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How Congress Should Deal with Surprise Medical Bills for Patients

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KEY TAKEAWAYS

Congress should fully examine the nature, extent, and causes of surprise medical bills, including how earlier federal policies may have compounded the problem.

If Congress acts on surprise bills, it should limit any legislation to self-funded plans that are beyond the reach of state regulators.

Congress should empower consumers, who need more information, freedom, and control of their own health care spending.

The federal government and most states are seeking to prohibit surprise medical bills, usually defined as bills from non-network providers for care provided at network facilities, as well as bills for emergency care. Surprise billing disadvantages patients and benefits insurers, hospitals, and other providers.

Leading congressional proposals to address these concerns fall short. None reduces medical costs, and instead will induce insurers and providers to shift the costs of the new mandates back to patients in opaque ways. Patients will bear the costs of "patient protections," most likely through higher premiums, higher cost-sharing, and more restrictive provider networks.

Instead of choosing among competing "patient protections" proffered by representatives of industries that benefit from surprise bills, Congress should pursue broader reforms that promote choice and

competition, minimize government interference and regulation, and ensure a level playing field between market actors by allowing patients to take more control of their medical care.

Background

Most privately insured consumers have coverage that distinguishes between network and non-network providers. Their policies offer strong financial incentives to seek care in network facilities and from network physicians. Consumers have responded to these incentives by checking to see that a doctor, hospital, or other facility is part of their insurance network before making medical appointments. But there is a catch: A patient whose knee surgery is performed by a network doctor at a network facility, for example, may learn only after the procedure that the anesthesiologist was not part of her insurance network, resulting in a surprise bill.

State and federal policymakers rightly want to ban this practice. As of March, seven states already had such laws in place, while 22 others had bills under consideration.[1] President Donald Trump has called on federal lawmakers to address the issue.[2] Several bills have been introduced in Congress. Both the Senate Committee on Health Education, Labor and Pensions (HELP) and the House Energy and Commerce Committee are advancing bipartisan legislation that includes provisions dealing with surprise medical bills.[3]

There is little data to help policymakers make informed decisions and the data that do exist suggest that the problem of surprise medical bills is most prevalent in circumstances where Congress already has tried to prevent them: out-of-network emergency department (ED) claims.

A provision of the Affordable Care Act (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.[4]

The statute goes on to require 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."[5]

The provision may seem well-intentioned. Someone with acute and severe symptoms should be able to seek emergency care at the nearest

facility without facing a financial penalty if that facility is out of network. The provision was designed to protect patients from surprise bills when they were treated at non-network EDs.

However, this provision may have had the opposite effect. According to two recent studies, patients are most likely to receive surprise medical bills if they are treated at an ED. That pattern holds whether the ED is at a network or non-network facility.

A 2018 review of a sample of medical claims submitted to self-funded plans found that only 3.3 percent of non-ED outpatient encounters at network facilities included a claim from a non-network provider. This suggests that policymakers might want to gather more information about this practice before taking sweeping regulatory action.

That same study, however, reported that 17.8 percent of outpatient encounters at network facilities that involved an ED visit resulted in a bill from a non-network provider.[6] That figure rises to nearly one in five ED encounters when both network and non-network facilities are included.[7] A widely cited 2017 study similarly found that between 14 percent and 20 percent of ED visits may result in surprise bills.[8] It also found that these non-network claims were highly concentrated in a small group of hospitals. Specifically, it found that half of hospitals issued surprise bills less than 2 percent of the time, while 15 percent did so 80 percent of the time.[9]

It also found that such bills were more common in hospitals that contracted with particular ED staffing agencies.[10] This suggests that a potentially small number of providers are disproportionately responsible for surprise billing for ED services and they may have devised practices that enable them to shift the costs imposed by the emergency care mandate Congress enacted in 2010 to patients.

Adopting a sweeping and unprecedented new set of federal mandates to address poorly understood problems that appear to have arisen from existing federal mandates is likely to produce bad policy that will have similarly unintended adverse consequences for patients.

Leading Federal Legislation on Surprise Billing

Congress seems nonetheless poised to move legislation quickly to deal with the issue. Both the Senate HELP Committee and the House Energy and Commerce Committee, as noted above, have produced bipartisan legislative text.

The two bills differ in a variety of ways, most particularly in the scope of the Senate bill, which is not confined to surprise medical bills, but also

offers policy prescriptions to address health care costs more broadly. While they also take slightly different approaches to surprise bills, both share two common overarching features.

First, both would hold patients harmless from surprise medical bills both for emergency care and for non-emergency care provided at in-network facilities.[11] When enrollees receive out-of-network medical care at a network facility, insurers would only be able to require them to pay in-network cost-sharing amounts, a requirement similar to the ACA provision on care received at out-of-network EDs. Using the example above, a patient whose knee surgery is performed by a network physician at a network facility would pay in-network cost-sharing rates for each of the services—and could not be presented with a surprise bill from the non-network anesthesiologist.

Second, both drafts would require non-network ED physicians (whether administering care at network or non-network facilities) and non-network physicians practicing at network facilities to accept the median rate an insurer pays network providers as payment in full. This approach is conceptually flawed, poorly suited to resolving a poorly understood problem, and one whose consequences are potentially far-reaching. Its conceptual flaws are obvious and have been noted elsewhere.[12] A regulated price is unlikely to match the market price.[13] If it is too high, physicians will be reluctant to participate in an insurer's network; if too low, insurers will have little incentive to form networks.[14]

Given that the insurance industry supports this approach and providers oppose it, the groups with the greatest economic stake in the matter appear to believe that the price is lower than providers otherwise might be paid. If so, providers can be expected to respond to the lower reimbursement by raising rates elsewhere, by increasing volume, or by other means, as some providers have done in response to the existing ED mandate.[15]

This leads to the proposal's design problem. It requires non-network providers to accept the median reimbursement paid to a plan's network providers. Put another way, a plan would pay non-network providers less than it pays *half* of its network providers. This diminishes the utility of network contracts.[16]

Finally, if government rate setting is viewed as a "patient protection" in these circumstances, it will lead to efforts to "protect" patients through government rate setting in others. This will produce further market distortions in an already distorted market. Consumers are better served by a market system in which they wield economic clout than by one in which government "protects" them through price setting.

Other Options for Dealing with Surprise Bills

A May 2019 bipartisan discussion draft bill produced by the Chairman and ranking Democrat on the Senate HELP Committee included two additional options for dealing with surprise medical bills: (1) requiring insurers and non-network providers to submit their disputes to binding arbitration, and (2) requiring insurers, hospitals, and non-network providers to enter into contractual arrangements to set non-network fees.

Arbitration. The committee draft proffered the option of forcing insurers and non-network physicians practicing at network facilities to resolve their differences through binding arbitration. More specifically, it instructed the Secretary of Health and Humans Services (HHS), "in consultation with the Secretary of Labor, [to] establish an independent dispute resolution [IDR] process...for resolving disputes" between insurers and providers.[17] It further required HHS to certify entities to run the IDR process, "taking into consideration whether each applicant entity is unbiased and unaffiliated with health plans and health insurance issuers and providers and free of conflicts of interest."[18]

These requirements impose several administrative challenges. First, the Secretary would have to determine whether an entity (or, more particularly, its board, officers, and arbiters) was "unbiased." This is an inherently subjective standard and one that is almost impossible to precisely define and effectively enforce. Second, it required IDR entities to be knowledgeable enough about health care markets to set market prices, yet unaffiliated with entities that participate in those markets. An IDR might recruit retired hospital CEOs, physicians, and insurance executives to serve as arbiters. That would meet the letter of the draft (which appears only to bar current, as opposed to past, affiliation), but not its spirit. More likely, the IDRs would have to seek out people who have arbitrated contractual disputes in unrelated fields on the assumption that procedural skills can substitute for substantive knowledge of health care markets.

The IDR entity would choose between final offers tabled respectively by the insurer and provider.[19] The discussion draft directed the IDR entity to select the "more reasonable" offer as the applicable rate. It provided little guidance for determining reasonableness.

In effect, arbitration merely outsources rate setting to arbitrators whose impartiality and lack of current industry affiliation is presumed to give them insight into what the market price for a service should be. There is little reason to believe that government-contracted arbiters will possess these faculties.

Finally, the arbitration concept is ill suited to the circumstances that Congress is seeking to address. Arbitration generally occurs in disputes arising from parties to a contract. These contracts commonly include a clause in which both parties agree to resolve their contractual disputes through arbitration.

Here, there is no contract. The two parties have declined to enter into one. Nor have they agreed to arbitration. The government has simply decreed it. For this reason, although proponents often cite "baseball arbitration" as their model, that reference is especially inapt.[20]

Contract Matching. Another option would prevent insurers from including a hospital or facility in its network unless each physician and provider of laboratory and diagnostic services is under contract as a participating provider.[21] Non-network physicians would have a choice between contracting directly with the insurer or having their fees included in the amount the insurer pays the facility.[22]

Under this option, hospitals, doctors, and insurers would resolve their differences through private negotiation. Each party has, implicitly or explicitly, represented itself as being in the consumer's insurance network. Each derives economic benefit from the arrangement. Hospitals and ambulatory surgical centers need anesthesiologists, and anesthesiologists need patients to anesthetize. Insurers need hospitals to agree to discounted rates, and hospitals need insurance companies to steer paying patients their way. This option leaves it to the various parties to work out contractual terms that best balance their respective interests.

Though less problematic than the alternatives, contract matching involves federal interference in private contracts. While it may be appropriate for government to ensure that consumers are not misled into thinking that they will be charged in-network cost-sharing rates when they seek care from a network physician at a network facility, it also is objectionable for the government to compel parties to establish contractual relationships.[23]

Conclusion

The problem of surprise medical bills is one whose nature and extent is still emerging. The practice benefits various segments of the health care industry at the expense of patients. The federal government may have inadvertently exacerbated the problem in 2010 by enacting legislation to protect patients from surprise bills when they receive care at non-network emergency departments. Adopting another round of "patient protection" mandates will likely inspire new efforts to shift the costs of these mandates to patients. Congress should instead consider the following steps:

1. **Slow down.** The political imperative to pass laws against surprise bills is powerful. The Senate HELP Committee and the House Energy and Commerce Committee are to be commended for proceeding in a bipartisan way, rather than reverting to partisan bickering. The committees should use this bipartisan moment to inquire more extensively into the nature, extent, and causes of the practice, including an examination of how earlier patient protection legislation may inadvertently have contributed to it.

2. **Limit the law's reach.** If Congress does legislate in this area, it should limit its reach. Federal intervention into health insurance markets that have traditionally been regulated by states has not worked out well for consumers. Premiums have skyrocketed, insurance markets have consolidated, cost-sharing requirements have grown more burdensome, networks have constricted, and choices have narrowed. If Congress does act on surprise bills, it should limit the legislation to self-funded plans that are beyond the reach of state regulators. Several states have gotten the jump on Congress in addressing this issue. States—including those that choose not to adopt new mandates—should be free to regulate their fully insured markets without federal interference.

3. **Be wary of solutions offered by industries that helped create the surprise-billing problem.** Surprise bills benefit insurers, providers, hospitals, and other facilities. The various parties that engage in the practice now offer competing solutions to protect their own interests. Congress should scrutinize each of these proposals and determine how they benefit the industries that are proposing them, and how they may lead to new practices that will harm consumers.

4. **Seek ways of empowering consumers instead of "protecting" them.** Congress should look for ways to let consumers wield the same economic power in medical care as they do throughout the rest of the economy. The best way to protect patients is to let them protect themselves through greater transparency, more information, and more freedom and control over their own health care spending. Congress should empower consumers, not protect them.

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Endnotes

1. Christina Cousart, "Highlights of State 'Surprise' Medical Billing Laws," National Academy for State Health Policy, March 18, 2019, https://nashp.org/highlights-of-seven-states-surprise-medical-balance-billing-laws/ (accessed June 25, 2019).
2. The White House, "Remarks by President Trump on Ending Surprise Medical Billing," May 9, 2019, https://www.whitehouse.gov/briefings-statements/remarks-president-trump-ending-surprise-medical-billing/ (accessed June 25, 2019).
3. Chairman's mark, U.S. Senate Committee on Health, Education, Labor and Pensions, June, 2019, https://www.help.senate.gov/imo/media/doc/Lower%20Health%20Care%20Costs%20Act1.pdf (accessed June 25, 2019), and Pallone-Walden Surprise Billing Discussion Draft, May 14, 2019, https://www.documentcloud.org/documents/6002466-Pallone-Walden-Surprise-Billing-Discussion-Draft.html (accessed June 25, 2019).
4. 42 U.S. Code 300gg-19a(b)(1)(C)(ii), http://uscode.house.gov/view.xhtml?req=(title:42%20section:300gg-19a%20edition:prelim) (accessed June 25, 2019).
5. Ibid.
6. 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 (accessed June 25, 2019).
7. Ibid.
8. 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, https://www.nber.org/papers/w23623 (accessed June 25, 2019).
9. Ibid., pp. 19, 20, and 52 (Figure 1).
10. Ibid., pp. 11–29.
11. Senate HELP Committee Chairman's Mark, sections 101–102, and House Energy and Commerce Committee Discussion Draft, May 2019, section 2.
12. Cooper, Scott Morton, and Shekita, "Surprise! Out-of-Network Billing for Emergency Care in the United States," p. 31, and Benedic N. Ippolito and David A. Hyman, "Solving Surprise Medical Billing," AEI Economic Perspectives, March 20, 2019, p. 4, http://www.aei.org/publication/solving-surprise-medical-billing/ (accessed June 25, 2019).
13. Cooper, Scott Morton, and Shekita, "Surprise! Out-of-Network Billing for Emergency Care in the United States," p. 31.
14. This is particularly true with respect to ED treatment, since payments to providers would be the same, regardless of whether the facility is included in the insurer's network.
15. One observed practice, for example, has been for the ED to increase the use of imaging and the percentage of patients admitted for inpatient care. See, for example, Cooper, Scott Morton, and Shekita, "Surprise! Out-of-Network Billing for Emergency Care in the United States," p. 26.
16. Some states that have adopted a similar approach have set reimbursement for non-network providers at some multiple of the median network rate. Connecticut, for example, sets it at the 80th percentile of network rates, while Maryland established reimbursement at 140 percent of the average. See Cooper, Scott Morton, and Shekita, "Surprise! Out-of-Network Billing for Emergency Care in the United States," p. 31.
17. Senate HELP Committee Chairman's mark, Title I, Subtitle B, section 103.
18. Ibid.
19. Ibid.
20. In the arbitration process used by Major League Baseball, a player with at least three, 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. (See Major League Baseball, "Salary Arbitration," http://m.mlb.com/glossary/transactions/salary-arbitration (accessed June 25, 2019).) 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 in the HELP Committee's discussion draft, 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.
21. Senate HELP Committee discussion draft, May 2019, Title I, Subtitle A, section 103(a).
22. Ibid., Title I, Subtitle A, section 103(b).
23. A more practical problem is that contract matching, per se, would not prohibit balance billing in non-network EDs. It would have to be joined with some other form of government intervention (such as rate setting or binding arbitration) in order to address this problem. Ippolito and Hyman, "Solving Surprise Medical Billing," p. 5.