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Commentary: Surprise Billing Legislation Should Lower Consumer Costs and Federal Costs

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Comprehensive bills before the House and Senate to ban surprise medical bills would protect patients while reducing health care costs and premiums. But if lawmakers give in to health industry pressure to move the bills in the wrong direction, the resulting legislation could instead *raise* costs and premiums, by further inflating payments for specialists who already command the highest rates. Lawmakers should resist efforts to water down the bills' cost containment potential and reject an arbitration approach to settling payment disputes between health plans and providers.

Surprise bills generally arise when someone receives out-of-network emergency care or encounters an out-of-network practitioner or service while receiving care at an in-network facility. Most insured people seek providers within their health plan's network, when feasible, but once at a hospital, they can encounter other providers that don't contract with their insurer. For example, an insured person may identify an in-network hospital and surgeon for a procedure, unaware that the anesthesiologist the hospital secures for the surgery is out of network. The insurer may pay part of the out-of-network provider's charges, but the patient is on the hook for the rest, and those large costs won't count toward their deductible or their limit on out-of-pocket costs. For some patients, surprise medical bills can be financially catastrophic.[1]

All major congressional proposals to address surprise billing would take important steps to protect patients. They would take patients out of the middle of payment disputes between plans and providers, limit patients' cost-sharing to what they would normally pay for in-network services, and require plans to count patients' cost-sharing toward their in-network deductible and out-of-pocket maximum. They'd also prohibit providers from "balance billing" — that is, charging their patients the difference between the provider's full charge and what the health plan pays, rather than accepting the plan's reimbursement as full payment.

But the proposals differ in how they would address payment rates for out-of-network services. The crux of the surprise billing problem is that ancillary providers whom patients don't choose (like the anesthesiologist in the example above) currently have a win-win financial opportunity: if they

[1] Kaiser Health News and NPR, *Bill of the Month*, https://khn.org/news/tag/bill-of-the-month/; Lindsey Bomnin and Stephanie Gosk, "Surprise medical bills lead to liens on homes and crippling debt," NBC News, March 19, 2019, https:/www.nbcnews.com/health/health-news/surprise-medical-bills-lead-liens-homes-crippling-debt-n984371.

stay out of network, they can balance-bill patients who are required to use their services at the in-network facility, and if they decide to participate in a plan, they can use that balance-billing option as leverage to negotiate excessive in-network rates. Physicians in anesthesiology, emergency medicine, and diagnostic radiology — specialists who are particularly likely to balance-bill — have median charges at least four times greater than Medicare rates, compared to two to three times the Medicare rate for other specialists, a recent study found.[2] Research documents that this market failure has been particularly exploited by a small set of physician staffing companies (firms that contract with hospitals to staff emergency and other specialty departments), which are often owned by hedge funds or private equity firms seeking to maximize profits.[3]

The best way to address surprise billing for patients and lower inflated prices due to balance billing would be to guarantee that all providers at an in-network facility are also in network.[4] For example, a facility could require each provider to contract directly with its in-network health plans. Alternatively, providers could be prohibited from billing directly; instead, their payment would be folded into the facility's charges, which would eliminate the possibility of out-of-network billing and force the facility and providers to negotiate mutually acceptable rates.

Another effective approach would be to establish a payment benchmark. A bipartisan bill that the Senate Health, Education, Labor and Pensions (HELP) Committee passed in July (S. 1895) does this, as does a bill passed by the House Energy and Commerce Committee (H.R. 2328, as amended). These proposals would base payments on market rates by requiring plans to pay out-of-network providers the median rate they pay in-network providers for the same or similar service in that geographic area. This would prevent specialists from balance-billing or extorting excessive in-network rates. It also could encourage providers that would otherwise stay out of network to instead negotiate with plans rather than accept the median rate.

Requiring plans to pay out-of-network providers the median in-network rate could reduce federal spending by $25 billion over ten years, the Congressional Budget Office (CBO) estimates.[5] It would do so mostly by lowering premiums, which in turn lowers federal costs associated with the tax exclusion for employer-sponsored health insurance and marketplace premium tax credits.

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[2] Loren Adler *et al.*, "State approaches to mitigating surprise out-of-network billing," Brookings Institution, February 19, 2019, https://www.brookings.edu/research/state-approaches-to-mitigating-surprise-out-of-network-billing/.

[3] Zack Cooper, Fiona Scott Morton, and Nathan Shekita, "Surprise! Out-of-Network Billing for Emergency Care in the United States," Yale University, March 2018, https://isps.yale.edu/sites/default/files/publication/2018/03/20180305_oon_paper2_tables_appendices.pdf; Bob Herman, "Private equity's thirst for health care providers," Axios, June 12, 2018, https://www.axios.com/private-equity-thirst-for-health-care-providers-1528737485-195192d5-db93-4c57-9a28-4b7af191d42e.html; Advisory Board, "Private equity keeps buying up health care companies. Should patients worry?" June 20, 2018, https://www.advisory.com/daily-briefing/2018/06/20/private-equity; Julie Creswell, Reed Abelson, and Margot Sanger-Katz, "The Company Behind Many Surprise Emergency Room Bills," *New York Times*, July 24, 2017, https://www.nytimes.com/2017/07/24/upshot/the-company-behind-many-surprise-emergency-room-bills.html.

[4] Loren Adler, Matthew Fiedler, and Benedic N. Ippolito, "Network matching: An attractive solution to surprise billing," American Enterprise Institute, May 23, 2019, http://www.aei.org/publication/network-matching-an-attractive-solution-to-surprise-billing/.

[5] S. 1895, Lower Health Care Costs Act, Congressional Budget Office, July 16, 2019, https://www.cbo.gov/publication/55457.

Consumers would likewise see premium savings; CBO estimates that premiums would fall by about 1 percent.

While this approach would reduce average payment rates by eliminating high-cost outlier payments, physicians now receiving below-median rates would get a payment boost. In fact, the downside of setting a benchmark rate based on the median is that it would often lock in rates that are excessive and uneven across specialties and insurers.[6]

Unfortunately, hospitals and specialists are pressuring the House and Senate to modify their bills in ways that would shrink or eliminate the downward pressure on payment rates and the resulting reductions in premiums and federal costs.

Health care providers have thrown their weight behind legislation introduced by Rep. Raul Ruiz that employs so-called "baseball-style" arbitration — where the provider and the health plan each name their best rate offer. In choosing between the offers, the bill instructs arbitrators to consider the 80th percentile of billed charges for a service (that is, an amount that's higher than what 80 percent of providers charge) as one factor in determining which is the fairer payment rate.

This is highly problematic and would lead to higher costs.[7] The 80th percentile of billed charges is well above the median and can be many times greater than the Medicare rate. (For example, the 80th percentile rate of anesthesiologists' charges is more than 11 times the Medicare rate.[8]) Billed charges are so inflated because providers set them unilaterally, unconstrained by market forces and often far exceeding the negotiated rates insurers actually pay. Rather than contain costs, therefore, baseball-style arbitration would give providers new incentives to raise their billed charges over time.

Moreover, the Ruiz bill's arbitration process isn't transparent, since neither the final rate nor the arbitrator's basis for it must be made public, and it lacks the predictability of a payment benchmark. Arbitration also carries high administrative costs that ultimately raise health system costs, even if the loser must pay both sides' costs.

Fortunately, the Energy and Commerce Committee bill doesn't take this extreme and costly approach. The committee weakened the bill approved by its health subcommittee by amending it to allow arbitration for services costing more than $1,250, but these are a relatively small number of services. Also, unlike the Ruiz bill, the amendment instructs the arbitrator to consider the median contracted rate, prohibits the arbitrator from considering billed charges, and requires publication of the competing bids and the arbitrator's payment determination.

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[6] Loren Adler *et al.*, Comments on No Surprises Act, May 28, 2019, https://www.brookings.edu/wp-content/uploads/2019/05/Energy-and-Commerce-Discussion-Draft-Comments.pdf.

[7] Loren Adler *et al.*, "Rep. Ruiz's Arbitration Proposal for Surprise Billing (H.R. 3502) Would Lead to Much Higher Costs and Deficits," *Health Affairs*, July 16, 2019, https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/07/16/rep-ruizs-arbitration-proposal-for-surprise-billing-h-r-3502-would-lead-to-much-higher-costs-and-deficits/.

[8] Adler *et al.*, "State Approaches," *op. cit.*

Lawmakers should resist the pressure to weaken the House and Senate bills. They must also work out other important details. Surprise billing has many forms, so legislation should take the broadest possible view of the potential care settings, practitioners, and insurance types. Legislation also should protect patients from excessive ground and air ambulance fees;[9] no bipartisan legislative proposal to date has done so, though ambulances are frequently an out-of-network service.[10] And, to improve uniformity and avoid a patchwork of rules across states, the federal law should either preempt relevant state laws or allow them only when (relative to federal law) they're more protective of patients and don't raise costs.[11]

[9] John Tozzi, "Air Ambulances Are Flying More Patients Than Ever, and Leaving Massive Bills Behind," Bloomberg, June 11, 2018, https://www.bloomberg.com/news/features/2018-06-11/private-equity-backed-air-ambulances-leave-behind-massive-bills.

[10] Sarah Kliff and Margot Sanger-Katz, "Politicians Tackle Surprise Bills, but Not the Biggest Source of Them: Ambulances," *New York Times*, July 22, 2019, https://www.nytimes.com/2019/07/22/upshot/ambulance-surprise-medical-bills-law.html.

[11] Adler *et al.*, "State Approaches," *op. cit.*