

# Surprise Medical Bills: How to Protect Patients and Make Care More Affordable

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## INTRODUCTION

From 1978–1989, Ed Koch was the irrepressible mayor of New York City. During Koch’s tenure, he was well known for asking his constituents, “How’m I doing?”<sup>1</sup> Koch’s constant repetition of this question helped create a visceral connection with his constituents, but the responses also provided him with immediate and unfiltered feedback about his job performance and the performance of the government that he oversaw.

Statutory anniversaries—like the impending tenth anniversary<sup>2</sup> of the enactment of the Patient Protection and Affordable Care Act (PPACA)—provide a useful opportunity to ask a variant of the same question: “how’s it doing?” We examine the problem of surprise medical bills and consider how PPACA (and state and federal governments) are doing when it comes to addressing that problem.

As its name and clunky acronym indicate, PPACA was supposed to protect patients and make care more affordable. However, PPACA didn’t do much of anything about the problem of surprise medical bills because its backers had bigger fish to fry. Unfortunately, in fixing the problem they were most interested in (that is, making heavily subsidized or free coverage available to people who didn’t have it), the backers simply ignored the far larger number of Americans who had insurance and were subject to surprise medical bills and balance billing.

We note at the outset that surprise bills are not a problem in other markets. When you take your car to a body shop after an accident, the mechanic who paints your door panel doesn’t send you an inflated, separate bill from the body shop—and then balance bill you when your insurance refuses to pay it in full. That isn’t because we have an elaborate system of arbitration for car door repairs. Nor is it because the government provides rate-setting for auto repairs, with different levels of payment for door panels than bumpers, and higher rates for fixing more expensive cars and trucks. Instead, there are no surprise bills from body shops because the market demands all-in pricing. Body shops respond by bundling all the necessary services into a single, all-in price and then billing for everything themselves. Why can body shops do what hospitals can’t? In this Article, we argue that policymakers can use contract-forcing regulation to make hospitals behave more like body shops—and prevent the majority of surprise bills.

Part I provides background on surprise medical bills, including anecdotal complaints and empirical evidence regarding their prevalence. Part II highlights the failure of PPACA to effectively address the problem and describes the efforts states have made—and pending efforts at the federal level—to fix the problem,

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1. Joel Rose, *Ed Koch Dies; Outspoken Mayor Brought N.Y. Back from the Brink*, NPR (Feb. 1, 2013, 6:30 AM), <https://www.npr.org/2013/02/01/170789121/ed-koch-outspoken-mayor-who-brought-n-y-back-from-the-brink-dies> [<https://perma.cc/B9EA-28JT>].

2. For unclear reasons, academics persist in referring to the “anniversary” of statutes, regulations, departments, agencies, and bureaus when it is actually the birthday they are celebrating.

along with the associated trade-offs. Part III outlines an innovative strategy for (mostly) fixing the problem of surprise medical bills and considers the implications of this sorry episode for the future of health law and policy.

## I. SURPRISE MEDICAL BILLS 101

### A. ANECDOTES

The news is full of stories about people with health insurance who are hit with large (and sometimes staggering) surprise medical bills. There's the man who got emergency back surgery and received bills totaling more than \$650,000.<sup>3</sup> There's the woman who had surgery for a chronic neurological condition and was billed \$240,000 by two plastic surgeons to close her incision—when a resident performed that procedure for free in her previous operations.<sup>4</sup> What about the man who had surgery for herniated disks in his neck and received a surprise bill of \$117,000 from the assistant surgeon—after the primary surgeon was paid only \$6,200?<sup>5</sup> Then, there's the man who had neurosurgery after a fall and received surprise bills totaling \$106,000,<sup>6</sup> and the woman who had spinal surgery and got a surprise bill of \$101,000.<sup>7</sup>

By comparison, the woman who was hit with surprise bills of more than \$40,000 for abdominal surgery got off cheap.<sup>8</sup> What about the family that was billed \$40,000 for a ride in an air ambulance?<sup>9</sup> Then, there's the couple that received a bill for \$18,000 from an emergency department after their young child was “treated” with a nap and a bottle of formula.<sup>10</sup> Plus, the nearly \$18,000 bill

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3. See Anna Werner, *Back Surgery Saved Him from Paralysis. Then the Bills Arrived: Over \$650,000*, CBS THIS MORNING (Sept. 23, 2019, 6:31 AM), <https://www.cbsnews.com/news/back-surgery-saved-him-from-paralysis-then-the-bills-arrived-over-650000> [<https://perma.cc/G59H-SW8R>].

4. See CHARLES SILVER & DAVID A. HYMAN, *OVERCHARGED: WHY AMERICANS PAY TOO MUCH FOR HEALTH CARE* 175–76 (2018).

5. See Elisabeth Rosenthal, *After Surgery, Surprise \$117,000 Medical Bill from Doctor He Didn't Know*, N.Y. TIMES (Sept. 20, 2014), <https://www.nytimes.com/2014/09/21/us/drive-by-doctoring-surprise-medical-bills.html>.

6. See Haley Sweetland Edwards, *How You Could Get Hit with a Surprise Medical Bill*, TIME (Mar. 7, 2016, 2:38 PM), <https://time.com/4246845/health-care-insurance-surprise-medical-bill> [<https://perma.cc/54J7-DRB7>].

7. See Sarah Kliff, *A Spinal Surgery, a \$101,000 Bill, and a New Law to Prevent More Surprises*, VOX (Mar. 19, 2019, 8:00 AM), <https://www.vox.com/health-care/2019/3/19/18233051/surprise-medical-bills-arbitration-new-york> [<https://perma.cc/5J5H-L9EJ>].

8. See Anna Werner, *Even with Insurance, Woman Hit with \$40,000 in Medical Bills*, CBS EVENING NEWS (Oct. 1, 2019, 6:39 PM), <https://www.cbsnews.com/news/even-with-insurance-woman-stuck-with-40000-medical-bill> [<https://perma.cc/MQ2J-5V8W>].

9. See Mireya Villarreal, *“It Would've Destroyed Us”: Family Left with Unexpected \$40,000 Bill for Son's Air Ambulance*, CBS EVENING NEWS (Apr. 2, 2019, 6:45 PM), <https://www.cbsnews.com/news/family-left-with-unexpected-40000-bill-for-sons-air-ambulance-2019-04-02> [<https://perma.cc/62H9-294L>].

10. See Jenny Gold & Sarah Kliff, *A Baby Was Treated with a Nap and a Bottle of Formula. His Parents Received an \$18,000 Bill*, VOX (July 20, 2018, 11:03 AM), <https://www.vox.com/2018/6/28/17506232/emergency-room-bill-fees-health-insurance-baby> [<https://perma.cc/9SPQ-GKZD>].

that a patient received for a simple urine test.<sup>11</sup> And then, there's the patient who received a bill for \$5,751 from an emergency department after she cut her ear and was treated with an ice pack.<sup>12</sup> Don't forget about the parents who were billed over \$4,000 in out-of-network charges because, although the hospital where their son was born was in-network, its neonatal intensive-care unit was not.<sup>13</sup>

Some news outlets now have regular features on outrageous surprise medical bills: NPR and Kaiser Health News have the "Bill of the Month,"<sup>14</sup> and CBS has "Medical Price Roulette."<sup>15</sup> The Daily Show devoted a segment to the issue—a testament to its popular appeal.<sup>16</sup>

Although we have focused so far on large surprise bills, even modest surprise bills can create considerable financial difficulties for many Americans. Accordingly, our analysis focuses on all surprise bills—both large and small.

#### B. HOW COMMON IS SURPRISE MEDICAL BILLING?

In a country of more than 300 million people, it is easy to find anecdotes about every horror and mishap under the sun. The important question is whether these awful anecdotes are representative. Unfortunately, the lengthy list of anecdotes presented in section I.A is just the tip of the iceberg. A Consumers Union survey found that almost one-third of privately insured respondents had received an unanticipated medical bill within the preceding two years.<sup>17</sup> A survey conducted jointly by the Kaiser Family Foundation and the *New York Times* reported that "among insured, non-elderly adults struggling with medical bill problems, charges from out-of-network providers were a contributing factor about one-third of the time."<sup>18</sup> According to a 2017 study in the *New England Journal of Medicine*, 22% of patients received a bill they did not expect—but that number

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11. See Fred Schulte, *How a Urine Test After Back Surgery Triggered a \$17,850 Bill*, NPR (Feb. 16, 2018, 5:01 AM), <https://www.npr.org/sections/health-shots/2018/02/16/584296663/how-a-urine-test-after-back-surgery-triggered-a-17-800-bill> [<https://perma.cc/MEU3-M8A3>].

12. See Sarah Kliff, *I Read 1,182 Emergency Room Bills This Year. Here's What I Learned*, VOX (Dec. 18, 2018, 7:00 AM), <https://www.vox.com/health-care/2018/12/18/18134825/emergency-room-bills-health-care-costs-america> [<https://perma.cc/QB65-BYJW>].

13. See Haley Sweetland Edwards, *The Hidden Cost of 'Surprise' Medical Bills*, TIME (Mar. 3, 2016, 6:28 AM), <https://time.com/4246077/medical-bills-hidden-cost>.

14. See *Bill of the Month*, KAISER HEALTH NEWS, <https://khn.org/news/tag/bill-of-the-month> [<https://perma.cc/64RU-VRD9>] (last visited May 18, 2020); *Bill of the Month*, NPR, <https://www.npr.org/series/651784144/bill-of-the-month> (last visited May 18, 2020).

15. See *Medical Price Roulette*, CBS NEWS (Sept. 23, 2019), <https://www.cbsnews.com/medical-price-roulette> [<https://perma.cc/59PS-8F58>].

16. See Lewis Black, *The Daily Show with Trevor Noah: Back in Black—Surprise Medical Bills*, COMEDY CENT. (Oct. 8, 2019), <http://www.cc.com/video-clips/8veed6/the-daily-show-with-trevor-noah-back-in-black—surprise-medical-bills>.

17. CONSUMER REPS. NAT'L RES. CTR., SURPRISE MEDICAL BILLS SURVEY: 2015 NATIONALLY-REPRESENTATIVE ONLINE SURVEY 2 (2015), <https://advocacy.consumerreports.org/wp-content/uploads/2015/05/CY-2015-SURPRISE-MEDICAL-BILLS-SURVEY-REPORT-PUBLIC.pdf> [<https://perma.cc/M773-G8LC>].

18. KAREN POLLITZ, KAISER FAMILY FOUND.: SURPRISE MEDICAL BILLS 1 (2016), <http://files.kff.org/attachment/issue-brief-surprise-medical-bills> [<https://perma.cc/V966-SQLR>].

was 89% for patients treated at in-network hospital emergency departments in McAllen, Texas.<sup>19</sup> Similarly, a recent study in the health policy journal *Health Affairs* found that “20 percent of hospital inpatient admissions that originated in the emergency department . . . 14 percent of outpatient visits to the [emergency department], and 9 percent of elective inpatient admissions likely led to a surprise medical bill.”<sup>20</sup> Another study of 9 million emergency-department visits from 2011 to 2015 found that 22% of patients who went to an in-network hospital received a bill from an out-of-network emergency-department physician.<sup>21</sup>

Most recently, a 2019 study in *JAMA Internal Medicine* using records from one large insurer found that 39% of almost 14 million visits to the emergency department at in-network hospitals resulted in an out-of-network bill.<sup>22</sup> That figure increased over the study period, from 32.3% in 2010 to 42.8% in 2016.<sup>23</sup> Out-of-network bills following hospital admission at in-network hospitals occurred at comparable rates—37% of admissions resulted in at least one out-of-network bill, increasing from 26.3% in 2010 to 42% in 2016.<sup>24</sup>

The problem of surprise medical bills is much worse at certain hospitals. A recent study using data from a national insurer found that less than 2% of emergency-department visits at the median in-network hospital generated out-of-network bills.<sup>25</sup> However, at just 15% of in-network hospitals, at least 80% of emergency department visits generated a similar bill.<sup>26</sup> In other words, at least for this insurer, most surprise medical bills appear to come from a relatively small portion of healthcare facilities. These figures indicate that most hospitals that are in-network for this insurer have largely solved the problem of surprise medical bills by either hiring physicians directly or requiring their physicians to accept the same insurance as the hospital.

On the other hand, some physicians or their management companies have decided that balance billing is so lucrative that it makes more sense to remain out-of-network, despite the resulting financial stress on patients. EmCare is one of the largest physician-management firms for emergency departments in the United States. One recent study used data from a large national health insurer to capture how emergency-department billing practices changed when EmCare took over.<sup>27</sup> On average, out-of-network billing rates increased by 80 percentage

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19. Zack Cooper & Fiona Scott Morton, *Out-of-Network Emergency-Physician Bills—An Unwelcome Surprise*, 375 *NEW ENG. J. MED.* 1915, 1916 (2016).

20. Christopher Garmon & Benjamin Chartock, *One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills*, 36 *HEALTH AFF.* 177, 177 (2017).

21. Zack Cooper et al., *Surprise! Out-of-Network Billing for Emergency Care in the United States* 9, 15 (Nat'l Bureau of Econ. Research, Working Paper No. 23,623, Jan. 2018), <https://www.nber.org/papers/w23623.pdf> [<https://perma.cc/3EVQ-3425>].

22. Eric C. Sun et al., *Assessment of Out-of-Network Billing for Privately Insured Patients Receiving Care in In-Network Hospitals*, 179 *JAMA INTERNAL MED.* 1543, 1545–46 (2019).

23. *Id.*

24. *Id.* at 1546.

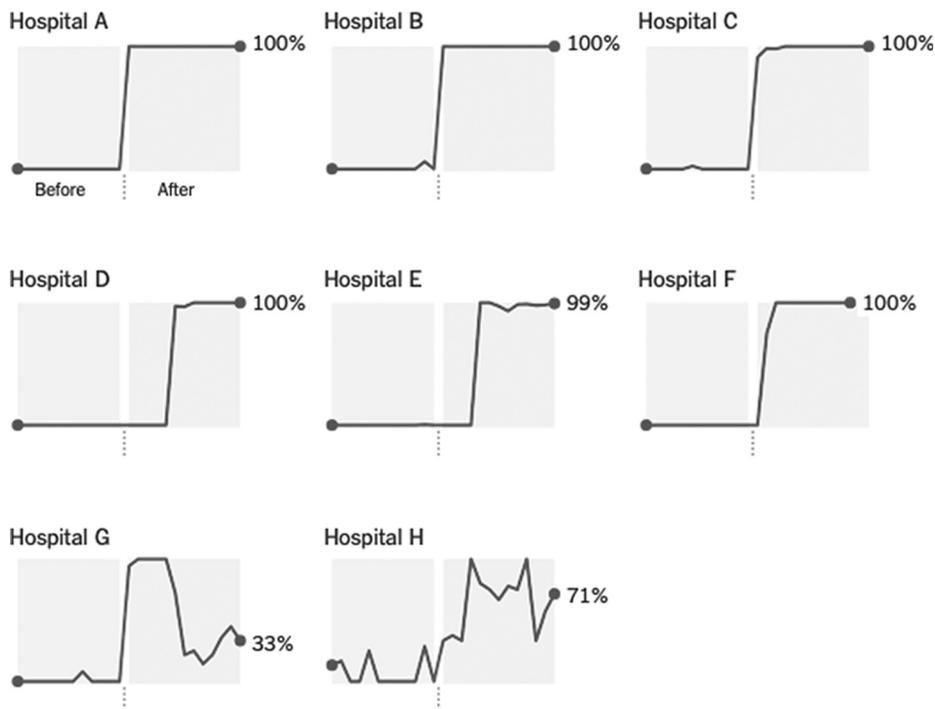
25. Cooper et al., *supra* note 21, at 4.

26. *Id.*

27. *See generally id.*

points and list prices almost doubled—substantially increasing both the frequency and magnitude of balance bills.<sup>28</sup> At many facilities, 100% of emergency-department patients received an out-of-network bill. Figure 1 is reproduced from a *New York Times* article about this study.<sup>29</sup> It shows what happened to the rates at which eight hospitals sent out-of-network bills after those hospitals hired EmCare to manage their emergency departments. At each hospital, the frequency of out-of-network bills increased dramatically, often rising from a low level to 100%. One of the authors of the study aptly described the change in billing practices as looking “like a light switch was being flipped on.”<sup>30</sup>

**Figure 1**



Note: Out-of-network rates for customers of one large insurer who visited an emergency department at eight hospitals, for the year before and after those hospitals switched to EmCare.

28. *See id.* at 24, 36.

29. *See* Julie Creswell et al., *The Company Behind Many Surprise Emergency Room Bills*, N.Y. TIMES: THE UPSHOT (July 24, 2017), <https://www.nytimes.com/2017/07/24/upshot/the-company-behind-many-surprise-emergency-room-bills.html>. For a similar figure containing additional hospitals, *see* Cooper et al., *supra* note 21, at 101–03.

30. Creswell et al., *supra* note 29.

To sum up, surprise medical bills are not isolated, accidental, or freakish. Instead, they are a common feature of the American healthcare marketplace. It is not an accident that in a 2018 Kaiser Family Foundation poll, respondents listed “unexpected medical bills” as their number one concern—ranking well ahead of prescription-drug costs and health-insurance premiums.<sup>31</sup>

We now turn to the economics of surprise medical bills. Our objective is to understand why some parts of the healthcare system generate them while others do not, and why similar bills are unheard of outside the healthcare system.

### C. ECONOMICS OF SURPRISE MEDICAL BILLS

As noted previously, surprise medical bills are generated when patients are unexpectedly treated and then billed by a provider who is out-of-network. In-network providers agree to accept payment from an insurance company as full compensation in exchange for inclusion in the network. Out-of-network providers decline to participate in the network and retain the right to charge whatever they like.

Healthcare providers typically have a list of “prices” for the products and services they provide (called a “chargemaster” in the hospital context). These “prices” bear some similarity to the MSRP (manufacturer’s suggested retail price) of a car. However, in healthcare, unlike most other markets, these supposed “prices” far exceed the typical price at which transactions occur.<sup>32</sup>

The pricing discrepancy is the result of the in-network/out-of-network dynamic referenced above. Providers agree to discount their supposed list prices in order to be included in an insurer’s network. From the patient’s perspective, seeing an in-network provider means they will face a lower out-of-pocket cost—both because their cost-sharing is based on a lower (negotiated) rate, and because they will not be “balance” billed for any amount that exceeds the fee their insurer agreed to pay. These advantages motivate patients to visit in-network providers when they have control over where they go.

Conversely, when patients go to an out-of-network provider, they are billed at full list price, and many providers will attempt to collect their entire charges via “balance billing.” Although a small number of patients knowingly choose to go to an out-of-network provider, most patients do not voluntarily select this higher priced option when they have any choice in the matter.

Given these dynamics, it should not come as a surprise that patients typically have little or no control over whether they are seen by the types of providers that generate surprise bills. For example, patients typically do not pick emergency departments on the basis of their billing practices. They go to the closest or most

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31. Jordan Rau, *Surprise Medical Bills Are What Americans Fear Most in Paying for Health Care*, KAISER HEALTH NEWS (Sept. 5, 2018), <https://khn.org/news/surprise-medical-bills-are-what-americans-fear-most-in-paying-for-health-care> [<https://perma.cc/2BQW-F58W>].

32. See Michael Batty & Benedic Ippolito, *Mystery of the Chargemaster: Examining the Role of Hospital List Prices in What Patients Actually Pay*, 36 HEALTH AFF. 689, 689 (2017) (noting that chargemasters are often more than 300% of actual average payment).

convenient emergency department or are taken there by ambulance. For virtually all patients, their visit to the emergency department is the first and last time they will meet the doctor. And even when patients deliberately elect to go to an emergency department at an in-network hospital, they have no way of knowing whether the physician they will see is in-network. The same dynamics apply to anesthesiologists, radiologists, and pathologists.

This is not to suggest that patients do not respond to surprise medical bills as best they can. One recent study showed that mothers who receive out-of-network bills after having their babies delivered are more likely than others to change hospitals for their next birth, and that those who did change reduced the risk of receiving an out-of-network bill by over 50%.<sup>33</sup> Unfortunately, that is an under-powered solution to the problem of surprise medical bills.

Surprise bills are most often generated in four situations:

- 1) *Emergency Care 1*: Patient receives emergency care at an emergency department in an in-network hospital, but one or more clinicians involved in his or her treatment (for example, emergency medicine physicians, ancillary physicians, or other specialists working in the emergency department) are out-of-network.
- 2) *Emergency Care 2*: Patient is treated at an out-of-network facility in an emergency.
- 3) *Routine Hospital Care*: Patient visits an in-network hospital but is treated by a physician who is out-of-network.
- 4) *Transport by Ambulance*: Patient is transported to a hospital by an out-of-network ambulance.

In Part III, we evaluate the merits of various attempts to protect patients from surprise bills in these four clinical scenarios, including the complications created by the differences between them. For example, the first, second, and fourth scenarios involve emergencies, but the third does not. And in two of the scenarios (the first and third), the patient's insurer has a pre-existing contract with the facility in which care is rendered, while in the other two (the second and fourth) it does not. These variations bear on the effectiveness of the reform strategies we outline below.

Although there is a distinct tendency to focus on the luckless patients who receive surprise bills, the effects are not limited to those patients. The categories of providers that engage in this behavior will only join networks if the in-network payments are very generous. Stated differently, providers will choose to be in-network only if the amount they receive from insurers is worth more to them than the right to balance bill patients by remaining out-of-network.

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33. Benjamin Chartock et al., *Consumers' Responses to Surprise Medical Bills in Elective Situations*, 38 HEALTH AFF. 425, 428–29 (2019).

Unsurprisingly, the physicians that are least likely to have to compete for patients' business (for example, emergency-department doctors, anesthesiologists, and radiologists) command very high in-network rates. Private insurers pay anesthesiologists, emergency physicians, and radiologists between 204% and 344% of what Medicare pays those same specialties.<sup>34</sup> The top 20% of anesthesiologists have list prices that are over 1,000% of Medicare rates.<sup>35</sup> By comparison, data from one large, national, preferred provider organization (PPO) showed that, across all physicians, payment rates averaged only 128% of Medicare's rate.<sup>36</sup> Providers that do not compete for business have the greatest leverage over insurers and patients because they can remain out-of-network without losing customers. Consequently, the strategy of balance billing works well for them.

Providers offer an alternative explanation for balance billing patients: insurers are too cheap. When insurers do not pay enough, providers elect to remain out-of-network. For example, Rebecca Parker, the president of the American College of Emergency Physicians, blamed "insurance company bad behavior."<sup>37</sup> Similarly, Dr. Steven Stack, who served as president of the American Medical Association, claimed, "The real crux of the problem is that health insurers are refusing to pay fair market rates for the care provided."<sup>38</sup> Hospital administrators agree that insurers are the guilty parties, and should "pay more, expand their networks, and eliminate the problem."<sup>39</sup> At least one law professor (now on leave while serving in Congress) agrees that insurance companies are to blame for balance bills.<sup>40</sup>

Naturally, insurers see things differently. They accuse doctors who balance bill for out-of-network charges of price gouging, and they accuse hospitals of being complicit in the misconduct, at the expense of the patients they treat. Insurers contend that it is hospitals' "responsibility to ensure all physicians treating patients in their facility are covered by the same insurance contracts as the

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34. LOREN ADLER ET AL., U.S.C.—BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POLICY, STATE APPROACHES TO MITIGATING SURPRISE OUT-OF-NETWORK BILLING 9 fig.4 (2019), [https://www.brookings.edu/wp-content/uploads/2019/02/Adler\\_et-al\\_State-Approaches-to-Mitigating-Surprise-Billing-2019.pdf](https://www.brookings.edu/wp-content/uploads/2019/02/Adler_et-al_State-Approaches-to-Mitigating-Surprise-Billing-2019.pdf) [<https://perma.cc/5MPJ-6WWB>].

35. *See id.* at 21 tbl.1.

36. *Id.* at 8.

37. SILVER & HYMAN, *supra* note 4, at 176.

38. Bob Herman, *Billing Squeeze: Hospitals in Middle as Insurers and Doctors Battle Over Out-of-Network Charges*, MOD. HEALTHCARE (Aug. 29, 2015, 1:00 AM), <https://www.modernhealthcare.com/article/20150829/MAGAZINE/308299987/billing-squeeze-hospitals-in-middle-as-insurers-and-doctors-battle-over-out-of-network-charges> [<https://perma.cc/JJQ5-5UPW>]; *see also* Letter from Marc M. Kerner, Professor, UCLA Sch. of Med., to Wall St. J. (June 17, 2019), in *Don't Blame Doctors for Those Surprise Bills*, WALL ST. J. (June 17, 2019, 5:27 PM), <https://www.wsj.com/articles/dont-blame-doctors-for-those-surprise-bills-11560806878> (presenting a letter arguing that "[t]he real problem is that insurers completely control and determine the rates paid to physicians").

39. Edwards, *supra* note 6.

40. *See Protecting Patients from Surprise Medical Bills: Hearing Before the Subcomm. on Health of the H. Comm. on Ways & Means*, 116th Cong. 2 (2019) (statement of Rep. Katie Porter) (blaming insurer for "putting profits before patients," but failing to note that it was the surgeon's decision to be out-of-network that was responsible for the balance bill).

hospital.”<sup>41</sup> Unfortunately, insurers have a hard time solving the problem of surprise bills because the doctors who are responsible for the most surprise bills know that they will have plenty of customers, whether they join insurers’ networks or not.

In response, some insurers are steering people away from hospitals that refuse to solve the problem themselves. Aetna encouraged its subscribers to avoid Allegheny Health Network hospitals in Pittsburgh when emergency-department physicians there began to balance bill “aggressively.”<sup>42</sup> UnitedHealthcare announced that it would stop covering any medical bills for members who unknowingly received out-of-network treatment by physicians at in-network hospitals.<sup>43</sup> It remains to be seen whether these strategies will be effective. Dissatisfaction with the overall situation has led multiple states to implement legislative reform, and Congress is currently considering several bills on the subject. We now turn to that issue.

## II. REFORMS

In the past half-decade, there has been considerable legislative activity on the problem of surprise medical billing.<sup>44</sup> We begin with efforts at the state level and then turn to the somewhat more recent federal efforts.

### A. STATE-LEVEL INITIATIVES

States have developed several distinct strategies to address the problem of surprise medical bills. All seek to take the patient out of the middle and sort out an appropriate payment level that the insurer must deliver to the provider. But, even in states that have adopted the same general strategy, there is considerable variation in the providers and circumstances covered, as well as in other design details. At last count, more than half the states have enacted legislation to address surprise medical bills.<sup>45</sup>

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41. Ayla Ellison, *Patients Hit with Surprise Bills for 22% of In-Network ER Visits*, BECKER’S HOSP. CFO REP. (Nov. 17, 2016), <https://www.beckershospitalreview.com/finance/patients-hit-with-surprise-bills-for-22-of-in-network-er-visits.html> [<https://perma.cc/UHX9-DNFJ>].

42. See Brooke Murphy, *20 Things to Know About Balance Billing*, BECKER’S HOSP. CFO REP. (Feb. 17, 2016), <https://www.beckershospitalreview.com/finance/20-things-to-know-about-balance-billing.html> [<https://perma.cc/4T7W-KLJX>].

43. *Id.*

44. See Michael Ollove, *Surprise Medical Billing: Some States Ahead of Feds*, PEW STATELINE (Apr. 5, 2019), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2019/04/05/surprise-medical-billing-some-states-ahead-of-feds> [<https://perma.cc/72U6-B54A>] (reporting that at least twenty-five states now have laws protecting patients from surprise medical bills, with at least twenty more actively considering legislation).

45. See Jack Hoadley et al., *State Efforts to Protect Consumers from Balance Billing*, COMMONWEALTH FUND (Jan. 18, 2019), <https://www.commonwealthfund.org/blog/2019/state-efforts-protect-consumers-balance-billing> [<https://perma.cc/KY3C-7RP9>]; Maanasa Kona, *State Balance-Billing Protections*, COMMONWEALTH FUND (Apr. 22, 2020), <https://www.commonwealthfund.org/publications/maps-and-interactives/2019/jul/state-balance-billing-protections> [<https://perma.cc/5UKP-NET3>]; see also KEVIN LUCIA ET AL., COMMONWEALTH FUND, *BALANCE BILLING BY HEALTH CARE PROVIDERS: ASSESSING CONSUMER PROTECTIONS ACROSS STATES 2–3* (2017), <https://www.commonwealthfund.org/sites/default/>

## 1. The Independent-Dispute-Resolution (IDR) Approach

One reform strategy is to create an independent-dispute-resolution (IDR) mechanism for handling surprise medical bills after they are sent out. Patients are required to pay only the amounts they would have incurred at an in-network facility—thus taking them out of the middle of the dispute. Providers may use the IDR process to determine how much the insurance company will be required to pay, over and above the amount they would have paid if the provider was in-network. The IDR process can either be structured to require “baseball arbitration,” or it can allow arbitrators to “split the baby.”<sup>46</sup>

Legislation enabling IDR usually specifies how the arbitrator should go about resolving pricing disputes—typically by listing several factors that must be considered by the arbitrator. One obvious complication with IDR is that it simply transfers the rate-setting determination into a nontransparent setting. Another complication is that the typical laundry list of factors makes the IDR process less predictable.<sup>47</sup> Arbitrators are likely to develop rules of thumb, which may or may not end up matching the actual market prices they are trying to approximate.<sup>48</sup>

New York is the leading example of the IDR approach. In 2015, New York enacted legislation authorizing the use of IDR for handling bills sent by out-of-network providers in emergency situations and in nonemergency situations when patients receive treatment at an in-network hospital or facility.<sup>49</sup> New York’s IDR is based on a baseball-arbitration model. The arbitrator is required to consider a series of factors before deciding which of the two figures—the final offer

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files/documents/\_\_\_media\_files\_publications\_issue\_brief\_2017\_jun\_lucia\_balance\_billing\_ib.pdf [https://perma.cc/6NF2-JAQZ].

46. See *Salary Arbitration*, MAJOR LEAGUE BASEBALL, <http://m.mlb.com/glossary/transactions/salary-arbitration> [https://perma.cc/S69G-N9JB] (last visited Apr. 13, 2020) (“Players who have three or more years of Major League service but less than six years of Major League service become eligible for salary arbitration if they do not already have a contract for the next season. Players who have less than three but more than two years of service time can also become arbitration eligible if they meet certain criteria; these are known as “Super Two” players. Players and clubs negotiate over salaries, primarily based on comparable players who have signed contracts in recent seasons. A player’s salary can indeed be reduced in arbitration – with 20 percent being the maximum amount by which a salary can be cut. . . . If the club and player have not agreed on a salary by a deadline in mid-January, the club and player must exchange salary figures for the upcoming season. After the figures are exchanged, a hearing is scheduled in February. If no one-year or multi-year settlement can be reached by the hearing date, the case is brought before a panel of arbitrators. After hearing arguments from both sides, the panel selects either the salary figure of either the player or the club (but not one in between) as the player’s salary for the upcoming season.”).

47. See *Sears, Roebuck & Co. v. Comm’r*, 972 F.2d 858, 863–64 (7th Cir. 1992) (“Lists without metes, bounds, weights, or means of resolving conflicts do not identify necessary or sufficient conditions; they never prescribe concrete results.”).

48. See David A. Hyman & Benedic Ippolito, *Arbitration Not the Answer to Fix Surprise Medical Billing*, REAL CLEAR POL’Y (Feb. 12, 2019), [https://www.realclearpolicy.com/articles/2019/02/12/arbitration\\_not\\_the\\_answer\\_to\\_fix\\_surprise\\_medical\\_billing\\_111042.html](https://www.realclearpolicy.com/articles/2019/02/12/arbitration_not_the_answer_to_fix_surprise_medical_billing_111042.html) [https://perma.cc/NNS8-BX7K]; Benedic Ippolito, *Get Rid of Surprise Medical Bills*, WALL ST. J. (June 11, 2019, 7:05 PM), <https://www.wsj.com/articles/get-rid-of-surprise-medical-bills-11560294309> (arguing that the IDR approach “simply punts the problem to arbiters who will determine rates for each service”).

49. See *Surprise Medical Bills*, N.Y. ST. DEP’T FIN. SERVS., [https://www.dfs.ny.gov/consumers/health\\_insurance/surprise\\_medical\\_bills](https://www.dfs.ny.gov/consumers/health_insurance/surprise_medical_bills) [https://perma.cc/KCZ9-DGTY] (last visited Mar. 3, 2020).

submitted by the provider or that of the insurer—to adopt as the “correct” price. The factors include provider experience and training, case complexity, patient characteristics, and the usual and customary charges for providing the same services.<sup>50</sup>

Several studies have examined the effect of New York’s statute. A mostly interview-based study found that consumer complaints about surprise medical bills had dropped dramatically, and provider and insurer stakeholders believed the process was fair, with decisions roughly evenly split between the two sides.<sup>51</sup> However, those involved acknowledge the limited scope of what New York had actually accomplished by adopting IDR:

Health care is complicated. Determining how providers set prices for their services, how insurers determine what to pay for those services, or ultimately what those services should actually cost is “three-dimensional chess.” New York’s Surprise Billing law doesn’t attempt to answer any of those questions. It simply says that patients should not be the ones expected to figure it out. On that score, the law has been a success. . . . For the most part, insurers and providers appear to be working out their differences without resorting to arbitration. Further, there is not yet clear evidence that the law’s use of UCR [usual, customary, and reasonable] as a benchmark price has had broadly inflationary effects.<sup>52</sup>

A careful quantitative study found that out-of-network billing in New York declined by 34% and in-network emergency-department physician payments declined by 9%.<sup>53</sup> However, a recent report by the New York State Department of Financial Services covering 2015–2018 found a substantial increase over time in the number of cases that were going through the IDR process—increasing the transaction costs for everyone involved.<sup>54</sup> And there are also serious concerns that New York’s guidance that arbiters should consider the eightieth percentile of billed charges is likely to increase overall healthcare costs and health-insurance premiums.<sup>55</sup> Indeed, a very similar proposal at the federal level was reportedly

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50. *See id.*

51. *See* SABRINA CORLETTE & OLIVIA HOPPE, GEORGETOWN UNIV. HEALTH POL’Y INST., CTR. ON HEALTH INS. REFORMS, NEW YORK’S 2014 LAW TO PROTECT CONSUMERS FROM SURPRISE OUT-OF-NETWORK BILLS MOSTLY WORKING AS INTENDED: RESULTS OF A CASE STUDY 8 (2019), [https://nationaldisabilitynavigator.org/wp-content/uploads/news-items/GU-CHIR\\_NY-Surprise-Billing\\_May-2019.pdf](https://nationaldisabilitynavigator.org/wp-content/uploads/news-items/GU-CHIR_NY-Surprise-Billing_May-2019.pdf) [<https://perma.cc/2AWS-B3HG>].

52. *Id.* at 10.

53. Cooper et al., *supra* note 21, at 6.

54. LINDA A. LACEWELL, N.Y. ST. DEP’T FIN. SERVS., NEW YORK’S SURPRISE OUT-OF-NETWORK PROTECTION LAW: REPORT ON THE INDEPENDENT DISPUTE RESOLUTION PROCESS 3 (2019), [https://www.dfs.ny.gov/system/files/documents/2019/09/dfs\\_oon\\_idr.pdf](https://www.dfs.ny.gov/system/files/documents/2019/09/dfs_oon_idr.pdf) [<https://perma.cc/37N8-HWHS>].

55. *See* Loren Adler, *Experience with New York’s Arbitration Process for Surprise Out-of-Network Bills*, U.S.C.—BROOKINGS SCHAEFFER FOR HEALTH POL’Y (Oct. 24, 2019), <https://healthpolicy.usc.edu/brookings-schaeffer/experience-with-new-yorks-arbitration-process-for-surprise-out-of-network-bills/> [<https://perma.cc/N3XE-GES8>]. As Adler explains:

estimated by the Congressional Budget Office to increase the federal deficit by “double digit billions” of dollars.<sup>56</sup>

## 2. The Rate-Setting Approach

The second strategy for handling surprise bills is an explicit form of rate-setting, which specifies a formula for determining the amount an insurer must pay when care is rendered by an out-of-network provider. Providers are prohibited from balance billing the patient—meaning they are required to accept the amount specified in the statutory formula as full payment for their services. Once again, patients are required to pay only the amounts they would have incurred at an in-network facility, thus taking them out of the middle of the dispute.

California is the leading example of the rate-setting approach. In 2016, California enacted legislation (A.B. 72) that requires health plans regulated by the California Department of Managed Health Care and the California Department of Insurance to pay out-of-network physicians at in-network hospitals the greater of the insurer’s local, average contracted rate or 125% of the Medicare reimbursement rate.<sup>57</sup> If a patient receives a surprise bill, they are instructed to file a complaint with their health plan, which will pay the provider the specified amount.<sup>58</sup> A.B. 72 also provides for the creation of an IDR to handle any disputes between insurers and providers.<sup>59</sup> A.B. 72 explicitly excludes emergency services rendered at in-network facilities and does not address care provided at out-of-network facilities at all.<sup>60</sup>

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The biggest concern raised about NY’s arbitration process is the state’s guidance that arbiters should consider the 80th percentile of billed charges . . . . [T]elling arbiters to focus on 80th percentile of charges—that is, an amount higher than what 80% of [] physician’s charge for a given billing code—drives this standard still higher.

. . . [S]o there was initially some hope that arbiters might eschew this clearly inflationary guidance. Unfortunately, however, the New York Department of Financial Services report finds that arbitration decisions have averaged 8% higher than the 80th percentile of charges.

Therefore, it is likely that the very high out-of-network reimbursement now attainable through arbitration will increase emergency and ancillary physician leverage in negotiations with commercial insurers, leading either to providers dropping out of networks to obtain this higher payment, extracting higher in-network payment rates, or some combination thereof, which in turn would increase premiums.

*Id.*

56. Peter Sullivan, *CBO: Fix Backed by Doctors for Surprise Medical Bills Would Cost Billions*, HILL (Sept. 24, 2019, 2:48 PM), <https://thehill.com/policy/healthcare/462833-cbo-rival-fix-for-surprise-medical-bills-costs-double-digit-billions> [<https://perma.cc/K6UM-E53B>].

57. Assemb. B. 72, § 2, 2016 Leg., Reg. Sess. (Cal. 2016). A.B. 72 built on the foundation set by a 2008 regulation issued by the California Department of Managed Health Care, which effectively banned balance billing when patients were covered by a health maintenance organization (HMO) or certain PPO plans. See Bing Pao et al., *Impact of the Balance Billing Ban on California Emergency Providers*, 15 W. J. EMERGENCY MED. 518, 519 (2014). The California Supreme Court upheld these regulations in 2009. See *Prospect Med. Grp., Inc. v. Northridge Emergency Med. Grp.*, 198 P.3d 86, 88–89 (Cal. 2009).

58. See CAL. DEP’T MANAGED HEALTH CARE, SURPRISE MEDICAL BILLS 2 (2017), <https://dmhc.ca.gov/Portals/0/HealthCareInCalifornia/FactSheets/fsab72.pdf> [<https://perma.cc/E7CU-3G22>].

59. Assemb. B. 72 § 1.

60. See CAL. DEP’T MANAGED HEALTH CARE, *supra* note 58, at 1–2.

A.B. 72 appears to have reduced the number of surprise medical bills—along with physicians’ leverage in negotiations with insurers.<sup>61</sup> Because insurers can affect their “local average contracted rate” by cancelling contracts with above-average rates, they can use this strategy to drive down their costs for out-of-network care.<sup>62</sup> In response, providers are consolidating—supposedly in an attempt “to regain their [lost] leverage.”<sup>63</sup> The logic of consolidation under these circumstances is straightforward and driven by statutory-network-adequacy requirements. If there is only one provider group in an area, it must be included in any and all networks, increasing provider leverage to demand higher rates than would otherwise be the case. But provider consolidation was happening already—so it is difficult to disentangle the extent to which A.B. 72 accelerated that process.

There is also evidence that some specialists are declining to be on-call at some hospitals with a high percentage of Medi-Cal patients.<sup>64</sup> If that trend continues, it may result in access problems at those hospitals. Providers insist that the access problem is far more extensive, asserting in a letter to Congress that “[t]he California law is reducing access for patients to in-network physicians and jeopardizing access to on-call physician specialists needed in medical emergencies.”<sup>65</sup> It remains to be seen whether these are short-term dislocations or are precursors of a new equilibrium in which access is restricted, which will depend on whether

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61. See Erin L. Duffy, *Influence of Out-of-Network Payment Standards on Insurer–Provider Bargaining: California’s Experience*, 25 AM. J. MANAGED CARE e243, e244, e245 (2019); see also Loren Adler et al., *California Saw Reduction in Out-of-Network Care from Affected Specialties After 2017 Surprise Billing Law*, U.S.C.–BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POL’Y (Sept. 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/> [https://perma.cc/GEV3-FR7D] (observing that the timing and magnitude of a “modest shift” toward in-network claims suggests the law may have reduced the share of out-of-network services delivered); Sarah Kliff & Margot Sanger-Katz, *In California, a ‘Surprise’ Billing Law Is Protecting Patients and Angering Doctors*, N.Y. TIMES: THE UPSHOT (Sept. 26, 2019), <https://www.nytimes.com/2019/09/26/upshot/california-surprise-medical-billing-law-effects.html> (offering varying perspectives on whether the California rate-setting approach is working well or poorly).

62. Duffy, *supra* note 61, at e244. Providers complain bitterly about this practice, but there is no reason to think that the in-network rates they previously negotiated reflect true market prices, at least for the categories of providers that were able to send surprise bills with impunity. As detailed above, those providers are able to extract far higher payment levels based on their implicit threat to remain out-of-network unless they are amply rewarded for being in-network. Once that threat is removed or at least diminished, it is not an accident that those specialists who were previously exploiting the situation see a decline in the rates they can command. Thus, it should not come as a surprise that Duffy finds anesthesiologists, radiologists, and orthopedists are experiencing “unprecedented decreases in payers’ offered rates”—since those were the specialists who were generating surprise bills. *Id.* at e245.

63. Press Release, Erin L. Duffy, Adjunct Policy Researcher, RAND Corp., *California Rules to Limit Surprise Medical Bills Are Working, but Influence Insurer–Provider Bargaining* (Aug. 12, 2019), <https://www.rand.org/news/press/2019/08/12.html> [https://perma.cc/6SJM-8UWY].

64. See Duffy, *supra* note 61, at e245.

65. Letter from David H. Aizuss, President, Cal. Med. Ass’n, to Anna Eshoo, Chairwoman, Energy & Commerce Comm., U.S. House of Representatives, and Michael Burgess, Ranking Member, Energy & Commerce Comm., U.S. House of Representatives (July 10, 2019), <https://tinyurl.com/y45gft3> [https://perma.cc/2C5U-QQNH] [hereinafter Letter from Cal. Med. Ass’n].

payment levels are set below the market-clearing price. However, even short-run limitations on access can have substantial adverse consequences for patients.

Others states also use a rate-setting approach, with some variation in the benchmark that is employed. For example, Alaska and Connecticut use the eightieth percentile of providers' charges, while Maryland uses the 140th percentile of in-network payments.<sup>66</sup> The choice of benchmark affects the impact of rate-setting reforms; benchmarks that are tied to charges are extremely prone to manipulation and are likely to result in increased healthcare spending.

### 3. The Pay-Up Approach

Two states effectively required insurers to simply pay the full billed amounts for out-of-network care—although both have since abandoned that approach. Prior to August 30, 2018, New Jersey required patients to be held harmless for all balance bills and compelled insurers to pay their standard in-network amount (whether the provider was in-network or not).<sup>67</sup> If the provider was not satisfied with the in-network payment, they could negotiate an additional fee from the insurer, but if the parties were unable to come to an agreement, “the carrier may have to pay billed charges to assure the covered person is held harmless.”<sup>68</sup> Prior to January 1, 2020, Colorado had a similar regulatory framework.<sup>69</sup>

This approach dramatically increases provider bargaining leverage; if a provider knows that their out-of-network bill will be paid regardless of the amount, they are able to extract a far higher rate from insurers to be in-network. We have been unable to locate any studies of the effect of the pay-up approach once used by New Jersey and Colorado, but we are confident it is likely to result in higher healthcare spending over time. It is almost certainly not an accident that both states have abandoned this approach.

### 4. The Transparency Approach

In 2018, New Jersey enacted legislation that, among other things, imposed transparency requirements on providers and insurers.<sup>70</sup> Before scheduling a non-emergency appointment, providers are required to inform the patient if they are out-of-network and to provide a disclosure of the patient's financial responsibility related to out-of-network treatment.<sup>71</sup> For nonemergency procedures, physicians

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66. ALASKA ADMIN. CODE tit. 3, § 26.110(a)(2)(B) (2020); CONN. GEN. STAT. ANN. § 38a-477aa(b) (3)(A) (West, Westlaw through 2019 July Spec. Sess.); MD. CODE ANN., INS. § 14-205.2(c)(2)(ii)(1) (West, Westlaw through 2019 Reg. Sess. of General Assemb.).

67. See E-mail from Chaneil McDevitt, Deputy Exec. Dir. of the IHC & SEH Programs, N.J. Dep't of Banking & Ins., to Caitlin Brandt, Assistant Dir. & Senior Research Analyst, Ctr. for Health Policy, Brookings Inst. (Apr. 6, 2018) (on file with authors).

68. *Id.*

69. E-mail from Loren Adler, Assoc. Dir., U.S.C.–Brookings Schaeffer Initiative for Health Policy, Brookings Inst., to authors (Jan. 17, 2020) (on file with authors).

70. Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act, ch. 32, § C.26:2SS-4–6, 2018 N.J. Laws 3–7. The Act also prohibited providers from balance billing patients and required the use of IDR to resolve billing disputes. *Id.* § C.26:2SS-7.

71. *Id.* § C.26:2SS-5a(1), (3).

are also required to identify any other providers who are scheduled for the procedure.<sup>72</sup> Carriers are required to maintain an up-to-date list of in-network providers, provide clear information on how out-of-network services are covered, and provide treatment-specific information as to estimated costs on request.<sup>73</sup>

There are reasons to doubt the effectiveness of this approach to surprise medical bills. Most importantly, this approach puts the burden on patients to avoid out-of-network providers. In many instances, that will not be feasible—and it is far from clear that patients are the “cheapest cost avoider” when it comes to preventing surprise bills. Second, there are obvious loopholes; providers can avoid the obligation to disclose for nonemergency procedures by not scheduling other providers in advance. Alternatively, they can disclose the required information at the last possible minute. Finally, *ex ante* transparency undermines the ability of patients to argue *ex post* that the billed amount was not agreed to and should not be enforced. Although transparency is popular in many settings, we think it is an under-powered and ineffective solution to the problem of surprise medical bills.

## 5. NAIC Model Act-Approach

The National Association of Insurance Commissioners (NAIC) proposes model acts for regulating insurance markets. The NAIC had a pre-existing model act for health-plan network adequacy, which it updated in 2015 to address the problem of surprise medical bills.<sup>74</sup> The updated model act targets the problem of surprise bills generated by out-of-network providers working at in-network facilities. The model act requires state-regulated plans to apply in-network cost-sharing rates for such bills. Out-of-network providers who provided services to patients at an in-network facility would be required to offer patients the options of: (1) paying the balance bill; (2) for balance bills exceeding \$500, submitting the claim to a mediation process; or (3) relying on any other rights and remedies available in the state in question.<sup>75</sup> In addition, health plans that require pre-authorization of facility-based care would be required to notify enrollees that surprise medical bills could arise, and plans would be required to provide enrollees with a list of facility-based providers that are participating in the plan network.<sup>76</sup>

## 6. Limitations of State-Based Approaches

Employee Retirement Income Security Act (ERISA) preemption means that many state-based regulatory approaches to surprise medical bills will be of limited

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72. *Id.* § C.26:2SS-5b.

73. *Out-of-Network Consumer Protections*, N.J. DEP'T BANKING & INS., [https://www.state.nj.us/dobi/division\\_consumers/insurance/outofnetwork.html](https://www.state.nj.us/dobi/division_consumers/insurance/outofnetwork.html) [<https://perma.cc/D4KB-KJGX>] (last visited Feb. 1, 2020).

74. See POLLITZ, *supra* note 18, at 3–4; see also HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY MODEL ACT § 7 (NAT'L ASS'N INS. COMM'RS 2015) (amended 2015).

75. HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY MODEL ACT § 7(B)(1)(e), (D)(2).

76. See *id.* § 7(B)(1).

effectiveness.<sup>77</sup> Stated differently, for a sizeable percentage of the population, state-based reforms won't be able to compel payers to pony up more money. Similarly, states are unable to regulate the cost of air ambulances because multiple courts<sup>78</sup> have held that their efforts are preempted by the Airline Deregulation Act of 1978.<sup>79</sup>

There is also significant variation across states in the breadth of their statutory protections. Some states prohibit balance billing only in the emergency department or only for non-emergency care rendered at an in-network facility, whereas others prohibit balance billing in both locations.<sup>80</sup> Several states prohibit balance billing for patients in a health maintenance organization (HMO), but not for those who are in a PPO.<sup>81</sup> One state (Missouri) only prevents balance billing if the provider and insurer voluntarily agree to participate in the dispute resolution process.<sup>82</sup> There is also variation in states' usage of IDR approaches versus rate-setting approaches.<sup>83</sup> Finally, a recent attempt to extend California's rate-setting framework (which applies to all in-network facilities) to emergency care rendered at out-of-network facilities was withdrawn in response to vehement opposition from healthcare providers, who apparently prefer IDR-based approaches.<sup>84</sup>

#### B. FEDERAL INITIATIVES

Federal law does not effectively address the problem of surprise medical bills. PPACA contained a series of network adequacy requirements—but these provisions are “poorly suited to address[] the problem of surprise out-of-network billing. . . . For a policy to insulate consumers from receiving surprise out-of-

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77. See Karen Pollitz et al., *An Examination of Surprise Medical Bills and Proposals to Protect Consumers from Them*, PETERSON-KFF HEALTH SYSTEM TRACKER (Oct. 16, 2019), <https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them/>.

78. See, e.g., *Air Evac EMS, Inc. v. Cheatham*, 910 F.3d 751, 755 (4th Cir. 2018) (affirming judgment enjoining West Virginia from enforcing maximum reimbursement caps and fee schedules for air ambulances).

79. Pub. L. No. 95-504, § 4, 92 Stat. 1705, 1707–08 (codified as amended at 49 U.S.C. § 41713(b)(1) (2012)) (preempting state efforts to regulate the prices, routes, and services of certain air carriers). For discussion of the scope of preemption, see generally U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-10-907, AIR AMBULANCE: EFFECTS OF INDUSTRY CHANGES ON SERVICES ARE UNCLEAR (2010), <https://www.gao.gov/assets/320/310527.pdf> [<https://perma.cc/GZE6-2KQA>]; U.S. DEP'T TRANSP., GUIDELINES FOR THE USE AND AVAILABILITY OF HELICOPTER EMERGENCY MEDICAL TRANSPORT (HEMS) (2015) (unpublished guidelines), <https://tinyurl.com/y474jvv5> [<https://perma.cc/FR2V-PTDT>]. For a contrary view arguing against preemption, see Karan Chhabra et al., *Are Air Ambulances Truly Flying Out of Reach? Surprise-Billing Policy and the Airline Deregulation Act*, HEALTH AFF. BLOG (Oct. 17, 2019), <https://tinyurl.com/y2erzn3e> [<https://perma.cc/R55B-CBBV>].

80. See Hoadley et al., *supra* note 45.

81. See *id.*

82. *Id.*

83. See *id.*

84. See Ana B. Ibarra, *Hospitals Block 'Surprise Billing' Measure*, CAL. HEALTHLINE (July 10, 2019), <https://californiahealthline.org/news/hospitals-block-surprise-billing-measure/> [<https://perma.cc/W6SY-UJ4B>]. For an example of providers' preference for IDR-based approaches, see Letter from Cal. Med. Ass'n, *supra* note 65, at 1 (“[W]e urge the Committee to support the Ruiz-Roe legislation, H.R. 3502[,] which is based on New York state's extremely successful law.”).

network bills, it needs to guarantee that a *specific* provider is in the network, but that's the very opposite of how network adequacy laws should operate."<sup>85</sup> However, PPACA's focus on network adequacy was consistent with the larger aims of the statute—that is, expanding the number of people with insurance, and changing the terms on which that insurance is offered. PPACA also included an underpowered provision intended to address coverage of non-network emergency services—but not to prevent balance billing in that or other settings.<sup>86</sup> Simply stated, PPACA did little to address the problem of surprise bills, notwithstanding its purported purpose of protecting patients and making care more affordable.

In response to PPACA's failure to effectively address this issue, there have been multiple recent attempts to enact federal legislation, including the Fair Billing Act,<sup>87</sup> the End Surprise Billing Act,<sup>88</sup> the No More Surprise Medical Bills Act,<sup>89</sup> the Protecting Patients from Surprise Medical Bills Act,<sup>90</sup> the Protecting People from Surprise Medical Bills Act,<sup>91</sup> the No Surprises Act,<sup>92</sup> and the Stopping The Outrageous Practice of Surprise Medical Bills Act (STOP Surprise Medical Bills Act).<sup>93</sup> In addition, the Lower Health Care Costs Act<sup>94</sup> and the Air Ambulance Affordability Act<sup>95</sup> both included provisions relating to surprise bills.

Congress is currently considering multiple bills intended to address surprise medical bills.<sup>96</sup> The bills differ in various ways, but all map onto the various approaches outlined previously. For example, S. 1895 (which was passed by the Senate Health, Education, Labor, and Pensions Committee) uses a rate-setting approach tied to the median in-network rate (which it terms a “benchmark for payment”),<sup>97</sup> whereas the House Energy and Commerce bill blends the rate-setting and IDR approaches.<sup>98</sup>

Initially, there was considerable optimism that a federal statute would emerge from this process, but subsequent developments (including a vigorous ad

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85. Christen Linke Young et al., *The Relationship Between Network Adequacy and Surprise Billing*, U.S.C.—BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POL'Y (May 13, 2019) (emphasis in original), <https://healthpolicy.usc.edu/article/the-relationship-between-network-adequacy-and-surprise-billing/> [<https://perma.cc/NA9W-LP2R>].

86. For background on the relevant provision (§ 2719A) and subsequent related litigation, see Katie Keith, *New Regulation Justifies Previous Position on Emergency Room Balance Billing*, HEALTH AFF. (May 9, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180509.247998/full/> [<https://perma.cc/Y53T-DK8V>].

87. H.R. 3877, 115th Cong. (2017).

88. H.R. 861, 116th Cong. (2019); H.R. 817, 115th Cong. (2017).

89. S. 3592, 115th Cong. (2018).

90. S. 1266, 116th Cong. (2019); H.R. 4223, 116th Cong. (2019).

91. H.R. 3502, 116th Cong. (2019).

92. H.R. 3630, 116th Cong. (2019).

93. S. 1531, 116th Cong. (2019).

94. S. 1895, 116th Cong. tit.1 (2019).

95. H.R. 3784, 116th Cong. § 2 (2019).

96. See Joyce Frieden, *Senator: Surprise Billing Law Will Pass Congress Within Weeks*, MEDPAGE TODAY (Oct. 14, 2019), <https://www.medpagetoday.com/practicemanagement/reimbursement/82717> [<https://perma.cc/Q4F2-E6M2>].

97. S. 1895 § 103.

98. H.R. 3630, 116th Cong. (2019).

campaign on the part of the affected specialties who would stand to lose money should such a law be enacted) seem to have dampened the backers' enthusiasm.<sup>99</sup> Indeed, the head of the House Ways and Means Committee recently sent out a letter proposing a nonlegislative solution to the problem of surprise medical bills.<sup>100</sup> The letter notes that Congress had "consistently encountered disagreement among stakeholders over reimbursement rates for out-of-network surprise bills and the extent to which a dispute resolution process can determine those rates," and it accordingly proposed the use of a negotiated rulemaking process that would "require the stakeholders to work out their differences."<sup>101</sup>

### III. PROTECTING PATIENTS AND MAKING CARE MORE AFFORDABLE

#### A. WHAT SHOULD WE DO ABOUT SURPRISE BILLS?

The reform strategies outlined in Part II all attempt to impute a market price *ex post* rather than force the parties to arrive at a market price *ex ante*. Contract reform can solve this problem, at least for two of the scenarios in which surprise billing occurs: when patients receive emergency or elective care at an in-network hospital, but one or more clinicians involved in their treatment are out-of-network.

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99. The ad campaign has been funded by a number of private equity firms that invested in physician-staffing companies that engage in surprise billing. See Rachel Bluth & Emmarie Huetteman, *Investors' Deep-Pocket Push to Defend Surprise Medical Bills*, KAISER HEALTH NEWS (Sept. 11, 2019), <https://khn.org/news/investors-deep-pocket-push-to-defend-surprise-medical-bills/> [<https://perma.cc/CQ2W-6263>]; Ezekiel Emanuel, *No One Likes Surprise Medical Bills. So Why Does Congressional Action Seem So Unlikely?*, WASH. POST (Sept. 4, 2019, 5:57 PM), <https://www.washingtonpost.com/opinions/2019/09/04/no-one-likes-surprise-medical-bills-so-why-does-congressional-action-seem-so-unlikely/>; Rachel Roubein, *Health Groups Backed Dark Money Campaign to Sink 'Surprise' Billing Fix*, POLITICO (Sept. 13, 2019, 4:57 PM), <https://www.politico.com/story/2019/09/13/health-groups-dark-money-hospital-bills-legislation-1495697> [<https://perma.cc/DUU5-ZB2Y>]; Avik Roy, *How Arbitration for Surprise Medical Bills Leads to Runaway Costs & Higher Premiums*, FORBES (Sept. 26, 2019, 7:00 PM), <https://www.forbes.com/sites/theapothecary/2019/09/26/how-arbitration-for-surprise-medical-bills-leads-to-runaway-costs-higher-premiums/#5845210a4442> [<https://perma.cc/J7NT-FH59>]; Margot Sanger-Katz et al., *Mystery Solved: Private-Equity-Backed Firms Are Behind Ad Blitz on 'Surprise Billing'*, N.Y. TIMES: THE UPSHOT (Sept. 16, 2019), <https://www.nytimes.com/2019/09/13/upshot/surprise-billing-laws-ad-spending-doctor-patient-unity.html>; Peter Sullivan, *Push on 'Surprise' Medical Bills Hits New Roadblocks*, HILL (Sept. 5, 2019, 6:00 AM), <https://thehill.com/policy/healthcare/460004-push-on-surprise-medical-bills-hits-new-roadblocks> [<https://perma.cc/V7M5-NG7N>].

For an example, see Doctor Patient Unity, *Closed*, YOUTUBE (Sept. 12, 2019), <https://www.youtube.com/watch?v=v5-rtYfUKzA>. This ad doesn't mention surprise medical bills at all. Other ads are more overt. See Physicians for Fair Coverage, *TV Commercial: Stop Surprise Medical Bills and Protect Patient Access to Quality Care*, ISPOT.TV, <https://www.ispot.tv/ad/oTXN/physicians-for-fair-coverage-surprise-medical-billing> (last visited Feb. 1, 2020); Sandra Fish, *August 2, 2019*, YOUTUBE (Aug. 2, 2019), [https://www.youtube.com/watch?time\\_continue=14&v=JkvaCtf0\\_Rc&feature=emb\\_logo](https://www.youtube.com/watch?time_continue=14&v=JkvaCtf0_Rc&feature=emb_logo) (showing advertisement from Doctor Patient Unity regarding rate-setting).

100. See Letter from Richard E. Neal, Chairman, Comm. on Ways & Means, U.S. House of Representatives, to Democratic Colleagues, Comm. on Ways & Means, U.S. House of Representatives 1 (Sept. 27, 2019), <https://www.scribd.com/document/428317457/Neal-Surprise-Billing> [<https://perma.cc/PHT3-5XPQ>] [hereinafter Letter from Chairman Neal]; see also Peter Sullivan, *Democratic Chairman Proposes New Fix for Surprise Medical Bills*, HILL (Oct. 1, 2019, 4:28 PM), <https://thehill.com/policy/healthcare/463896-dem-chairman-proposes-new-fix-for-surprise-medical-bills> [<https://perma.cc/U8Q4-Y8JV>].

101. Letter from Chairman Neal, *supra* note 100, at 1.

Contractual reform will ensure that at in-network facilities, all providers that touch or bill a patient are in-network. One easy strategy to ensure that result is to enact federal legislation that prohibits physicians at in-network facilities from billing patients and insurers. Stated differently, physicians who treat patients at hospitals would need to contract with those hospitals for payment—and the hospitals would include that amount in the facility fee they are already negotiating with insurers when deciding whether to be in-network or not.

This approach is preferable to the alternatives outlined in Part II for several reasons. First, rather than having to adjudicate surprise, out-of-network bills after they happen, our approach will prevent these bills in the first place. Second, this solution does not require policymakers to determine and impute a market price, nor does it require them to update the resulting price. It also avoids the costs of establishing and funding an arbitration system, which has been estimated at \$1 billion.<sup>102</sup>

Contractual reform would force hospitals and affiliated providers to negotiate rates that are sufficient to attract affiliated physicians to work at the hospital, or else risk being excluded from insurance networks. In other words, contractual reform would force the parties to arrive at a market price for the services in question. This market price will obviously be included in the hospital's facility fee, but that increase will be more than offset by the elimination of balance billing—and the reduction in in-network rates that will have to be paid to providers who will no longer have the leverage that resulted from their ability to balance bills. The total cost of care should materially decline. Finally, this strategy eliminates the unintended consequences that are associated with a rate-setting approach.

Regulation through contract-forcing builds on the reality that most hospitals have already solved the problem of surprise bills—and all hospitals already bundle and bill for a host of services. Patients would be outraged if they received an out-of-network balance bill for the nurse that cared for them or the janitor that cleaned their room. They should be similarly outraged that they are sent bills for care rendered by physicians in the same facilities, including physicians who are in-network but bill for their services separately.

A contract-based solution will certainly affect bargaining dynamics between insurers and physicians and will reduce rates closer to true market prices. We think it unlikely that insurers will be able to push rates below the true cost of services because 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 will arrive at a natural market price that does not reflect the ability of some providers to send surprise medical bills, which increased their leverage to command high in-network rates. Without that ability, we should

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102. See Loren Adler et al., *Rep. Ruiz's Arbitration Proposal for Surprise Billing (H.R. 3502) Would Lead to Much Higher Costs and Deficits*, HEALTH AFF. BLOG (July 16, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20190716.355260/full/> [<https://perma.cc/U5G3-BX96>] (reporting CBO estimate that it would cost \$1 billion to establish a nationwide arbitration system handling surprise bills).

expect those rates to be lower than the status quo—albeit not below the cost of providing the services in question.

Unfortunately, our contract-based approach will not work when patients are treated at out-of-network facilities or transported by out-of-network ambulances. For these situations, we must either use a form of *ex ante* rate-setting or use the legal system to set prices *ex post*. For those who insist on a rate-setting approach, we suggest that payment be tied to 150% of the average in-network payment for the same services.<sup>103</sup> In neither instance should we give any weight to the charges that are generated by incumbent providers of the service.

*Ex post* litigation over prices is an alternative to rate-setting. The legal system has considerable experience assigning prices to services that are delivered in emergencies. As two of us noted in an earlier article:

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?<sup>104</sup>

The law of restitution also deals with situations in which services are provided in emergencies that prevent parties from negotiating fair prices in advance. After noting that “[a] person who performs, supplies, or obtains professional services required for the protection of another’s life or health is entitled to restitution,” the Restatement (Third) of Restitution and Unjust Enrichment identifies the appropriate measure of compensation as “a reasonable charge for the services in question.”<sup>105</sup> Normally, the reasonable charge is the service provider’s market rate, which is established by evidence. In the healthcare context, the evidence could include payments received for similar services from Medicare, Medicaid, private insurers, and other sources. These sources will usually point toward prices far below providers’ “rack rates”—a fact that explains why there are “balance bills” to begin with.<sup>106</sup>

Although litigation is an option in the current system, the dynamics of balance billing mean that it is providers (or their collection agencies) that sue patients, rather than the other way around. Restitution-type theories come up (if at all) only when patients show up and know enough to challenge the billed amounts

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103. In our judgment, 150% of the average in-network payment for the same services is in the sweet-spot—it is not high enough to disrupt physicians’ willingness to be in-network, nor is it low enough to worry about paying below the true market price for the services in question.

104. David A. Hyman & Benedic N. Ippolito, *Comment on the Potential Pitfalls of Combating Surprise Billing*, in REGULATION, Fall 2019, at 45, 47, <https://www.cato.org/sites/cato.org/files/2019-10/regulation-v42n3-1-updated.pdf> [<https://perma.cc/DEH9-4NC5>].

105. RESTATEMENT (THIRD) OF RESTITUTION AND UNJUST ENRICHMENT § 20 (AM. LAW INST. 2011).

106. For some examples of large balance bills, see *supra* Section I.A.

using a restitution-based theory. However, patients rarely show up, and courts routinely enter judgment based on bills that are full of phony-baloney numbers.<sup>107</sup> There are practical limits on what an *ex post* litigation-based system can do to address the problem of surprise medical bills.

To sum up, our contract-based approach has no impact on the vast majority of providers, who do not engage in surprise billing. It also eliminates the need for policymakers to impute a market price or create and fund a dispute resolution system to do the same, as the IDR-based approach requires.

What about the other two settings in which surprise bills are generated—when a patient receives emergency care at an out-of-network facility or is transported by an out-of-network ambulance? A litigation-based approach is clumsier and more expensive but avoids the need for regulations that fix prices. Because administrative price-setting always has unintended consequences, litigation is the better option for these two settings, despite its obvious defects.

#### B. MOVING BEYOND THE IMMEDIATE PROBLEM

If our goal is to protect patients and make care more affordable (and we think both of those are laudatory goals), what should we do, over and above fixing the problem of surprise medical bills? The short answer, which two of us develop at far greater length elsewhere,<sup>108</sup> is address the root cause: a malign combination of excessive use of health insurance, inadequate competition, and defective incentives. Hospitals could do what body shops do, but many seem to go out of their way to create opportunities for surprise bills. If we want to prevent surprise bills—and make the healthcare system responsive to patients' needs and pocketbooks—we should start by addressing the underlying drivers of the system. The retail health sector, which delivers an array of services that patients often pay for

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107. See, e.g., Selena Simmons-Duffin, *When Hospitals Sue for Unpaid Bills, It Can Be 'Ruinous' for Patients*, NPR: HEALTH INC. (June 25, 2019, 2:37 PM), <https://www.npr.org/sections/health-shots/2019/06/25/735385283/hospitals-earn-little-from-suing-for-unpaid-bills-for-patients-it-can-be-ruinous> [<https://perma.cc/YXA3-5RCM>] (noting that hospital bills are often unreasonable, but most people don't show up to contest them, and most that do show up simply agree that they owe the billed amounts).

On June 14, only a handful of the 300 people summoned to court [for unpaid medical bills] show[ed] up.

....

Part of the advocates' strategy to help patients fight these lawsuits is to encourage them to contest their bills, rather than admit they owe the money.

....

The underlying thinking is that patients rarely have a chance to negotiate the cost of medical services in advance and that bills may be unreasonable, especially in light of their financial circumstances. A patient who contests may be able to negotiate a better price or have the bill forgiven.

*Id.* In fairness, it is not clear how many of these bills are surprise medical bills, but we have no reason to think that different dynamics prevail when providers use the legal system to collect their balance bills.

108. See SILVER & HYMAN, *supra* note 4, at 1–22.

directly, does this, and it never generates surprise bills.<sup>109</sup> Retail providers post their prices and charge only the amounts they post. Why the difference? If retail providers were to send out surprise bills, they would lose customers in droves. As more and more medical services are delivered via retail outlets, the problem of surprise bills will become less and less severe.

#### CONCLUSION

The Patient Protection and Affordable Care Act certainly wasn't supposed to solve everything that was wrong with the American healthcare system. But PPACA didn't do much of anything about the problem of surprise medical bills, nor did it do much of anything about cost control.<sup>110</sup> This is because the operative theory of PPACA's proponents was "coverage first."<sup>111</sup> As Professor Jonathan Gruber recalls his discussions with the transition-team members responsible for health reform:

"I told them . . . that you can either try to expand coverage or you can try to do something to control costs. But trying to control costs too much dooms whatever you do, because the lobbyists will kill you. . . ."

The industry will happily allow universal coverage . . . "because that creates more customers. What it won't allow is cost control."

Which meant that the industry's idea of reform would be for the government to create more customers who would, through insurance subsidized by the government, Romneycare-style, pay the same sky-high prices for hospital care, drugs, and medical devices that everyone was already paying.<sup>112</sup>

So much for protecting patients and ensuring affordable care.

Balance billing is a problem because neither doctors nor hospitals have a financial interest in ending the practice. Some hospitals have taken the lead in eliminating surprise medical bills, making it clear that all hospitals could solve this problem if they wanted to. But other hospitals haven't followed their lead because they are content to allow the problem to continue. They see no upside to eliminating surprise bills because, no matter what they do, patients will keep arriving at their doors.

That strategy wouldn't work in a market with more effective competition, particularly if that market relied more heavily on first-party payment. That is where

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109. *See id.* at 315–40.

110. *See supra* note 86 and accompanying text.

111. Jonathan Gruber, *The Facts from Massachusetts Speak Clearly: Response to Douglas Holtz-Eakin*, 30 J. POL'Y ANALYSIS & MGMT. 194, 195 (2010). Professor Gruber's defense of this approach was that "the choice facing Congress was to do a 'coverage first, with some attempts at cost control' bill, or *no bill at all*." *Id.* at 195 (emphasis in original). We leave it to readers to determine for themselves whether "no bill at all" would have been a better choice, given subsequent developments.

112. STEVEN BRILL, *AMERICA'S BITTER PILL: MONEY, POLITICS, BACKROOM DEALS, AND THE FIGHT TO FIX OUR BROKEN HEALTHCARE SYSTEM* 71 (1st ed. 2015) (internal quotation marks omitted).

we should be headed, rather than going back repeatedly to the government regulatory well in the hopes that this time—at last—we will finally get it right. If we want health law to play a positive role in that process, we should learn from our past mistakes, rather than repeat them. A “coverage first” model won’t fix the problems with the American healthcare system. To believe otherwise is to ignore the political economy of healthcare, and our long and illustrious history of failed attempts to regulate the highly dysfunctional market that prevails.