billing provisions, HR 2328 would extend funding for public health programs including those that support health centers and health education; extend funding for several programs financed through the Medicare trust funds, change some other aspects of Medicare, and change supplemental coverage for some military retirees; reduce scheduled funding cuts to state allotments to hospitals that treat a disproportionate share of uninsured and Medicaid patients; and increase funding for Medicaid in the U.S. territories. S. 1895 would extend funding for community health centers and certain other federal health care programs.

[5] While the HELP Committee bill applies the median network rate paid by a particular insurer in a particular area, it does not exhaust the rates that Congress might impose on providers. For example, Congress could require that insurers pay non-network providers the median rate paid by *all* insurers in the area. It could also apply a higher rate (e.g., 120% of the median) or a lower one (e.g., 110% of Medicare rates). Finally, it can employ a hybrid approach, requiring a median network rate but allowing arbitration in cases where the amount in dispute exceeds $1,250. The House Energy and Commerce bill takes this approach.

policy would reduce the federal deficit by $24.9 billion over ten years.[6] That savings is sufficient to finance reauthorization of funding for community health centers and certain other expiring federal health programs and still deliver $7.6 billion in deficit reduction over the next decade.[7] The House bill, which differs in some ways from its Senate counterpart, would fund reauthorization of many of the same programs and achieve some deficit reduction.[8]

Insurers and some big employers have generally been those most supportive of this proposal. By requiring non-network physicians to accept an insurance company's in-network rate and prohibiting those same physicians from billing patients at higher rates, the government would be offering physicians a powerful inducement to join networks organized by health insurers. In addition, the House bill would tie changes in the median network rate to the rate of growth in the consumer price index.[9] The pace of CPI-U growth lags that of payment rates for network providers.

All else equal, those changes would translate into lower premiums. CBO projects a net reduction in premiums of around 1%.[10] That would reduce federal spending on premium subsidies for exchange-based coverage. It also would reduce premiums in the employer-sponsored health insurance market. Lower premiums would translate into higher federal revenues. That is because the portion of employee compensation devoted to health coverage, which is exempt from federal income and payroll taxes, would decline, and employee income, which is taxable, would therefore rise.

Many provider organizations and physicians object to this approach because, in addition to transferring leverage to insurers, it would hamper their ability to collect fees that they consider reasonable for the services they supply as non-network providers.

---

[6] CBO Cost Estimate, S. 1895, the Lower Health Care Costs Act, July 16, 2019, p. 1. https://www.cbo.gov/system/files/2019-07/s1895_0.pdf

[7] Ibid.

[8] The surprise billing provisions of HR 2328 differ somewhat from its Senate counterpart. In addition to requiring non-network providers to accept a median network rate in certain circumstances, it would allow parties to appeal to an independent dispute resolution process in cases where the amount in dispute between the insurer and provider exceed $1,250. CBO concluded that this would reduce savings associated with imposing the median network rate on certain non-network providers by 25%. The savings associated with the House surprise billing legislation total $21.9 billion, compared with $24.9 billion for the Senate bill. CBO Cost Estimate, HR 2328, Reauthorizing and Extending America's Community Health Act, pp. 6-12. https://www.cbo.gov/system/files/2019-09/hr2328.pdf

[9] CBO, HR 2328, p. 7

[10] CBO, S. 1895, p. 3.

It would, consequently, disserve their financial interests, for the same reasons that it supports the financial interests of insurers and employers.

The experience of California suggests that imposing network rates on non-network physicians does tilt the playing field to the benefit of insurers. A 2017 law requires fully insured plans to pay non-network physicians at in-network hospitals the greater of the insurer's contracted rate or 125% of the Medicare rate. A study by the USC-Schaefer Brookings found a 17% reduction in out-of-network bills filed by practitioners in the medical specialties most directly affected by the law (anesthesiology, diagnostic radiology, pathology, assistant surgeons and neonatal-perinatal medicine).[11] The study's authors, however, said that they had insufficient data to assess the impact of the law on the cost of care.[12]

There are cogent policy reasons to oppose government setting the rates for out-of-network care. The government operates numerous large programs—Medicare and Medicaid, for example—in which it sets prices for medical services. These administered prices have caused numerous problems. First, the prices are often not a reflection of market dynamics and thus are often set either too high (leading to excessive utilization) or too low (leading to lack of available treatments).[13] Second, the prices are subject to intense political pressure from interested parties and thus fail to adjust to changing market dynamics in a way that aids innovation and beneficial disruption. Third, the government-set prices have not arrested spending growth in these programs, which continue to increase at unsustainable rates.[14] In sum, this approach has failed to make these programs function efficiently, and administered prices are

[11] Loren Adler, Erin Duffy, Bich Ly and Erin Trish, "California Saw Reduction in Out-of-Network Care from Affected Specialties after 2017 Surprise Billing Law," USC-Brookings Schaeffer on Health Policy, September 26, 2019. https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/09/26/california-saw-reduction-in-out-of-network-care-from-affected-specialties-after-2017-surprise-billing-law/.

[12] "Unfortunately, given the limited time post-implementation, we are unable to comprehensively evaluate how such recent state policies may have impacted network breadth, the cost of care, and other market dynamics." Adler, et al., "California Saw Reduction in Out-of-Network Care."

[13] Medicare's underpayment of primary care physicians has led to projections of shortages of such physicians. That shortage, ironically, extends to geriatricians, despite the trillions in Medicare dollars spent on seniors. See, for example, Adam Golden, Michael A. Silverman and S. Barry Issenberg, "Addressing the Shortage of Geriatricians," *Academic Medicine*, September 2015. https://journals.lww.com/academicmedicine/FullText/2015/09000/Addressing_the_Shortage_of_Geriatricians___What.22.aspx

[14] Health care entitlements are the largest and fastest-growing portion of the federal government, eclipsing social security, defense spending and non-defense discretionary spending. See "Historical Budget Data," Congressional Budget Office, May 2019, tabs 4 and 5. https://www.cbo.gov/about/products/budget-economic-data#2

See also "Ten-Year Budget Projections," Congressional Budget Office, August 2019, tables 1-4 and 1-5. https://www.cbo.gov/about/products/budget-economic-data#2

GALEN INSTITUTE

among the reasons for this failure. Given the concerns with government rate-setting, it is unwise policy to import these rates into the private market.

There are even more reasons to be concerned about extending government rate-setting to private transactions. Government is not party to transactions between commercial insurance companies and doctors, and it does not finance these transactions. Despite the regulatory and financial control it exerts over the provision of medical services largely through Medicare and Medicaid, the federal government has thus far refrained from dictating what a doctor may bill a privately-insured patient for such services.

Congress appears poised to expand the federal government's reach in this manner without properly examining the consequences. It seems narrowly focused on prohibiting the politically unpopular practice of balance billing in a way that expands government's power and secures CBO's certification that it has "paid for" reauthorizing certain expiring programs.

This blinkered approach misses broader implications. Government rate-setting may save money, although that assumes that physicians and hospitals can't find ways that haven't occurred to CBO analysts to wring additional money out of insurers and consumers. Private actors are no less adept than Congress at finding offsets.[15] Even if it succeeds, the effect of resorting to this approach could be lasting and profound. If Congress makes rate-setting the solution to surprise bills, which consumers rightly resent, it may be difficult to explain why it shouldn't adopt the same approach to medical bills that aren't surprises, which consumers also often find unpleasant. Therefore, Congress should pause its efforts and fully consider the consequences if it plans to impose this approach for non-emergency care. If Congress does move in this direction, it should clearly delineate the limits of its rate-setting approach, such as for emergency care at non-network hospitals. Applying it broadly to all categories of surprise bills will affect negotiations between insurers and physicians. Government should not tilt these negotiations in favor of either party.

CBO's take on a median rate benchmark

CBO believes that requiring non-network physicians to accept the median

[15] One observed practice that appears to have occurred in response to the ACA's attempt to deal with surprise medical bills arising from emergency care is an increase in the use of imaging and the percentage of patients admitted for in-patient care. Zack Cooper, Fiona Scott Morton and Nathan Shekita, "Surprise! Out-of-Network Billing for Emergency Care in the United States," NBER Working Paper 23623, July 2017, revised January 2018, p. 26. https://www.nber.org/papers/w23623

network rate for emergency services and for non-emergency care provided at network hospitals will have broad effects. It found that both the House and Senate bills, although they adopt slightly different approaches to rate-setting, would lead to a convergence in private insurance reimbursement of affected physicians.

First, according to CBO, non-network physicians in affected specialties would face new pressures to join insurance networks. Those who join an insurer's network will at least be able to negotiate their rates. Those who do not join the network will be paid an amount that is less than what that the insurer pays half the physicians who join the network.[16]

Second, according to CBO, insurers would likely reduce payments to network physicians who currently are reimbursed above the median rate and increase payments to network physicians who currently are reimbursed below the median rate.

Third, the House bill would achieve budgetary savings in part by linking the growth in median network rates to the overall inflation rate.[17] CBO believes that this would represent a cut in insurance payments to network physicians over time.

Thus, according to CBO, a provision designed to reduce patient cost-sharing for certain services provided by *non-network physicians* will achieve budgetary savings by reducing private insurance payments to *network physicians* over time.

Arbitration—The providers' preferred solution

Providers, too, are seeking a form of rate-setting, albeit one they find more congenial to their interests. They advocate binding arbitration.[18] Under this approach, a government-appointed arbiter would settle disputes between non-network providers and insurance companies, and providers would be prohibited from balance billing patients for emergency care or for non-

[16] While CBO's forecasts about behavioral effects are admittedly speculative, there is evidence that this is what happened in California. In response to a 2017 law setting rates for non-network medical care provided at network facilities, that state saw an abrupt decline in bills from non-network physicians in the affected specialties.

[17] CBO, HR 2328, p. 8.

[18] For example, Raul Ruiz (D-CA) and Phil Roe (R-GA) have sponsored the "Protecting People from Surprise Medical Bills Act." The measure would ban balance billing for non-emergency care at network facilities and for emergency care at any facility, regardless of whether it is part of an insurer's network. Insurers and physicians would have to negotiate a reasonable level of reimbursement. Failing that, either party can trigger an independent dispute resolution process before arbiters selected by the Labor and HHS secretaries. The decisions of the arbiters would be binding on both parties. https://roe.house.gov/uploadedfiles/ruiz-roe_surprise_billing_legislation_section_by_section.pdf

emergency services provided at a network hospital. The patient would be responsible only for network cost-sharing rates.

The provider and insurer would then try to arrive at a mutually-agreeable rate for the services. If that fails, they would present their respective offers to a federally certified arbiter. The arbiter would then choose one or the other as the more reasonable rate. The arbiter's decision would be binding on both parties, who would not have recourse to judicial review.

This approach suffers from many of the same flaws as rate-setting. First, it involves government imposition of contractual obligations on non-contracting parties. Arbitration is ordinarily something to which contracting parties agree in advance. This is true, for example, in baseball arbitration to which this approach is often erroneously compared. Major League Baseball contracts, like many others throughout the economy, include provisions defining circumstances in which parties agree to submit their disputes to arbitration and to bind themselves to an arbiter's ruling.[19] Here, the government would impose on two parties who have refused to contract with each other (an insurer and a doctor or a facility that has not joined an insurer's network) a process to which neither has agreed.

Second, this approach effectively outsources rate-setting to government-certified "experts" who are presumed to be impartial and wise. Instead of setting rates directly, the government would deputize arbitrators to set medical prices on an ad hoc basis.

Advocates of this approach say that, over time, fewer cases would be brought to arbitration. That does not appear to be the experience in New York State, where arbitration is required for resolution of these bills.[20] But if the number of cases brought to arbitration were to decline over time, it might indicate nothing more than that the parties have learned through trial and error the prices that the arbiter has selected. Once an insurer or provider has won

[19] In the arbitration process used by Major League baseball, a player with at least three (in most cases), but fewer than six, years of major league experience is eligible for arbitration. Unlike players eligible for free agency, the player is only permitted to negotiate with his current team. Under terms of the collective-bargaining agreement, a player and owner who bargain to impasse are bound to present their final offers to an arbitration panel. The panel picks the more reasonable offer of the two. (http://m.mlb.com/glossary/transactions/salary-arbitration) Thus, in "baseball arbitration" the two parties are under contract and are bound by a collective bargaining agreement that requires the inclusion of an arbitration clause in the standard contract. This bears little resemblance to the arbitration regime envisioned here, where there is neither a contract between the parties nor a collective bargaining agreement stipulating the circumstances under which the parties must submit to arbitration and waive their rights to judicial review.

[20] Rachel Bluth, "To End Surprise Medical Bills, New York Tried Arbitration. Health Care Costs Went Up." NPR, November 5, 2019. https://www.npr.org/sections/health-shots/2019/11/05/776185873/to-end-surprise-medical-bills-new-york-tried-arbitration-health-care-costs-went- The article cites an analysis by New York's Department of Financial Services, which found that the number of arbitration cases rose from 115 in 2015 to 1,014 in 2018.

a few cases, both sides know the arbiter's personal preferences. Since the government has conferred plenary price-setting authority on the arbiter, it is generally futile, in addition to being costly, to continue to bring similar cases to arbitration. The arbiter's preferred rates may not be reduced to a schedule the way Medicare rates are, but over time those rates will become clear to insurers, doctors and hospitals in the arbiter's domain.

In New York, it also appears that arbitration has led to growing prices over time, as the arbiters were instructed to consider the 80th percentile of *billed* charges.[21] CBO estimates that arbitration would increase payments by 5% and increase the federal deficit by "double digit billions."[22]

A new approach to surprise medical bills

Congress is essentially being asked to choose between—or combine—two forms of rate-setting, one favored by insurers and the other by providers. It should largely reject both approaches.

The following table lays out a better alternative, one that is more targeted and that principally relies on transparency to protect consumers against surprise bills. The table segments the surprise billing problem into four distinct categories, depending on the network status of the facility and on whether the medical services whose prices are at issue are emergency or non-emergency. Surprise bills would be banned in all four categories, although by somewhat different means.

GALEN INSTITUTE

[21] Loren Adler, Erin Duffy, Paul B. Ginsburg, Mark Hall, Erin Trish and Kristen Linke Young, "Rep. Ruiz's Arbitration Proposal for Surprise Billing (HR 3502) Would Lead to Much Higher Costs and Deficits," *Health Affairs*, July 16, 2019. https://www.healthaffairs.org/do/10.1377/hblog20190716.355260/full/

[22] Peter Sullivan, "Fix Backed by Doctors for Surprise Medical Bills Would Cost Billions," *The Hill*, September 24, 2019. https://thehill.com/policy/healthcare/462833-cbo-rival-fix-for-surprise-medical-bills-costs-double-digit-billions

Surprise Billing Recommendations

	In-Network	Out-of-Network
Non-emergency care	**Disclosure (up front price information)** and penalties on false and misleading information about network status. For scheduled care, facilities and providers would be required to provide a good faith estimate. Moreover, penalties would be established on insurers who represent facilities, and on facilities that represent themselves, as being in-network when they permit balance billing for services delivered at that facility.	**Disclosure (up front price information).** For scheduled care, facilities and providers would be required to provide a good faith estimate. Facilities and providers cannot balance bill patients after delivering non-emergency services unless they provided them with good faith estimates of balance billed amounts before providing the services.
Emergency care	**Penalties on false and misleading information about network status.** Penalties would be established on insurers who represent facilities, and on facilities who represent themselves, as being in-network when they permit balance billing for services delivered at that facility.	**Prohibit balance billing and require reasonable reimbursement.** Facilities and providers could not balance bill for any emergency services, as defined in EMTALA. Insurers would be required to provide facilities and providers with reasonable reimbursement for such services, as defined in existing regulations (45 CFR 147.138(b)(3)(i)).

Balance billed amounts refer to what the provider bills the patient minus what the insurer pays.

GALEN INSTITUTE

Services at network facilities (emergency and non-emergency)

Consumers understand that there are financial benefits to getting care at network hospitals. Those advantages include both lower cost sharing and the guarantee that out-of-pocket spending will be counted against their deductible and out-of-pocket limits. They also understand that they lose those advantages when they seek care at non-network facilities. Those facilities can present them

with bills their insurer won't pay in full, and payments generally won't count toward their deductible or out-of-pocket limits.

For these reasons, consumers typically prefer network facilities and try to ensure that they receive care in facilities, and from providers, that are in-network. They generally rely on representations from their insurance company and from the facility itself as to network status. Relying on these representations, they most often schedule medical care from a network doctor at a network facility.

What they're often not told (or are unaware of) is that other doctors—anesthesiologists, radiologists and pathologists, for example—who practice at network facilities may not be part of their insurer's network. Since these doctors lack a contractual arrangement with the insurer, they can present patients with balance bills.

It is reasonable to conclude that in these circumstances, insurers and facilities have provided consumers with incomplete and misleading information. Consumers who rely on this information may face unexpected financial penalties, raising truth-in-advertising concerns.

It is appropriate for Congress to protect consumers against false and misleading information. One way to do this would be to establish penalties against any insurer that represents a facility as being in-network, and against any facility that represents itself as being in network, if the facility allows doctors to balance bill patients for services provided at that facility. These penalties would apply to all medical services at network facilities, whether emergency or non-emergency.

This approach would hold insurers and facilities accountable for the information they provide consumers. A consumer who schedules medical services by a network doctor at a network facility should pay network cost-sharing rates for every service or procedure provided in that facility.

The virtue of this approach is that it identifies why surprise billing is problematic and unfair. Consumers would benefit by being able to rely on representations of a facility's network status. Knowing that they will be responsible only for network cost sharing at network facilities empowers them to make informed choices.

This would not involve direct or indirect government rate-setting, unlike approaches Congress is currently considering. It would, however, require hospitals, doctors and insurers to establish private arrangements that protect consumers against false and misleading representations.

GALEN INSTITUTE

All three parties have identifiable interests and considerable leverage: insurers need hospitals in their networks, hospitals benefit from additional volume that comes from participating in a network, ancillary physicians need privileges at hospitals (emergency physicians, for example, need emergency departments to treat patients), and hospitals need to grant privileges to ancillary physicians to stay in business (without anesthesiologists, for example, a hospital would have to shutter its operating rooms). All three parties—insurers, hospitals, and doctors—have financial leverage and incentives to cooperate with the other parties, the essential ingredients for a market-based solution. They should be left to construct mutually beneficial arrangements, rather than having rates imposed by Congress or government-appointed arbiters.

Some would argue that those who practice in medical specialties that are in high demand, such as anesthesiologists, may negotiate much higher rates with insurers to compensate for the revenue lost due to the balance-billing ban. That is certainly a possibility. Some markets may be dominated by a single anesthesiology practice, just as some markets may be dominated by a single hospital system or a single insurer. Rectifying instances in which a particular industry segment has acquired pricing power, however, is best addressed by antitrust regulators whose mission is to ensure competitive marketplaces as well as governments eliminating barriers to competition.[23]

Transparency for non-emergency services (both in and out of network)

There is a second fundamental unfairness about medical bills for non-emergency services, whether they are provided at network or non-network facilities. Unlike virtually every other service in our economy, consumers don't know the prices (including the prices their insurer has negotiated or their share of those prices) of non-emergency services until long after those services have been provided. This is the second surprise in surprise medical bills.

Congress can address this by requiring providers to supply a good-faith estimate of the costs of a scheduled procedure before it occurs, unless the

[23] For a discussion of dozens of ways that policymakers—at both the federal and state levels—can reduce barriers to entry and competition, see the Trump Administration's report, "Reforming America's Healthcare System Through Choice and Competition." https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf An entity that has substantial pricing power is one that provides a rare or unique product or service with few rivals in the market. An increase in the price for services the entity provides may not affect demand because there are no alternative products on the market that consumers can choose instead. See Will Kenton and Caroline Banton, "Pricing Power," Investopedia. https://www.investopedia.com/terms/p/pricingpower.asp

patient affirmatively declines to receive such an estimate.[24] The estimate, which in the case of facility-based services would be supplied by the facility, would include allowed charges for that procedure. Providers and facilities would be required to produce such an estimate within 48 hours of a request or at the time a service is scheduled, unless the patient refuses it. Providers who don't give patients a good faith estimate in advance would be prohibited from balance billing for that service after the fact.

Good faith estimates are commonplace. Plumbers, contractors, auto mechanics, dentists, and other professionals routinely provide them to consumers. The medical system is unique in withholding price information from consumers until weeks or months after the provision of services. Ending this practice would empower consumers to take more control over their health care decisions.

Price transparency would impose administrative costs on hospitals and medical practices. People who now generate after-the-fact bills would have to use similar processes to assemble good faith estimates before the provision of care. But the costs should be relatively minor, and the advance price estimates would rectify longstanding and costly distortions caused by medical price opacity and should save administrative costs on the back-end of claim and billing resolution. Consumers who take the time to obtain estimates will have the information they need to choose between providers, a process that should encourage provider efficiency, leading to price reductions over time. These savings will likely be more than sufficient to offset the administrative costs of giving consumers information they deserve.

Some will argue that such estimates are impossible because of various complications that may arise in the course of a medical procedure. But that is a problem common to estimates provided in advance in virtually every industry. A plumber may find complex and costly problems in repairing what was thought to be a simple leak, for example. The good faith estimate is based on what the plumber knew at the time.

An estimate of the costs of a medical procedure carries similar uncertainties. A surgeon's office may know the allowed rate for gall bladder removal and base a good faith estimate on that price. But complications might arise in the

[24] The Centers for Medicare and Medicaid Services (CMS) on November 15, 2019, finalized a rule requiring hospitals to post a list of their negotiated rates with insurers beginning in 2021 as well as to provide a list of prices for the top 300 shoppable services in their facility in a consumer-friendly format. That same day, CMS proposed a rule requiring insurers to provide patients with what is essentially an advance explanation of benefits. "Calendar Year 2020 Hospital Outpatient Prospective Payment System (OPPS) Policy Changes: Hospital Price Transparency Regulations," CMS Fact Sheet, November 15, 2019. https://www.cms.gov/newsroom/fact-sheets/cy-2020-hospital-outpatient-prospective-payment-system-opps-policy-changes-hospital-price

course of surgery that require additional charges. In that case, the surgeon will have met his or her responsibility by supplying the patient with a good faith estimate in advance of the procedure.

Insurers, too, would have the obligation to translate the allowed rates into an estimate of the patient's cost-sharing responsibilities. Those obligations would vary across policyholders, depending, for example, on the benefit design, whether the policyholder had met an annual deductible and whether they were above or below the plan's out-of-pocket spending limit.

Insurers and providers routinely make this information available to patients after they receive medical care. Providing good faith estimates in advance would benefit consumers and introduce choice and competition into a market distorted by price opacity.

Emergency care at non-network facilities

Thus far, we posit that truth-in-advertising requirements will address surprise bills at network facilities and good faith estimates will address surprise bills for scheduled care. The one remaining scenario—emergency care at non-network facilities—presents the most vexing problem. Unlike scheduled medical services, cost estimates are neither feasible nor useful. Unlike emergency services at network facilities, there are no contractual relationships between insurers and providers. And unlike non-emergency services generally, hospitals are legally required to provide emergency services to patients in need of such services.

There also is a broad societal consensus that patients needing emergency care shouldn't be penalized for failing to shop for a network facility. A person experiencing chest pains or being transported in an ambulance has little choice but to receive care at the nearest place equipped to provide medical care.

Congress tried in the Affordable Care Act to address this problem. The effort failed. Specifically, the ACA prohibits insurers from placing:

> "any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship to the plan."[25]

GALEN INSTITUTE

[25] 42 USC 300gg-19a(b)(i)(C)(ii). https://www.law.cornell.edu/uscode/text/42/300gg-19a

The ACA further requires that "if such services are provided out-of-network, the cost-sharing requirement … is the same requirement that would apply if such services were provided in-network."[26] In other words, insurers may only require *in-network cost sharing* from patients who receive emergency care at *out-of-network facilities*. Moreover, their cost sharing must count toward a policy's deductible and out-of-pocket spending limits. That effort to protect patients from balance billing when they receive emergency care at non-network hospitals, paradoxically, does not appear to have limited balance bills at either in-network or out-of-network hospitals. A 2018 review of a sample of medical claims submitted to self-funded plans found that 17.8% of outpatient encounters at network emergency departments resulted in bills from non-network physicians.[27]

There is no guarantee that a second foray into this area will be any more successful than the first in avoiding unintended consequences. Nevertheless, Congress understandably is under pressure to address this nettlesome problem.

This can best be accomplished by amending a federal law governing emergency care. The Emergency Medical Treatment and Active Labor Act (EMTALA) imposes two specific obligations on Medicare-participating hospitals that offer emergency services: 1) to provide a medical screening examination when a request is made for examination; and 2) to provide treatment for an emergency medical condition, including active labor, regardless of an individual's ability to pay.[28] Hospitals are also required to provide stabilizing treatment for patients with emergency medical conditions. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, it must transfer the patient to another facility.[29]

Like the provision of the ACA discussed above, EMTALA does not prohibit balance billing to patients who receive emergency care. Congress could amend the statute to impose such a requirement on physicians who provide emergency care to patients with private insurers, in the case where the facility is not part of the insurer's network.

[26] Ibid.

[27] Gary Claxton, Matthew Rae, Cynthia Cox and Larry Leavitt, "An Analysis of Out-of-Network Claims in Large Employer Health Plans," Peterson-Kaiser Health System Tracker, chart: "Outpatient service days that include an emergency room claim are much more likely to include a claim from an out-of-network provider," August 13, 2018. https://www.healthsystemtracker.org/brief/an-analysis-of-out-of-network-claims-in-large-employer-health-plans/#item-start

[28] 42 USC 1395dd. https://www.law.cornell.edu/uscode/text/42/1395dd

[29] Ibid.

That raises the issue of what an insurer would be required to pay the facility and providers in that instance.[30] Existing federal regulations define reasonable reimbursement for such care. Those rules require the insurer to pay the greatest of: 1) the median network rate; 2) the Medicare rate; or 3) the amount the insurer generally uses to determine payments for out-of-network services (such as the usual, customary and reasonable amount). The rule goes on to clarify that if an insurer typically pays 70% of the usual, customary and reasonable amount and requires policyholders to pay the remaining 30%, it must pay 100% of that rate.

Under our proposal, the patient would then be responsible to pay the network cost-sharing rate to the provider, who could not balance bill the patient for any additional sums.

This approach offers several advantages. First, it uses the statutory framework of EMTALA, which applies specifically to emergency services provided at Medicare-participating hospitals. It thus is tied to an explicit and existing federal funding nexus, rather than to a more general assertion of congressional authority. Second, it relies on existing regulations issued pursuant to the ACA to determine reasonable payment for services. Third, it requires providers to be paid the greater of the network rate and the non-network rate, rather than forcing non-network providers to accept rates that apply to insurance networks to which they don't belong. Fourth, although it does deny providers the option to balance bill patients, it does not advantage insurers at the expense of providers, as the rate-setting approach in pending legislation does.

The approach also has disadvantages. First, it does, as noted, prevent providers from setting a price for emergency services at non-network hospitals. It therefore is susceptible to some of the same criticisms as rate-setting provisions in pending congressional legislation. In this case, however, the rate-setting applies only to very specific and narrow circumstances: the provision of emergency services at non-network hospitals. Second, it arises from the failure of Congress's attempt to deal with this problem. It is thus limited to making a second try at doing so, rather than more broadly addressing surprise medical bills with sweeping rate-setting. The ACA provision, as discussed above, sought to protect patients who obtained emergency services at non-network hospitals. Instead, surprise bills for emergency services appear to have proliferated at both network and non-network facilities. Revisiting this specific problem with a narrowly tailored solution is one way to assure that this rate-setting is narrowly circumscribed.

GALEN INSTITUTE

[30] 45 CFR 147.138(b)(3)(i). https://www.law.cornell.edu/cfr/text/45/147.138

A second objection is that this provision is unlikely to provide the offsetting savings that Congress needs to pay for the extension of politically-popular programs. Those anticipated savings, as discussed above, would derive generally from giving insurers added leverage over providers in joining networks and by limiting increases in the median network rate to increases in the CPI. This recommendation for how to deal with amounts paid for out-of-network emergency care, as with the recommendations in this report generally, are not designed to produce budgetary offsets. They are designed to address the surprise billing problem in a way that relies, to the greatest extent possible, on choice, competition, and negotiation among private parties, rather than on federal rate-setting. It recommends ways to empower patients to protect themselves against surprise bills; it is not intended to provide offsets for the costs of extending unrelated programs.

Extent of federal regulation

Lawmakers also must confront the issue of the extent to which the federal government should act on surprise billing and the extent to which it should defer to the states.

That issue is somewhat complicated with respect to the regulation of insurance. Federal pension law greatly limits state regulation of self-funded health plans. An estimated 61% of people with employer-sponsored coverage are enrolled in such plans.[31]

The ACA greatly enlarged federal regulations of individual and fully-insured group health plans.[32] States, however, retain authority to regulate such plans with respect to surprise medical bills. California and New York, as discussed above, are among the states that have done so. Congress could limit its requirements on insurers to self-funded plans, allowing states to apply their own requirements to fully insured plans.

Conclusion

Addressing the balance billing problem appeared to offer Congress a rare gift: a politically popular bill whose enactment would pay for the extension of politically popular programs. Such a bill could be passed without amendment

GALEN INSTITUTE

[31] 2019 Employer Health Survey, Kaiser Family Foundation, September 25, 2019. https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/

[32] See especially section 1201 of PL 111-148, as amended by PL 111-152.

or debate. Nestled in the bowels of a massive year-end spending measure, it could be whisked to the president's desk without the bother of full House and Senate deliberation.

Throughout most of this year, congressional deliberations have sought to ban surprise bills in a way that would produce enough savings to "pay for" unrelated federal spending. A brawl between lobbying titans to determine which industry bears the legislation's cost has so far prevented Congress from reaching a resolution.

Congress may yet pass such legislation, but legislation that includes arbitration or widespread rate-setting would be a mistake. The cost of that success will be exposing physicians in private programs to federal rate-setting, a practice that is at the heart of proposals to move toward a single-payer system. Both Medicare for All and proposals to "build on Obamacare" through a "public option" empower government to set prices for medical goods and services.[33] Solving the surprise billing problem through rate-setting lays the predicate for expanding government price setting beyond these narrow circumstances.

The justification for such rate-setting—that CBO believes it will save money—reinforces this predicate. If government can save a little money by using rate-setting to end surprise bills, why not save a lot of money by applying it more broadly? That said, we believe there is compelling reason to protect patients from balance billing for emergency services at out-of-network facilities, so long as it is confined to those narrowly defined circumstances.

Congress should consider alternative approaches to surprise billing. It should evaluate these approaches on their merits, not based on whether CBO believes they will finance the reauthorization of unrelated federal programs. Such an approach would eschew rate-setting in favor of assuring that consumers receive accurate information. If Congress does introduce rate-setting, it should limit it to the unique issues raised by the provision of emergency services at non-network facilities. And it should leave room for states to pursue alternative approaches to insurance regulation, rather than imposing uniform federal rules.

Such an approach would have broader, salutary consequences. Equipping consumers (and employers) with timely and accurate information about medical prices would help reverse the sclerotic effect of price opacity.[34] It

GALEN INSTITUTE

[33] Former Vice President Joe Biden has made such a proposal in his presidential campaign. See "Health Care," Joe Biden for President. https://joebiden.com/healthcare/

[34] For a full discussion of this issue, see Brian Blase, "Transparent Prices Will Help Consumers and Employers Reduce Health Spending," September 27, 2019. https://galen.org/assets/Blase_Transparency_Paper_092719.pdf

would create room for price competition that could lead to the redesign of insurance products still largely stuck in the fee-for-service model of the 1930s. And it would redirect the efforts of government, one of the leading causes of wasteful and inefficient medical spending, toward enabling a consumer-centered marketplace that curbs health care costs through choice and competition.

Doug Badger was a Special Assistant to former President George W. Bush at the National Economic Council focusing on health care policy, where he was instrumental in crafting the Medicare Modernization Act. He subsequently was named Deputy Assistant to the President for Legislative Affairs. He served in the White House from 2002 to 2006. He previously served as a top health policy advisor to Senate leadership. He is a Senior Fellow at the Galen Institute, a Visiting Fellow at The Heritage Foundation, and can be reached at wdbadger@yahoo.com.

Brian Blase was a Special Assistant to President Trump at the National Economic Council focusing on health care policy from January 2017 through June 2019. In this capacity, he helped develop the Trump Administration's health policy agenda and coordinated the implementation of many of those policies. He also served as a top health policy advisor to Senate leadership. He is now a Senior Fellow with the Galen Institute, also a Visiting Fellow at Heritage, as well as the president of Blase Policy Strategies. He can be reached at brian@blasepolicy.org.

GALEN INSTITUTE