

# The Potential Pitfalls of Combating Surprise Billing

*A “baseball-style” arbitration process has shown promise in New York state.*

❖ BY IKE BRANNON AND DAVID KEMP

In recent years, several states have instituted measures to protect patients from “surprise billing” or “balance billing”—unexpected bills for “out-of-network” care providers. On the federal level, Congress is also considering proposals to address this problem.

The impetus for these policies is recognition of a failure in the health care market. Health care providers and insurers negotiate network contracts that are intended to drive insureds to specific providers who offer services at rates approved by the insurer. Out-of-network providers are free to set their own charges, but the balance that remains between what providers charge and insurers’ approved rates is sometimes passed onto the insured. These bills, which can be for both unscheduled emergency and scheduled non-emergency treatment, can total thousands of dollars and be a significant financial burden on patients. This is particularly worrisome because even patients who take care to seek treatment at in-network facilities or with in-network providers can still inadvertently be treated by out-of-network providers working there, or ancillary out-of-network providers involved in a procedure.

States have adopted different strategies to address the issue and there are currently three plans being considered in Congress. All of the options protect patients by requiring that, in a surprise billing scenario, patients are only responsible for the copay, co-insurance, or deductible that they would pay if they received the same treatment from an in-network doctor.

However, some of the proposals threaten to nullify the benefit of patient protection by introducing negative distortions to the

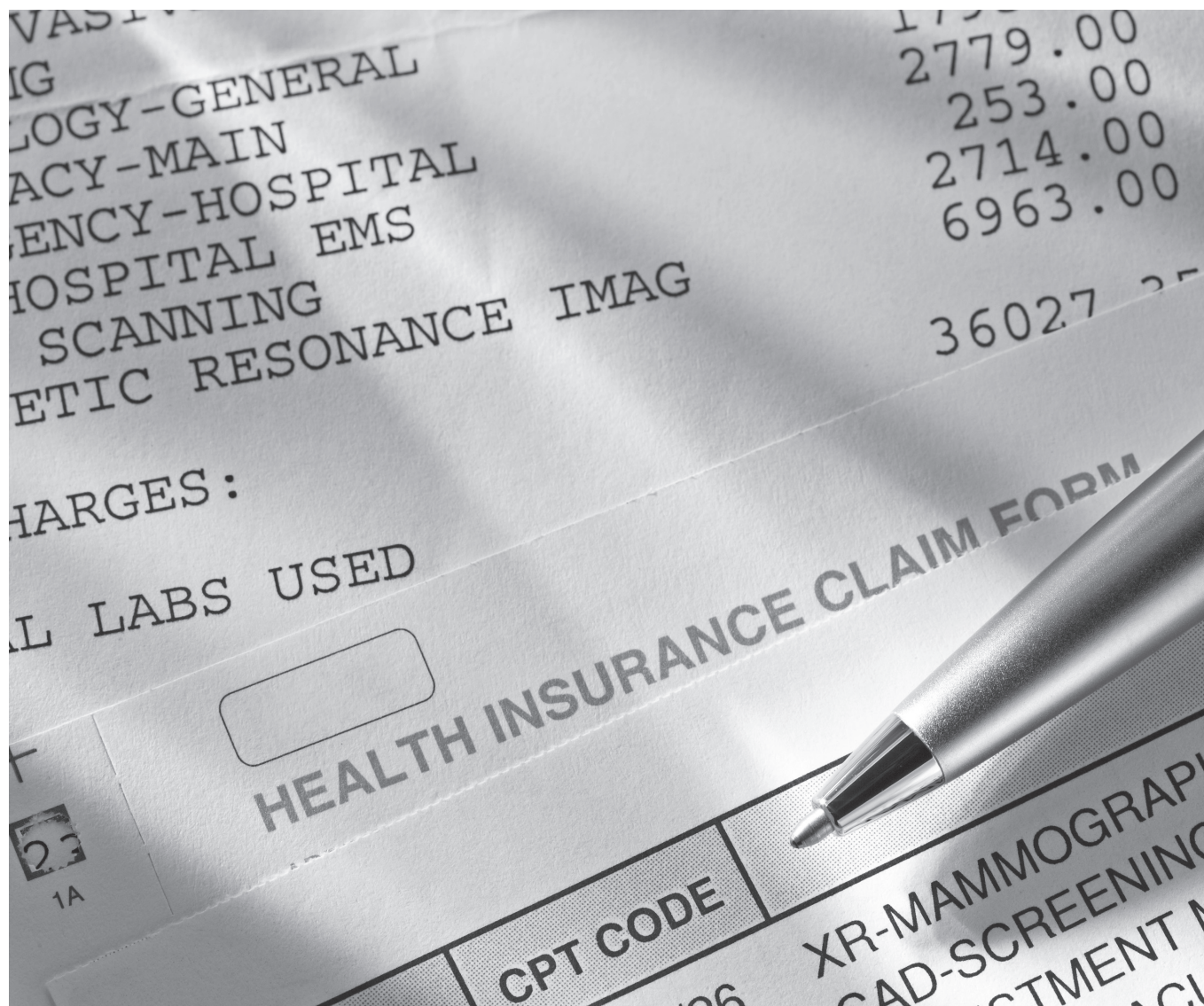
health care system. In particular, some propose an in-network guarantee that would mandate that all providers operating at an in-network facility be considered in-network. Others suggest the “benchmarking” of payments, which would impose government-set price caps on the rates for services provided by out-of-network providers. Both of these ideas would bias the negotiations between insurers and providers, favoring the insurers. This would result in unintended negative consequences such as increased insurance premiums or reduced access to care.

The less intrusive option would be to establish an independent dispute resolution (IDR) process. This system would rely on a neutral arbiter to serve as the final backstop in negotiations between out-of-network providers and health plans over the proper fees for health care services. The design of such a process and the criteria used in a review of the reimbursement amounts offered and requested are key to ensuring that the process avoids the pitfalls of more direct government interventions. But because a well-designed IDR system is less intrusive and keeps the price-setting ability in the hands of the market participants—providers and insurers—it is more likely to protect patients without creating counterproductive unintended consequences.

Fundamental to any proposed solution is that it should address the key concern of surprise billing and protect patients. Just as important, however, the solution needs to ensure that the new mechanisms and dynamics it introduces to the already complex health care system do not undermine its own goals.

## BACKGROUND

Surprise billing is a consequence of the structure of insurance benefit plans in the United States. In order to reduce costs, insur-



ers negotiate contracts with health care providers: in-network providers agree to discount the rates they charge for their services, and in return they may receive long-term contract certainty, reduced administrative costs (as rates are pre-negotiated), and access to a larger volume of patients. Providers outside the network, on the other hand, get none of these benefits but can charge higher prices for their services.

Although a patient who consciously elects to receive higher-cost services from an out-of-network provider should be responsible for the increased cost, in some cases a patient is inadvertently treated by an out-of-network provider. These are not isolated incidents; one study estimated that, in 2014, 20% of inpatient emergency room cases, 14% of outpatient emergency room visits, and 9% of elective inpatient admissions likely led to surprise out-of-network bills.

While surprise billing most often occurs in emergency situations where a patient is incapable of making treatment decisions, it can also happen in a non-emergency setting when a patient is

treated by an out-of-network provider working at an in-network facility. Most hospitals give privileges to hundreds of providers and it may not choose or be able to require that all of them be in the same network. This means that even if patients elect to seek treatment at an in-network hospital or facility, they can still—unknowingly—receive treatment from an out-of-network provider.

After a patient receives treatment, the health care provider will send reimbursement requests to the patient's health plan and the provider and insurer can immediately settle pre-negotiated, in-network rates. However, they may need to negotiate the out-of-network bills, and when providers and health plans are unable to reach an agreement the balance may be charged to the patient.

The unique position of emergency physicians compounds the frustration of surprise billing. Under the 1986 Emergency Medical Treatment and Active Labor Act (EMTALA), emergency departments must provide a medical examination to anyone seeking treatment and are required to treat uninsured, Medicare, and

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Medicaid patients. Emergency providers are also not able to discuss a patient's ability to pay or insurance coverage. (The act applies to emergency departments that receive Medicare payments, which covers almost all hospitals in the United States.) Patients may be unaware that they are receiving treatment from an out-of-network provider, and physicians are legally prohibited from telling them.

As a result of EMTALA, care for a large proportion of emergency room patients by emergency physicians results in either no reimbursement whatsoever or an insufficient, government-mandated reimbursement. That means that a large portion of emergency providers' costs are effectively distributed to commercially insured patients.

The trend of health plans offering narrower networks, along with concomitantly larger discounts, exacerbates the problem of surprise billing by offering fewer in-network options for beneficiaries. There are fewer incentives for insurers to contract with emergency providers because emergency physicians' legal obligation under EMTALA means that they must accept all patients. Health plans are not required to provide an adequate network of emergency providers for their consumers.

EMTALA rightly creates an effective safety net of emergency providers for all patients. In doing so, however, it skews contract negotiations in favor of insurers, leading to a higher likelihood of surprise bills for patients. An effective solution should protect patients from surprise bills, incentivize health plans to more transparently convey information about in-network doctors and facilities to patients, and incentivize mutually beneficial contracts between providers and insurers to address the fundamental cause of surprise bills.

#### PROPOSED METHODS TO FIX SURPRISE BILLING

The one thing that federal lawmakers appear to agree on is that patients need to be replaced as the backstop in negotiations between providers and insurers. An ideal solution would facilitate fair payments to health care providers that cover the costs of services provided, assess reasonable rates that help keep insurance premiums low, and is transparent, improves access to care, and delivers quality treatment for patients.

There are three solutions to surprise billing currently being considered: benchmarking surprise bills to a median in-network rate, mandating that all providers in an in-network facility are reimbursed as if they were in-network, and establishing an IDR process.

All three plans protect patients by requiring that if they inadvertently receive out-of-network treatment, their cost-sharing responsibility would be the same as if treated by an in-network provider. The difference between the three is how they seek to govern negotiations between providers and insurers.

A key concern should be to ensure that, whatever proposal is chosen, the regulations do not unfairly favor providers or insurers. If a plan favors providers, insurers may end up paying more and thus increasing premiums, whereas a plan that favors insurers could mean that providers are unable to cover costs and must

reduce the supply of emergency or other services.

#### BENCHMARKING PAYMENTS

Benchmarking out-of-network payments, or rate setting, is counterproductive. Enacting fee caps, no matter what the benchmark rate is (including the proposed median in-network rate), creates a rigid system that does not allow prices to reflect the true costs of the services provided. Whether the benchmarked rate is higher or lower than the costs, rate setting benefits either providers or insurers and thus forecloses the possibility of an equitable solution that avoids distortions.

Because of difficulties in accurately measuring a market rate and appropriately adjusting for myriad factors—including a treating physician's experience and training and the complexities of a particular case—a benchmark would almost assuredly either underbid providers or increase insurers' costs.

In particular, a frequently proposed benchmark has been the local, median in-network rate. However, creating this low rate ceiling ignores the reasons that providers and insurers contract in the first place and significantly skews negotiations in favor of health plans. Requiring that insurers pay out-of-network providers the median in-network rate means that the insurers will receive the discounted rates and eliminate any incentive to offer the benefits of being in-network in return.

This guarantees that providers will receive insufficient payments. Providers are willing to contract with insurers because the discounts they offer are worth the benefits they receive from being part of the network. The median in-network price would reimburse out-of-network providers at rates below their costs and would lead to reduced access to emergency medicine as providers are unable to break even.

This proposal would also create myriad opportunities for manipulating network negotiations between providers and insurers, as health plans could further narrow their networks and receive greater discounts from a select group of providers. The median in-network rate can be calculated from all health plans in a geographic area, by each individual insurer, or even by each insurer's separate health plan offerings. Each of these options creates opportunities for insurers to engineer lower rates, but the latter proposal is particularly deleterious. It allows insurers to determine their own median in-network rate through narrow networks by canceling with providers who have higher pre-negotiated rates, thus creating a portfolio of in-network providers with the lowest median rate. This would inevitably lead to a downward spiral in prices as the median in-network rate declines. Out-of-network reimbursements would in turn diminish further and concerns about patient access to care and doctor choice would grow.

California's decision to use rate-setting to combat surprise billing is illustrative of the harmful effects. In 2016 the state enacted a bill that sets out-of-network rates at the lower of the median in-network rate or 125% of Medicare rates. If physicians who provided non-emergency services think that they deserve a

higher rate, they can contest the payment through an IDR process.

California's law is relatively new and there is limited empirical evidence of its efficacy. However, anecdotal evidence indicates that, although the act has protected patients, the benchmarked rates are too low, the IDR process is poorly designed and has been slow and costly, and the new rules have distorted negotiations in favor of insurers. Health plans have already started to cut their pre-negotiated payments and terminated contracts with providers in order to lower in-network fees. This outcome, which aligns with the prediction that insufficient benchmarked rates lead to insurer manipulation and lower reimbursements for providers, will create a supply shortage that offsets the benefits of patient protection.

### IN-NETWORK GUARANTEE

Another proposal to curb surprise billing is to mandate that every provider at an in-network facility also be considered in-network. The mandate could require physicians operating at an in-network facility to contract with the same health plans as the facility or else establish facilities to serve as a middleman between insurers and independent physicians, billing insurers and then reimbursing providers.

However, either option would effectively alter the balance of power in negotiations between providers and insurers, as well as create increased administrative burdens for facilities. Such an outcome would ultimately lead to higher health care costs.

Requiring that providers belong to the same networks as facilities where they practice would remove all negotiating leverage of providers, eroding most of the benefits that such negotiations create. Practitioners contract with health plans—and provide them a discounted rate—because the benefits they receive via more certainty and greater volume offset the forgone revenues from reduced reimbursements. Mandating that providers join the insurance network of the hospital where they do a significant amount of their business would effectively empower insurers to further reduce their pre-negotiated rates, possibly to prices below the actual costs of services. Because of the unique economics of emergency physicians, these lower prices would place a financial strain on emergency providers who already receive no or insufficient reimbursements for treatment of uninsured, Medicare, and Medicaid patients.

The consequence of this imbalance would be more physicians electing not to practice at in-network facilities or fewer emergency physicians in general, leading to reduced access to care and doctor choice for patients.

Allowing physicians to remain out of network but forcing them to rely on the facility as a middleman creates similar problems. Inserting an unnecessary third party into the negotiation between the provider and health plan will engender complexity and necessitate a new bureaucracy. Providers would need to inform hospitals of the services performed, and hospitals would then use this information to negotiate with insurers. This further biases negotiations in favor of insurers who—unlike the hospitals newly inserted into this role—have experience

negotiating rates for the out-of-network providers' specialties. And, because health plans act as price setters, any increased administrative costs will not be reflected in an increase in fees and will thus be borne by physicians.

Both routes to achieving an in-network guarantee would undermine the ability of providers to recoup the already high costs of emergency care and ultimately reduce access to care.

### INDEPENDENT DISPUTE RESOLUTION

IDR replaces patients with a neutral arbiter as a final backstop when negotiations between providers and insurers fail to reach an agreement. Unlike an onerous in-network guarantee or distortionary rate setting, a functional IDR process encourages the two parties to reach an agreement before relying on an outside party to settle the dispute.

Key to an effective IDR system for surprise billing is that it calls for a fixed or “baseball-style” arbitration, so-called because it is used in Major League Baseball. Instead of a process where each side proposes a price and a third-party arbitrator can then name a final rate—invariably between the two proposals—in a fixed IDR system the arbiter can only pick one of the two proposed prices. In so doing, the process avoids serving the same function as rate setting and incentivizes providers and insurers to meet in the middle.

Without a fixed IDR, the arbiter simply takes the place of a bureaucracy in determining the appropriate price for the services provided. Realistically, when given free rein to determine the costs of particular treatments, an arbiter will develop a framework that can favor either providers or health plans, and introduce the same distortions as benchmarked payments. Fixed IDR avoids this by putting the onus to determine prices on the provider and insurer.

The IDR process requires important guidelines to ensure that arbitration is not abused. Key among these are rules governing who pays the costs, a lower threshold, and clearly outlined criteria to consider in each decision. Having the losing party in a dispute pay the costs of the IDR would distribute the costs between parties, discourage relying on arbitration when one party has a weak case, and further bolster incentives to find middle ground. It is also apparent that a minimum threshold must be established: without one, providers and insurers would be able to abuse IDR in trivial disagreements. A realistic threshold for IDR would be for payments to be above \$750; reimbursements below this limit should automatically match prices offered by providers.

Finally, the criteria that must be considered in an IDR have the potential to shape an arbiter's decision. An effective IDR would account for particular circumstances, such as a provider's training and independent case complexities. The arbiter should also seek to compare proposed prices to the true costs of the treatments performed and their market rate without discounts, not an in-network rate that underbids providers. This would necessitate a transparent, independent database that can help arbiters determine the real value of different services.

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A baseball-style IDR process that includes such guidelines offers the best way to keep balance in the negotiations between providers and insurers. Instituting a lower threshold, applying the costs of the IDR to the losing party, and establishing objective criteria would ensure that the system will not favor one side over the other. And the nature of fixed IDR encourages both sides to move toward the center and an equilibrium price, creating less market distortion than other proposals to address surprise billing.

**SURPRISE BILLING IDR IN NEW YORK**

In recent years, multiple states have passed laws to address surprise billing. While California and other states have elected to rely on more distortionary measures, New York, Illinois, New Hampshire, New Jersey, and Texas have established IDR processes. In 2014, New York became the first state to enact a baseball-style arbitration system, and its experience is particularly instructive.

The New York law mandates that patients who receive emergency treatment or are unknowingly treated by an out-of-network provider in a non-emergency situation be protected from surprise bills by insurers and providers. After a patient is treated, if the provider and insurer are unable to agree on the reimbursement and the disputed amount is above \$683.22 (the threshold is adjusted annually for inflation), the health care provider can submit the dispute to an IDR entity. These reviewers have training in health care billing and reimbursement, and consult with practicing physicians in the same or similar specialty as the treating doctor. The process accounts for the circumstances of the case and the patient's characteristics, the experience and training of the physician, the usual and customary costs of the service, and whether there is a large disparity between the out-of-network fees the physician has received for providing the same services to other patients or the reimbursements the health plan has paid to similarly qualified out-of-network providers.

If feasible, the arbiter may direct a negotiated settlement. Otherwise, it makes a binding decision about which proposal is more reasonable, with the loser paying the cost of the arbitration.

Evidence indicates that New York's IDR process is balanced and has effectively protected patients. A Georgetown University Health Policy Institute case study interviewed providers, insurers, and consumer advocates and reported that all stakeholders agreed that the law was successful in decreasing harm to patients.

The IDR process has also avoided overly favoring either providers or insurers. Through October 2018, there were 2,140 completed IDR disputes. Some 29% have been awarded in favor of health plans, 26% in favor of providers, 27% were split decisions (meaning multiple services were disputed, with the IDR finding in favor of different parties for the individual fees in question), and 18% were able to be settled. Clearly, and likely because of the fixed nature of the process, IDR has not been biased toward either side.

These results do not include the effect that the IDR has had on encouraging parties to reach an agreement on their own and eschew arbitration entirely. This phenomenon is more difficult

to measure, but anecdotal evidence suggests that the law has also succeeded in this regard.

Furthermore, the IDR process has not led to any significant increase in insurance premiums, demonstrating that the system has not introduced substantial distortions to New York's health care system. In fact, after the passage of the law, New York's average premiums rose at a rate lower than the rest of the country.

Evidence has also shown that New York's IDR framework has prompted a decline in out-of-network billing altogether. An analysis of the law found that it reduced the frequency of out-of-network billing by 34% relative to New England states. This result is an indication that IDR has incentivized more physicians to accept in-network contracts and health plans to expand their networks. Ultimately, this may be the best outcome of New York's IDR law.

**NETWORK ADEQUACY AND TRANSPARENCY**

A robust, fixed IDR process is the most important measure to address surprise billing. But as New York's experience has shown, concomitant actions to address the root causes of the problem can help expand the health care safety net by compelling insurers to create sufficient provider networks and giving beneficiaries necessary information about their health plans.

The first of these actions is to create network adequacy standards. These requirements mandate that health plans must ensure that they are able to offer reasonable access to in-network providers in different specialties at all times, including emergency services. Insurers have been incentivized to narrow networks in order to cut costs and lower premiums. This strategy has led to insufficient networks that increase the likelihood of surprise out-of-network bills.

Appropriate network adequacy standards also address health plans' lack of incentives to contract with emergency providers. As stated above, because EMTALA requires that emergency providers accept patients at all times, regardless of insurance coverage, insurers can eschew contracts with such providers with the knowledge that their beneficiaries will receive treatment and the health plan can underpay providers after the fact. Network adequacy requirements will compel insurers to instead contract with emergency providers and thus limit a major cause of surprise billing.

The second measure is to increase network transparency. This includes both price transparency and up-to-date information on which providers are in-network. Providing patients with information on their cost-sharing responsibilities and a directory that includes which providers and facilities are in-network will help avoid situations where patients elect to receive services from an out-of-network doctor without understanding the costs or consciously seek care at an in-network facility and inadvertently receive treatment from an out-of-network doctor.

Most importantly, a database that tracks payment information needs to be established to ensure that patients, providers, insurers, and the IDR entities have the best information when making decisions. This database should be maintained by a neutral party

or several firms that can compete for innovative ways to cut costs and track information.

## CONCLUSION

Both network adequacy and transparency would increase the effectiveness of a well-designed IDR process. However, the most important tool is the IDR process itself, as New York's surprise billing law has shown. The state's response to surprise billing stands as an example of a successful approach to decreasing unanticipated out-of-network bills without introducing harmful distortions. The law has achieved its goal of protecting patients without punishing providers or insurers, and the available evidence in the five years since its passage shows that its implementation has gone smoothly.

IDR has proven to be the best mechanism to limit surprise bills. Neither mandating an in-network guarantee nor benchmarking payments can take into account the complexities of the health care system and would create damaging ripple effects that would negatively affect the broader health care market. Chief among these would be deleterious effects on the negotiations between providers and insurers. Advantaging either side harms patients by creating supply shortages or increasing premiums, thus undermining the benefit of protecting patients from balance billing.

IDR avoids these pitfalls and more closely aligns with a free-market process of setting prices. A well-designed fixed arbitration system, as seen in New York, leaves the ability to set prices in the hands of buyers and sellers, providers and insurers, and therefore more accurately reflects the true costs of the medical services provided.

While the ultimate purpose of any surprise billing legislation should be to protect the consumer, we need to do this without reducing the efficiency of the health care market. A baseball-style independent dispute resolution process offers the most efficient and least invasive option for protecting patients. R

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# Comment

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There is no shortage of horrific anecdotes about surprise medical bills—cases where patients are unexpectedly billed at highly inflated prices by providers who do not accept their insurance. With public opinion firmly in support, Congress is poised to enact legislation to address this issue. In this article, we argue that a commonly suggested arbitration-based system, such as the one endorsed by Ike Brannon and David Kemp (see p. 40), is not the best option for solving this very real problem.

The problem of surprise medical bills is not limited to a few

shocking anecdotes. Studies show that 14–20% of emergency department (ED) visits may result in a surprise bill, with that number exceeding 40% in some states. (Recent research using data from Oputm finds even higher rates of surprise billing.) Data from a national insurer show that, at the median hospital, only 1% of ED visits at in-network hospitals generated out-of-network bills. At just 15% of hospitals, however, more than 80% of ED visits generated a similar bill. Even among elective admissions—where patients presumably have control over where they receive care—nearly 10% of patients are at risk of receiving a surprise bill and being “balance-billed” when their insurer refuses to cover it. Some sectors of health care (such as air ambulances and at least one ED staffing company) appear to be built on a business model of sending surprise bills.

Physicians who are not chosen directly by patients exploit these dynamics to set artificially high prices for their services. These providers will only join an insurer's network if the amount they receive is worth more than the right to balance-bill patients by remaining out-of-network. A recent report shows that the physicians least likely to be chosen by a patient (i.e., ED physicians, anesthesiologists, and radiologists) set their list prices roughly twice as high as similar physicians who are more likely to be chosen by patients. This strategy allows these providers to make more when they choose to be in-network, and increase the size of any resulting balance bill when they are out-of-network.

The public is understandably concerned about the problem. In a poll conducted by the Kaiser Family Foundation in August

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2018, respondents listed “unexpected medical bills” as their top concern—ranking well ahead of prescription drug costs and health insurance premiums. In response, state policymakers have enacted various strategies for dealing with the problem of surprise medical bills. Congress is poised to follow them. The list of policy options is mercifully short: arbitration, contract-based strategies, and rate-setting.

**The IDR idea** / Brannon and Kemp argue that arbitration (or an Independent Dispute Resolution [IDR]) represents the best solution because it “keeps the price-setting ability in the hands of the market participants ... without creating counterproductive unintended consequences.” They also highlight the value of IDR in appropriately balancing negotiations between market actors: an in-network guarantee or benchmarking would “lead to an imbalance in the negotiations between insurers and providers. Biasing the system toward either side leads to unintended negative consequences, such as increased insurance premiums or reduced access to care.”

We agree with Brannon and Kemp that the problem of surprise medical billing is best solved by requiring market actors to privately negotiate market prices. But an IDR does not accomplish this, nor does it prevent surprise medical bills. Instead, arbitration is an ex post dispute resolution system that represents a non-transparent version of the price-setting approach that Brannon and Kemp properly reject. Arbiters, not market actors, ultimately determine payment rates. In addition, Brannon and Kemp’s suggestion that reform should strive to balance incentives and not disrupt the status quo is inapt. Current bargaining dynamics are

responsible for the problem of surprise medical billing. Reform should fix these problems by changing everyone’s incentives, rather than reward those who have engaged in strategic behavior in the past. Finally, although Brannon and Kemp suggest that narrow networks are responsible for the rise of surprise billing, the evidence indicates otherwise. We examine each of these issues below.

We begin by briefly reviewing the circumstances that can give rise to surprise bills. Providers decide whether to contract with a particular insurer (i.e., to be in-network) or not (i.e., to be out-of-network). Providers who are in-network agree to accept a contracted price, while out-of-network providers set their own prices and can seek to collect from the patient the difference between the total bill and the amount paid by the insurer.

Patients who knowingly choose to receive care from an out-of-network provider have no basis for complaint when they receive a balance bill. But in many situations, patients reasonably believe their physician is in-network or they have no control over whether a provider is in-network or out-of-network. Thus, surprise medical bills are likely to arise in three distinct settings:

- Patient receives care at an ED in an in-network hospital, but one or more clinicians involved in the treatment (e.g., emergency medicine physicians, ancillary physicians, or other specialists working in the ED) are out-of-network.
- Patient receives elective care at an in-network hospital, but an ancillary physician (e.g., an anesthesiologist) is out-of-network.
- Patient is taken to an out-of-network facility in an emergency or is transported by an out-of-network ambulance.

So how should we address this problem? Brannon and Kemp suggest that IDR will address these dynamics and that the other two available solutions (contract-based strategies and rate-setting) are far inferior. We respectfully disagree.

**Missed opportunity** / The first problem with IDR is that it does not prevent surprise medical bills from being sent. Instead, it provides an after-the-fact mechanism for resolving disputes. This represents a missed opportunity. Second, the arbiter must ultimately set a price. Arbiters are generally instructed to pick a “reasonable” price, often choosing between prices proposed by the insurer and the

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provider. But arbiters must still develop a decision rule to decide these cases. Enacted and proposed legislation typically specify some parameters for determining a “reasonable” price (e.g., the in-network median payment rate, the 80th percentile of billed charges in New York). This process turns arbiters into implicit rate setters who conduct their work in a completely non-transparent way. For example, New York’s IDR system was introduced about five years ago and we have little evidence on the size of rulings.

The lack of transparency associated with IDR is particularly worrisome because a number of proposed or implemented arbitration guidelines are based on billed charges. For example, as noted above, New York state law instructs arbiters to consider the 80th percentile of charges in an area. Ongoing work confirms that arbiters are following this standard in deciding the disputes that come before them. Because providers can set their charges as high as they see fit and IDR ensures they will be paid at that level as long as they are out-of-network, it is not surprising that most observers expect New York’s IDR-based approach will result in higher health care costs. Indeed, Brannon and Kemp cite a

Georgetown University report in which providers freely admit that, as a result of New York's IDR-based approach, they now receive "higher reimbursements to be in-network than they had prior to the law." This problem is not limited to New York; Alaska has a similar provision, and a similar charge-based bill pending in the U.S. House of Representatives (the Protecting People From Surprise Medical Bills Act) has 71 co-sponsors.

We also respectfully disagree with Brannon and Kemp's focus on the importance of ensuring balanced negotiations. Policymakers should focus on correcting the market failures that give rise to surprise medical bills. Some providers face effectively no tradeoff between prices and volume of their services. If patients cannot avoid certain providers, those providers can charge prices that dramatically exceed market rates without any adverse consequences. The data suggest that some (but certainly not all) providers do just that.

This emphasis on striking the appropriate balance appears to partially motivate Brannon and Kemp's suggestion that narrow insurance networks are a substantial contributor to the problem of surprise medical bills. This argument is intuitively plausible, but the data indicate network breadth is unlikely to be driving this phenomenon. A recent study found similar rates of surprise billing among those with employer-sponsored insurance (19%) as those with marketplace plans, which generally have much narrower networks (22%). In addition, rates of surprise medical bills are similar across many types of insurance (HMOs, PPOs, and HDHPs), even though HMOs have much narrower networks. Other studies indicate that surprise bills are most common when patients do not control which provider they see—consistent with the three scenarios outlined above. Taken together, these findings suggest that narrow networks are unlikely to be driving the majority of surprise billing.

**Contract-based alternative** / So what should we do instead? In our view, a contract-based solution, which would require all providers at an in-network hospital to either contract with the same insurers as the hospital or secure payment from the hospital (who will bundle those costs as part of their in-network facility fee), will outperform IDR. A contract-based approach entirely eliminates the sending of surprise medical bills at in-network settings and puts the burden of negotiating market prices on those closest to the situation. A contract-based approach requires nothing from the vast majority of providers that do not engage in surprise billing, and it eliminates the need for policymakers to impute a market price or create and fund a dispute resolution system to do the same.

In fairness, Brannon and Kemp have a legitimate concern that a contract-based solution may allow insurers "to further reduce their pre-negotiated rates, possibly to prices below the actual costs of services." But this supposed problem will sort itself out when the surprise bills originate from in-network facilities. If insurers insist on rates that are below the cost of services, physicians will

look to hospitals to make up the difference—and hospitals will build that amount into their negotiations with insurers over facility fees. In short order, we would arrive at a natural market rate that did not reflect the ability of some providers to send surprise medical bills. Without that ability, we should expect rates to be lower than the status quo, albeit not below the cost of providing the services in question.

To be sure, a contract-based approach will not work in situations where patients are taken to an out-of-network facility in an emergency or are transported by an out-of-network ambulance to an in-network facility. We note that the legal system has developed strategies for handling such circumstances. Under admiralty law, courts will not enforce a bill for marine salvage that exceeds the market value for the services in question. Knowing this, everyone uses a standard form contract and disputes over billing are uncommon. What does it say about the medical profession that its billing practices would not pass muster if brought before a court handling a dispute over marine salvage?

## CONCLUSION

Out-of-network balance bills are unique to health care. When you take your car to a body shop, the painter who repaints the door panel does not send you an inflated, separate bill and then balance-bill you when your insurance refuses to pay it in full. This is not because we have an elaborate arbitration system to adjudicate door panel repair bills; it is because the market demands all-in pricing.

In health care, normal market forces have failed to prevent surprise medical bills. Although a well-designed IDR system can help resolve such disputes, design details matter greatly in how effective this approach will be in arriving at market prices. A contract-based approach is likely to outperform IDR. R

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