Surprise Medical Billing

Under current law, many patients receive unexpected medical bills. In general, patients anticipate that if they choose doctors and hospitals in their insurer's network, they will benefit from the lower costs negotiated by their insurer and that these costs will be limited to their premium, deductible, copayments, and coinsurance. However, even patients who deliberately seek in-network treatment can receive surprise medical bills when they, without choosing or even knowing it, receive care from a doctor or facility not in their insurer's network.

This happens most commonly in two circumstances. First, patients receive surprise bills for emergency care. During emergencies patients have little control over the facility to which they're taken, the doctors who treat them, or even the ambulance that transports them. Often, it's only afterwards that they learn that the providers who cared for them were out of network. This happens even when the patient makes an extra effort to go to an in-network hospital because hospitals routinely contract with out-of-network providers. Second, surprise bills occur when patients go to their in-network doctor or hospital for non-emergency care but are treated by ancillary providers like anesthesiologists, radiologists, or labs who are out of network. Again, this treatment happens without the consent or knowledge of the patient.

Surprise medical bills come in two forms. First, the patient must pay higher out-of-network rates set by their insurer for services performed by out-of-network providers. Second, if the out-of-network medical provider isn't satisfied with the reimbursement amount paid by the patient's insurer, that provider can bill the patient directly for the difference between the out-of-network amount and the total the provider charged. This is called a "balance bill."

The Sources & Shapes of Surprise Medical Bills

Emergencies

During emergencies, patients often receive treatment from out-of-network providers. Without their knowledge or consent, patients may be

- Taken to an out-of-network facility
- Treated by an out-of-network doctor
- Transported by an out-of-network ambulance

Ancillary Care

Patients go to their in-network doctor or hospital for non-emergency care, but may still receive services from out-of-network ancillary providers such as:

- Anesthesiologists
- Radiologists
- Labs

Out-Of-Network Payments

When patients receive out-of-network treatment, they must pay higher out-of-network rates set by their insurer.

Balance Bills

If the out-of-network provider isn't satisfied with the insurer's reimbursement rate, they can bill the patient directly for the difference between the insurer's out-of-network rate and the total charge. This is called a "balance bill."

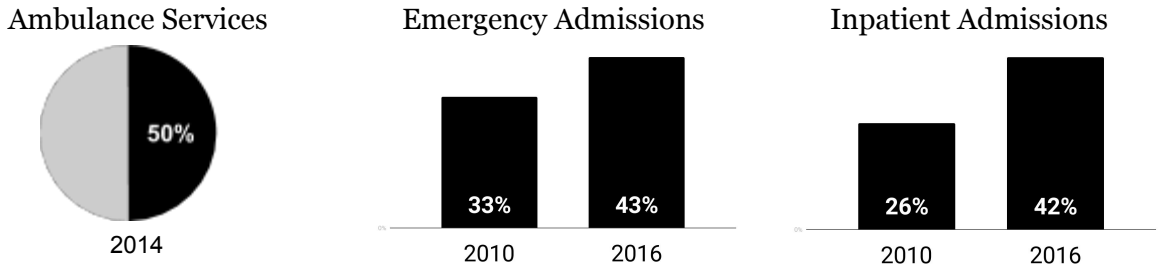
Surprise medical bills are common. A study published in *HeathAffairs* found that in 2014 half of ambulance services resulted in a surprise bill. A study published by the Journal of the American Medical Association (JAMA) found that 43% of emergency department admissions resulted in

surprise bills in 2016, up from 33% in 2010. The JAMA study also found that 42% of inpatient admissions resulted in surprise bills in 2016, up from 26% in 2010.

Surprise bills are also increasingly expensive. The JAMA study found that between 2010 and 2016 a patient's average emergency room surprise bill increased from $220 to $628. Over the same period, the average surprise bill from ancillary services for an inpatient admission increased from $804 to $2,040. In some cases, surprise bills can reach tens-of-thousands or hundreds-of-thousands of dollars.

How Often Do Services Result in Surprise Medical Bills?

% of Patients who Receive Surprise Medical Bills



Under current federal law, few legal limits exist on surprise medical bills. Even if patients deliberately choose an in-network facility or doctor, do not consent to the use of out-of-network providers (often because they're unconscious or otherwise incapacitated), and are not informed that they will be personally responsible for thousands-of-dollars in costs, they are still legally obligated to pay the surprise bills. If they are unable to pay them, patients often face debt collectors and legal action. In more extreme but still frequent cases, the result for the patient is bankruptcy.

Surprise medical bills so offend everyone's sense of fairness that, even in our era of bitter partisan division, strong bipartisan determination to fix the problem has emerged. To date, twenty-eight states have passed legislation that provides varying levels of protection. However, federal limits on state jurisdiction mean that no state law can address the problem fully. Recognizing the limits of state law, remarkable bipartisan commitment for federal solutions has also grown. President Trump has called for federal action. Congress is considering five different bills that have won strong bipartisan support. In fact, the issue is getting so much attention in Congress that you've likely seen TV ads on the issue.

The unusual level of bipartisan agreement extends to several core features that are shared among the different bipartisan bills being considered. Most importantly, each would end surprise billing for patients in most circumstances. Patients who are unknowingly treated by out-of-network providers in emergency situations or treated by out-of-network ancillary-care providers when they've deliberately chosen an in-network provider would only be charged in-network-rates. They would not receive balance bills.

This remarkable consensus does not extend, however, to the detailed strategies for ending surprise bills. Here, the core debate centers on how to determine how much insurers should pay out-of-network providers once the patient's responsibility has been limited to their in-network charges. This debate does not divide cleanly along partisan lines. Instead, the controversy is mostly between insurers and medical providers. In the simplest terms, insurers want to pay out-of-network providers less, while providers want insurers to pay them more.

Each of the bills before Congress largely ends Surprise Medical Billing. The real debate centers on how much insurers should pay out-of-network providers once the patient's responsibility has been limited to in-network charges.

The five bipartisan bills before Congress offer different mechanisms for resolving this insurer-provider dilemma. The first is for the federal government to establish a payment standard. Congress would legislate the level of payment to be made from insurers to out-of-network providers. The second is to allow the provider and insurer to negotiate the provider's payment and, in cases where they can't come to an agreement, turn to an independent dispute resolution (IDR) system. Under this mechanism, if either side submits the case to IDR, the arbitrator would make a binding decision. The third mechanism combines the first two. In this combined option, Congress would set a payment standard, then allow either the insurer or the provider to "appeal" that payment through the IDR if they felt it was the wrong amount for their case.

The Mechanisms For Determining How Much Insurers Should Pay Out-Of-Network Providers

Payment Standard	Independent Dispute Resolution (IDR)	Combined
Congress would legislate the level of payment to be made from insurers to providers who are out-of-network.	The provider and insurer to negotiate the provider's payment. If either side has a dispute, they submit the case to IDR where an arbitrator would make a binding decision.	Congress would set a payment standard, then allow either the insurer or the provider to "appeal" that payment through the IDR if they felt it was the wrong amount for their case.

The differences between these mechanisms are less significant than they may initially appear. In each, the federal government establishes benchmarks for how much the insurer should pay the out-of-network provider. Even with IDR, the legislation mandates the standards the arbitrator applies to determine fair payment. As a result, the debate is as much about the benchmark for determining fair compensation as it is about the mechanism itself.

The benchmarks vary widely and the differences matter. Each benchmark impacts the financial interests of insurers and providers differently. Those differences also affect the rest of us. If insurers pay providers too little, we may face shortages of quality care, particularly in hard-to-serve markets including rural communities. If insurers pay providers too much, those costs will ultimately come back to us, the patients, in the form of higher insurance premiums and taxes.

The Surprise Billing Market Failure

At the heart of the debate about the mechanisms (payment standard, IDR, or a combination of payment standard and IDR) and the benchmarks (calculations used to determine how much an insurer pays a provider) is a free-market failure.

Again, this isn't a partisan issue. Liberal and conservative economists agree on the fundamentals driving the market failure. In the world of health care, insurers offer providers a profitable exchange for coming into their networks. Although insurers ask providers to accept lower in-network payment rates, insurers offer a steady stream of work from patients who are self-interested in choosing the lower costs for services from in-network providers.

Patient choice, however, doesn't extend to emergency room doctors and ancillary care providers. In emergency circumstances, patients are often taken to the nearest facility regardless of whether or not it is in network. Even if the facility is in network, the providers might not be. Patients also don't choose their ancillary care providers. They may choose an in-network orthopedic surgeon to perform their knee replacement, but they don't choose the anesthesiologist who will work with that surgeon. Similarly, patients can choose an in-network gastroenterologist to perform their colonoscopy, but they don't choose the lab that will review the resulting biopsy.

This inability of patients to choose their emergency or ancillary care providers leads to the market failure. Fundamentally, patients' inability to choose their providers means that providers don't compete with each other for patients' business. This absence of competition means that emergency and ancillary care doctors who remain out of network can surprise bill essentially unlimited amounts knowing that, without choosing or consenting to out-of-network care, the patient will nevertheless be legally obligated to pay the charges.

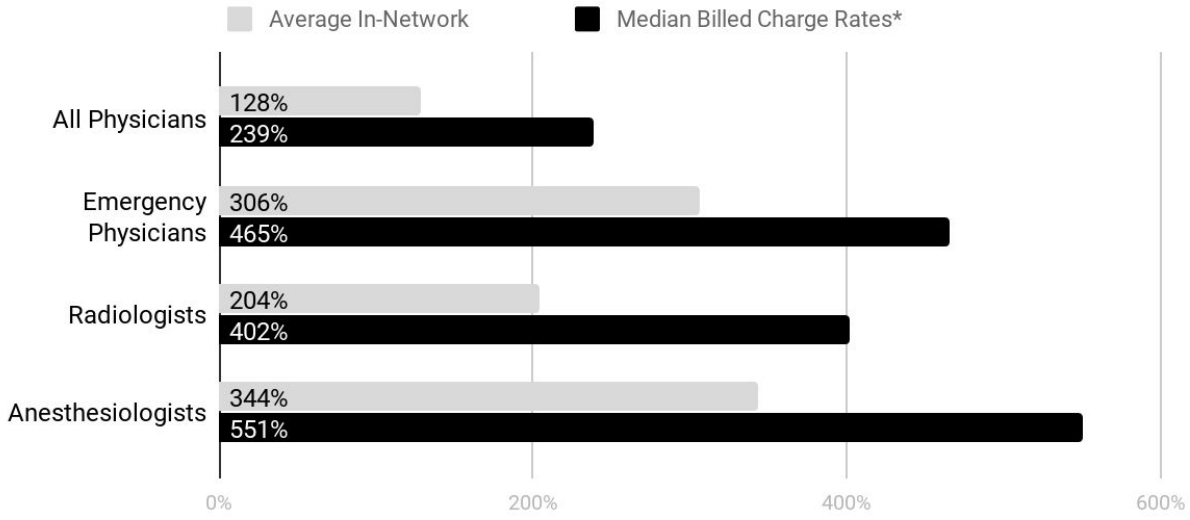
But the market failure isn't limited to the unconstrained surprise bills that emergency and ancillary care providers can charge a patient who unwittingly found themselves receiving out-of-network care. The market failure also significantly influences the in-network charges we all pay. Emergency and ancillary providers' option of surprise billing gives them leverage to negotiate much higher in-network rates with insurers than providers who can't surprise bill. At the negotiation table, insurers know that unless they offer higher in-network rates than they

otherwise would, emergency and ancillary providers may stay out of network so that they can get higher payments through surprise billing.

The magnitude of the market failure at both levels is seen in the disproportionately high rates that emergency and ancillary providers charge. At the first level, emergency care and ancillary care providers' billed charges are disproportionately higher than for providers who don't have the option to surprise bill. A "billed charge" is the provider's list price. Billed charges tend to be high for all providers, whether they can surprise bill or not, because they are largely unconstrained by competitive market forces. They are set unilaterally by the provider and are rarely actually paid. Most medical services are paid at the in-network rates negotiated by insurers and providers. In fact, one of the few circumstances in which a billed charge is actually paid is when emergency and ancillary care providers demand billed charges through surprise billing.

While billed charges are high for all physicians, they are much higher for those who have the option to surprise bill. A 2019 study conducted by the USC-Brookings Schaeffer Initiative found that the median billed charge for all physicians is 239% of what they would be reimbursed by Medicare. The "median" is the point at which half the doctors charge more and half charge less. In other words, the median is the 50th percentile. The same USC-Brookings study found that emergency physicians' median billed charges, however, are 465% of Medicare rates. The median billed charges for ancillary care physicians are also disproportionately high. Radiologists' median billed charges are 402% of Medicare rates and anesthesiologists are 551%. These median billed charge rates are captured in the red bars in Figure 1.

Figure 1: Different Rates Charged by all Physicians and by those Who Can Surprise Bill Relative to Medicare Rates



*The numbers for the Median Billed Charges can be directly compared with one another and the numbers in for the Average In-Network Rates can be directly compared to each other. However, it's important to note the limitation in comparing the Median Billed Charges with the Average In-Network Rates to each other. The Billed Charge Rates are expressed in terms of the median while the In-Network Rates are expressed in terms of the average. The median is different from the average in that it is the value at which half of the charges are above it and half are below it, which can also be described as the 50th percentile. Because there are extraordinarily high values in both, the average will be higher than the median.

Figure 1 also shows the disproportionately high rates that emergency and ancillary care providers can negotiate for their in-network services (see pink bars). In-network rates that insurers negotiate with providers are obviously lower, in general, than providers' billed charges (or list prices) that providers set unilaterally. The 2019 USC-Brookings analysis found that the average in-network rate for all physicians is 128% of Medicare rates. According to the same study, however, the average in-network rates for providers who can surprise bill are much higher than for physicians overall. The average in-network rate for emergency physicians is 306% of Medicare rates, 204% for radiologists, and 344% for anesthesiologists. These disproportionately high in-network rates for emergency and ancillary providers, in turn, drive up insurance premiums generally, as a Congressional Budget Office (CBO) study found.

Surprise medical bills happen because patients aren't able to *choose* their emergency or ancillary care providers. In the absence of patient choice, emergency and ancillary care providers charge disproportionately high rates.

An alternative explanation for the higher in-network rates for those who can surprise bill is that they have more training than the average physician and are justifiably charging for their expertise. However, even other specialists with as much or more advanced training, but who don't have the same option to surprise bill, aren't able to charge comparably high rates. The USC-Brookings analysis reported that the average in-network rates for even very highly trained specialists who don't have an option to surprise bill tend to be lower than for emergency and ancillary doctors. For example, the average in-network rate is 239% of Medicare for general surgeons, 248% for orthopedic surgeons, and 259% for cardiologists.

A study conducted by researchers at Yale illustrates the underlying dynamic that drives emergency and ancillary care providers' disproportionately high charges. They found that emergency physician practices owned by private equity firms deliberately exploit the market failure to increase their profits by invoking either a strategy aimed at the first level of market failure (charging the patient high out-of-network balance bills) or at the second level (negotiating high in-network rates with insurers). One firm simply chooses for most of their doctors to remain out of network, refusing the in-network rates insurers would offer in order to charge the patient with a higher surprise bill. Another firm focuses on leveraging their doctors' ability to surprise bill in order to negotiate higher in-network rates. With the option to stay out of network in order to reap higher payments open to them, this firm negotiates in-network reimbursement rates that are disproportionately high. These firms are helping fund many of the pro-provider TV ads on surprise billing.

Pro-Provider TV Ads on Surprise Billing

A series of still images from TV ads sponsored by Doctor Patient Unity, which was discovered to be funded by the private equity firms, TeamHealth and Envision Healthcare

TEAMHealth. Envision HEALTHCARE

What the Five Bills Share

As mentioned earlier, each of the five bipartisan bills aims to address this market failure in two core ways. First, and most importantly for patients, each eliminates surprise medical bills. The five bipartisan bills eliminate both higher out-of-network charges and balance bills for emergency services and out-of-network services provided at in-network facilities, including ancillary services like anesthesiology, radiology, and lab work. Under any of the five bills, patients would only pay their regular in-network obligations as they would with any other medical bill.

Second, each of the five bills aims to "fill in the missing number" of what the insurer should pay the out-of-network provider. The supporters of each bill argue that their strategy draws on the power of markets to set fair prices.

In the remainder of this brief, we review the five bipartisan bills. Our review of each bill has three components. First, we describe a bill's unique provisions. Second, we review the strongest arguments for and against those provisions. Third, we review the available evidence for the competing claims.

In this last regard, two sources of evidence are especially helpful. First, the non-partisan Congressional Budget Office (CBO) provides rigorous evaluations of proposed legislation. Second, the twenty-eight states that have passed surprise billing legislation are effectively serving as the "laboratories of democracy." The two largest and most studied states are New York and California. The New York law takes the IDR approach. The California law combines the payment standard and IDR approach. Although the available evidence isn't complete or definitive, the research still provides meaningful insights into the likely impacts of the proposed federal bills.

We first review S. 1895 which takes a payment-standard-only approach. Next, we review the two bills that offer Independent Dispute Resolution (IDR) only. H.R. 3502 and H.R. 5826 draw on the New York law . The last two bills we review are H.R. 2328 and H.R. 5800. Both of these last two bills draw on the California law in combining the payment standard approach with IDR.

At the conclusion of the brief, you will be asked whether you support or oppose each of the legislative approaches.

As you read the reviews of each of the five bills and then indicate your support or opposition, it will be helpful to consult Table 1 for a comparison of the differences. In fact, you may want to print out the PDF version of Table 1.

Table 1: The Five Bipartisan Bills

	S. 1895	H.R. 3502	H.R. 5826	H.R. 2328	H.R. 5800
Ends Surprise Bills for:					
Emergency Services	Yes	Yes	Yes	Yes	Yes
Ancillary Services	Yes	Yes	Yes	Yes	Yes
Ground Ambulance Services	No	No	No	No	No, but study
Air Ambulance Services	Yes	No	No, but study	No	Yes
Post Emergency Inpatient Stabilization	Yes	No	Yes	Yes	Yes
Approach for Applying Benchmarks	**Mandated Payment Standard**	**Independent Dispute Resolution (IDR):** ● Insurer and Provider Negotiate Payment ● Can appeal to IDR ● Final Offer Arbitration	**Independent Dispute Resolution (IDR):** ● Insurer and Provider Negotiate Payment ● Can appeal to IDR ● Final Offer Arbitration	**Combined:** ● Mandated Payment Standard ● Cases over $1,250 can be appealed to IDR (Final Offer Arbitration)	**Combined:** ● Mandated Payment Standard ● Cases over $750 can be appealed to IDR (Final Offer Arbitration)*
Benchmarks for Out-of-Network Payment Standards	Insurer's Own Median In-Network Rate for the Prior Year	Doesn't Apply	Doesn't Apply	Insurer's Own Median In-Network Rate for 2019, indexed to inflation	Insurer's Own Median In-Network Rate for 2019, indexed to inflation
Arbitration consider-ations	Doesn't Apply	Arbitrator considers: ● Median In-Network Rate of all Insurance Plans ● Other factors including case severity or provider training ● 80th Percentile of Providers' Billed Charges	Arbitrator considers: ● Insurer's Own Median In-Network Rate for 2019, indexed to inflation ● Information parties provide relating to their final offer, except for Billed Charges	On appeal, arbitrator considers: ● Median In-Network Rate of all Insurance Plans ● Severity of case and provider training	On appeal, arbitrator considers: ● Median In-Network Rate of all Insurance Plans ● Severity of case and provider training ● Market share of the parties

*Except for air ambulance cases, which can only be appealed for cases over $25,000

Payment Standard: S. 1895 – The Lower Health Care Costs Act

Mandated Payment Standard

Summary of What it Does

Ends Surprise Bills for:	
Emergency Services	Yes
Ancillary Services	Yes
Ground Ambulance Services	No
Air Ambulance Services	Yes
Post Emergency Inpatient Stabilization	Yes
Benchmarks for Out-of-Network Payment Standards	Insurer's Own Median In-Network Rate for the Prior Year
Arbitration considerations	Doesn't Apply

Details of What it Does

Senate Bill 1895 (S. 1895) would eliminate surprise medical bills for emergency and ancillary care services. It would also eliminate surprise medical bills for air ambulances and for post-emergency inpatient stabilization. It would not eliminate surprise medical bills for ground ambulances (See Table 1).

Having eliminated the patient's responsibility to pay more than their in-network rate for out-of-network care, S. 1895 would then establish the insurer's own median in-network rate for the same items or services in the same geographic area as the payment standard for out-of-network providers. S. 1895 would not offer an Independent Dispute Resolution (IDR) mechanism.

Senator Lamar Alexander (R-TN), the Chairman of the Senate Health, Education, Labor and Pensions (HELP) Committee, and Senator Patty Murray, the senior Democrat (known as the Ranking Member) on the committee, co-sponsored the bill. It passed the HELP Committee on a 20 to 3 vote on June 8, 2019. Eleven of the 12 Republicans on the committee and nine of the 11 Democrats voted yes.

Democratic Senators and presidential candidates Bernie Sanders and Elizabeth Warren, who have two of the Senate's most liberal voting records, and Republican Senator Rand Paul, who has one of the most conservative voting records in the Senate, were the only votes against it.

S. 1895 is a multicomponent bill that seeks to reduce many kinds of healthcare costs through several strategies. In addition to eliminating surprise medical billing, S. 1895 would reduce prescription drug prices, improving public health efforts, and protect patients' private data.

Senate HELP Committee members were voting on the overall bill, not just the surprise medical billing provisions.

Arguments For and Against

There is wide agreement that S. 1895's mandated median in-network payment standard would reduce the disproportionately high rates that emergency and ancillary providers charge. There is also wide agreement that the mandated payment standard rate-only approach would reduce payment rates more than the IDR-only approach. There is less agreement on whether the payment standard rate-only approach would reduce charges more than the approach that combines a payment standard and IDR.

Most insurers support S. 1895. Many medical providers, particularly emergency and ancillary providers, oppose it. Many of S. 1895's supporters are neither insurers nor medical providers, but individuals within and beyond the health care world who believe that emergency and ancillary care providers' current rates are unjustifiably high and require significant correction.

Proponents of S. 1895 argue that the bill will end disproportionately high payments to emergency and ancillary care providers by capping out-of-network payments at the insurer's own median in-network rates.

Proponents of S. 1895 argue that mandating that insurers pay out-of-network emergency and ancillary providers their own median in-network rate is the right correction to the market failure. Proponents argue that these rates reflect the negotiations between the insurer and the area's providers to determine the value of a given medical service. They argue that this approximates a free market much more closely than the rates that emergency and ancillary providers can unilaterally impose because of their ability to surprise bill.

Opponents of S. 1895 argue that the bill will reduce payments so much that it will cause shortages of emergency and ancillary care, especially in hard-to-serve markets including rural areas.

Opponents of S. 1895, including most providers, argue that S. 1895 reduces payments so much that it will cause shortages of emergency and ancillary care, especially in hard-to-serve markets including rural areas. Opponents also argue that S. 1895 will reduce the amount of care that is delivered in-network.

Opponents further argue that S. 1895 is government rate setting. A government-mandated payment at the median in-network rate, they argue, inappropriately compensates services that differ in complexity and quality at the same payment level. Opponents argue that the existing market recognizes and rewards differences in the quality of both providers and facilities. Some doctors have more training and experience and produce better outcomes. Some facilities are more advanced. Opponents argue that the government shouldn't flatten the market by mandating that the same payment standard across these differences.

Finally, opponents argue that S. 1895's payment standard approach gives insurers unilateral control unchecked by market forces. Insurers, they argue, can manipulate their own median in-network rate to their advantage. One way is to manipulate their data on which the median in-network rate is calculated. Some insurers, opponents argue, may also challenge even legitimate bills as part of a cost-cutting strategy. Opponents to S. 1895 argue that providers should be able to charge more when working with insurers who are deliberately gaming the system.

Proponents of S. 1895 disagree with opponents' contention that the bill will reduce payments for emergency and ancillary care to the point of reducing access or the quality of care. Proponents argue that current payment levels are so high that, even with the reduction in payments resulting from S. 1895, these areas of medical practice would still be highly attractive to providers. They argue that providers will not exit the market as a result of S. 1895.

Proponents, including many who are not insurers, take particular issue with opponents' argument that S. 1895 will lead to less care being delivered in-network and more care being delivered out-of-network. Economists from the left and right argue that this argument is both counter-intuitive and at odds with economic theory. Since the effect of the law is to eliminate the incentives of staying out-of-network offered by surprise billing, economic theory predicts that more providers will come in network.

Proponents respond to opponents' arguments about insurer manipulation of their data on which median in-network rates are calculated by pointing to provisions to protect against that in the bill. Specifically, S. 1895 requires that the Department of Health and Human Services develop the methods for calculating those rates.

The Evidence

The Congressional Budget Office (CBO) study of S. 1895 supports the general agreement between proponents and opponents that the bill will reduce disproportionately high rates charged by medical providers who can currently surprise bill. CBO estimates that under S. 1895 the average payment rates for emergency and ancillary services that now produce surprise bills would "drop by 15 percent to 20 percent at the national level."

The CBO study also finds that as S. 1895 drives down payments to providers, insurance premiums will also decrease. This follows from the argument, noted earlier, that high out-of-network charges drive up in-network charges and high in-network charges, in turn, drive up the premiums we pay to our insurers. CBO estimates that the reduction in the average insurance premium overall would be about 1%. This number is small because the services that currently result in surprise medical bills are a small portion of the total services covered by

insurers. However, the 1% reduction is large enough to reduce the federal deficit by $24.9 billion over ten years. Most of the deficit reduction comes from the savings the government will realize in federal subsidies for lower-income Americans to purchase private insurance.

Kaiser HealthNews (KHN) and PolitiFact HealthCheck conducted a fact check on opponents' claims that S. 1895 would hurt both accessibility and quality. KHN and PolitiFact HealthCheck found opponents' claims to be false for two reasons. First, independent experts concluded that the logic of opponents' claims is flawed. Second, although S. 1895's opponents state their claims about the bill's impacts as fact, they can't provide anything but anecdotal evidence.

The findings of two recent empirical studies on the effects of California's surprise billing legislation also contradict opponents' claims that reducing payments to out-of-network providers would also reduce the amount and quality of care delivered in network. In fact, both studies found that the amount of in-network care increased under the California law in accordance with liberal and conservative economists' predictions. Because the California law combines payment standards with IDR, we will review these studies at length when we consider the federal bipartisan bills that adopt a combined approach. However, proponents of S. 1895, while acknowledging that California law includes IDR, nevertheless argue that the results indicate that payment standards don't cause the care shortages that opponents claim they will.

Evidence supporting opponents' claim that insurers can and would manipulate their data in order to reduce the calculation of median in-network rates comes from several large, class-action lawsuits. Even without surprise billing legislation, insurers and providers often negotiate contracts in which the insurer agrees to pay out-of-network providers a percentage of the insurers' median in-network rate. These lawsuits accused insurers of manipulating their data to reduce their median in-network rates, which, in turn, reduced the payments insurers made to out-of-network providers. The insurers named in these lawsuits agreed to settle for hundreds-of-millions of dollars without admitting wrongdoing. Nevertheless, many agree with opponents' claims that insurers' have deliberately manipulated their data to establish artificially low median in-network rates. Otherwise, they argue, the implicated insurers wouldn't have settled for hundreds-of-millions of dollars.

IDR: H.R. 3502 – The Protecting People from Surprise Medical Bills Act

 **Independent Dispute Resolution (IDR)**

Summary of What it Does

Ends Surprise Bills for:	
Emergency Services	Yes
Ancillary Services	Yes
Ground Ambulance Services	No
Air Ambulance Services	No
Post Emergency Inpatient Stabilization	No
Benchmarks for Out-of-Network Payment Standards	Doesn't Apply
Arbitration considerations	Arbitrator considers: ● Median In-Network Rate of All Insurance Plans ● Other factors including severity of case and provider training ● 80th Percentile of Providers' Billed Charges

Details of What It Does

House Bill 3502 (H.R. 3502) eliminates surprise medical bills for emergency and ancillary services. It does not, however, eliminate surprise bills for air or ground ambulances. Nor does it eliminate surprise bills for post-emergency inpatient stabilization (see Table 1).

In contrast to S. 1895, H.R. 3502 takes an Independent Dispute Resolution (IDR) approach rather than mandating a payment standard. H.R. 3502 allows insurers and providers to negotiate the out-of-network payment appropriate to each case. In cases in which the insurer and provider are unable to agree, either can submit their case to the IDR process. In IDR, both the insurer and provider submit their "final offer" to a qualified arbitrator. The arbitrator then chooses the offer which they consider to be the most fair and appropriate. The arbitrator's decision is binding. This form of dispute resolution is sometimes called "baseball style" arbitration.

H.R. 3502 establishes three benchmarks for the arbitrator to consider when determining which of the final offers is most appropriate. First, the arbitrator can consider the median in-network rate of *all* insurance plans in that area. Second, the arbitrator can consider distinguishing factors such as the case's severity and the provider's education and experience. Third, the arbitrator can consider the 80th percentile of providers' billed charges.

Representative Raul Ruiz (D-CA) and Representative Phil Roe (R-TN) sponsored H.R. 3502. It is co-sponsored by 55 Republicans and 46 Democrats. It has not had a committee vote yet.

Arguments For and Against

There is wide agreement that H.R. 3502's IDR-only approach would do less to reduce the disproportionately high payments to emergency and ancillary providers than either the payment standard or the combined payment standard-IDR approaches. Most providers support H.R. 3502. Most insurers oppose it.

While there is broad agreement that H.R. 3502 does less to reduce payments than the other approaches, there is some disagreement as to whether the bill would reduce payments to providers, leave them unchanged, or actually increase them. Some proponents of H.R. 3502 argue that the bill would reduce payments because the IDR mechanism provides a check on the ability that emergency and ancillary providers now have to unilaterally impose disproportionately high rates. Some proponents argue that even if it doesn't reduce payment rates, H.R. 3502 is superior because it would better protect access to quality emergency and ancillary services.

Proponents of H.R. 3502 argue that it is superior to other surprise medical billing solutions because it offers a more market-based approach.

Proponents also argue that H.R. 3502 is superior because it offers a more market-based approach. Mandating a payment standard is just government price fixing, they argue. H.R. 3502, in contrast, allows the market of insurers, providers, and, as needed, arbitrators, determine the appropriate payment for each case. Proponents argue that H.R. 3502 responds to the specific, special circumstances of each case, including the education and experience of the provider and the quality of the facility. Finally, proponents argue that H.R. 3502 avoids the market-fixing impulses of insurers who would manipulate their own median in-network rates to reduce payments to providers. H.R. 3502 rejects the insurer's *own* median in-network rate not only as a payment standard, but also as a benchmark for its arbitrators to consider within IDR. H.R. 3502 establishes the median in-network rate of insurers in that geographic area as a benchmark for arbitrators to consider.

Many opponents don't concede that H.R. 3502 offers a more market-based approach than the other proposed pieces of surprise medical billing legislation. These opponents argue that H.R. 3502 enacts its own form of rate setting when it requires its arbitrators to consider specific benchmarks. They also argue that the IDR mechanism that H.R. 3502 establishes creates an additional layer of cumbersome and expensive government-run bureaucracy.

H.R. 3502 proponents counter that final offer arbitration is an efficient form of dispute resolution. By requiring the arbitrator to choose between the parties' "final offers" without offering a compromise position, the process pushes those parties toward making reasonable offers.

Furthermore, proponents argue that requiring the losing party to pay for the arbitration ensures that arbitration won't be invoked too frequently or frivolously.

Opponents of H.R. 3502 argue that the bill will actually increase the disproportionately high rates that emergency and ancillary care providers currently charge.

Opponents also argue that rather than addressing the existing market failure with a functioning market solution, H.R. 3502 draws on, and then multiplies that failure. These opponents' most vehement critique focuses on the requirement that arbitrators consider the 80th percentile of provider-billed charges as a benchmark during arbitration.

As noted earlier, billed charges (or list prices) are set unilaterally by the provider. They are high for all medical providers, but disproportionately high for emergency and ancillary providers. Because of the existing market failure, opponents argue, the 50th percentile (or median) of billed charges is already far too high (see Figure 1). The 80th percentile, however, is likely to operate as an on-going payment escalator. If insurers don't offer providers the 80th percentile of provider billed charges, providers will take their claims to IDR. At any point in time, 80% of providers are being paid less than the 80th percentile. However, as more providers resist settling for less, the 80th percentile goes up. This will lead more providers to argue that they, too, should get the new higher rate. As a result, the 80th percentile will continue to rise.

Rather than correcting the unjustifiably high rates that emergency and ancillary care providers have charged patients through surprise medical bills, H.R. 3502 opponents argue that establishing the 80th percentile of provider billed charges as a benchmark multiplies that market failure and then locks it into federal law.

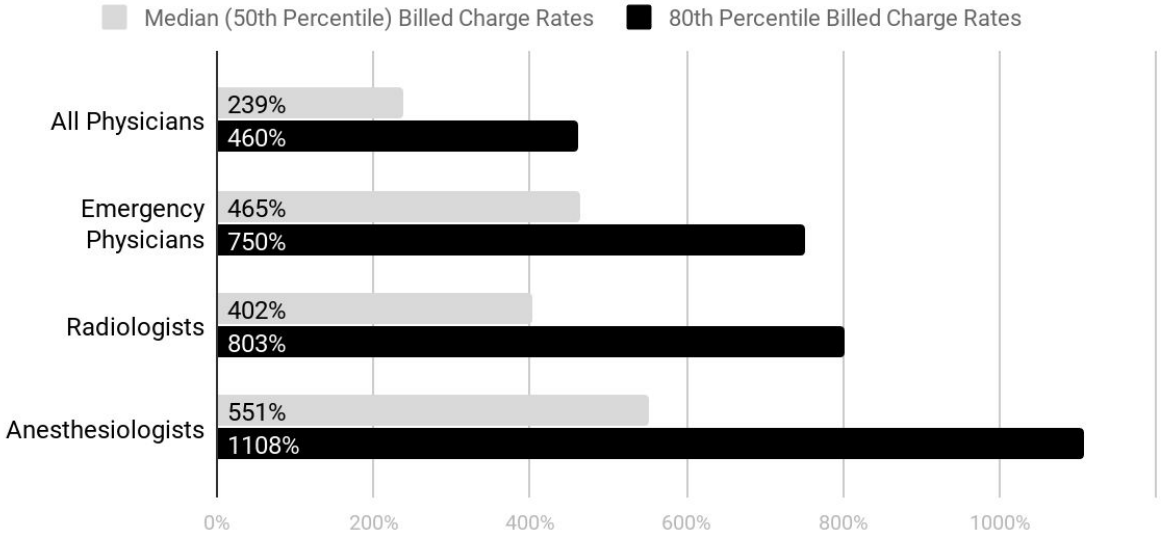
The Evidence

A full CBO study of H.R. 3502 has not been conducted and made publicly available. However, The Hill recently obtained a CBO email describing the findings from their initial analysis. According to The Hill's September 24, 2019 article, CBO found that H.R. 3502 would increase the budget deficit by about $15 billion dollars. That estimate seems to be based, at least in part, on evidence CBO referenced about the impacts of a similar approach in New York. According to the article in The Hill, the CBO email said that the New York law increased payments to doctors by "as much as 5 percent."

H.R. 3502 opponents find the CBO estimate credible. In fact, some argue that additional evidence suggests that H.R. 3502 will likely increase payments by even more than 5% over the long run. The first source of evidence supporting opponents' claims are the data showing how much higher the 80th percentile of billed charges is than the median, or 50th percentile. For convenience, we've included in Figure 2 below the data on the 50th percentile (or median) billed charges from Figure 1 in the discussion above about the market failure. The same

USC-Brookings Schaeffer study from which those data are drawn also provided data on the 80th percentile of billed charges. As also seen in Figure 2, the 80th percentile is 750% of Medicare rates for emergency physicians, 803% for radiologists, and 1,108% for anesthesiologists.

Figure 2: Differences between Median and 80th Percentile Billed Charge Rates Relative to Medicare Rates



H.R. 3502 proponents counter by criticizing CBO's estimate, in part, because the empirical evidence that CBO relies on is not publicly available. The only formal study publicly available is the Yale study discussed earlier, a study that is cited by the New York Department of Financial Services. The Yale study found evidence that the New York law caused payments to decrease, not increase, in price. Although the New York law sets the arbitrators' benchmark at the 80th percentile of billed charges, the Yale researchers found that the in-network payments for emergency department services went down by an average $43 or 8.8% from what they had been before New York passed the law. The researchers also examined prices for emergency department services in five surrounding states. Prices in those states over the same period were unchanged, increasing the confidence that the reduction in prices in New York was due to passing the surprise billing law.

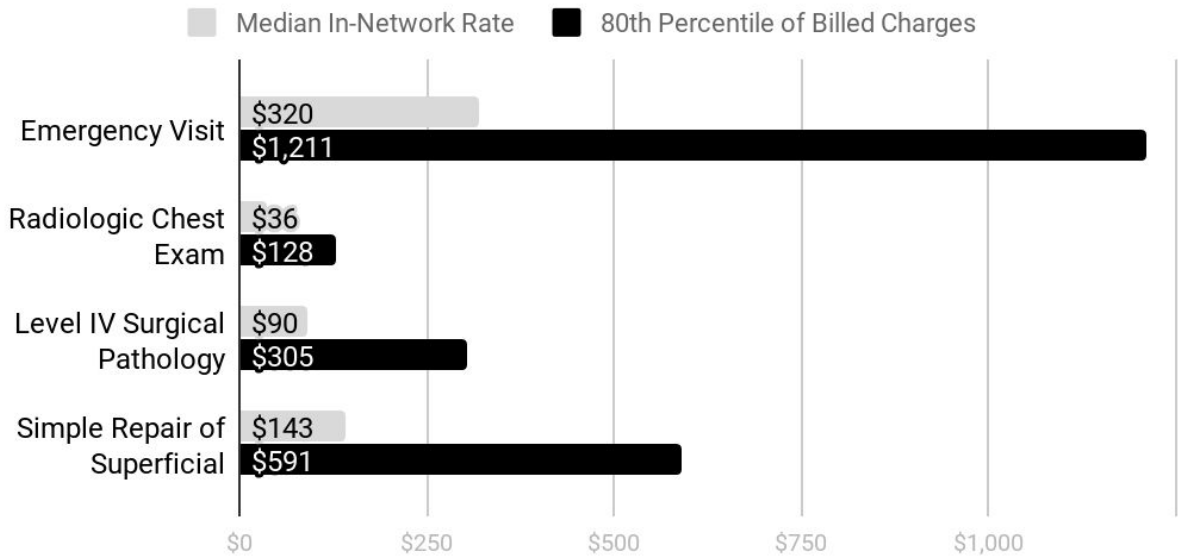
H.R. 3502 opponents have criticized the Yale study. Although New York passed its surprise bill law on April 1, 2014, and it went into effect on April 1, 2015, the Yale researchers only analyzed data through the end of 2015. Nine months of experience under the law is inadequate, some argue, to draw a definitive conclusion about its effects on prices.

That argument is bolstered, opponents argue, by two findings about how the IDR system in New York is functioning. First, the number of claims being arbitrated under the New York law is rising significantly over time. According to data from the New York State Department of Financial Services, there has been a 546% increase in claims submitted to IDR from 2015 to 2018. In 2015, the first year under the law, 243 cases were submitted compared to 1,571 in 2018.

Scholars (see, for example, Ury, Brett, and Goldberg and Rogers, Bordone, et. al.) observe that a central objective of any dispute resolution system is to provide clarity so that disputes in the vast majority of cases can be settled by the parties without appealing to the formal mechanism. If both parties can reasonably anticipate what an arbitrator or judge will decide, they can simply settle the matter themselves on those terms and save the time, hassle, and risk of the formal procedures. Robert Mnookin, a professor of negotiation and dispute resolution at Harvard Law School, refers to this effect as "bargaining in the shadow" of a dispute resolution system. While it may take some time to find the equilibrium, over the long run, the number of appeals to a well-designed IDR system should go down. To this point, that is not happening in New York.

The second finding about the IDR experience in New York that critics cite is that, as intended, arbitrators' decisions are clustering around the 80th percentile of billed charges. In fact, a USC-Brookings Schaeffer Initiative analysis of the data provided by the New York State Department of Financial Services finds that arbitrators' decisions in New York have awarded payments that are an average of 8% higher than the 80th percentile of billed charges. The same USC-Brookings study confirmed that in New York, as in the rest of the country, the 80th percentile of billed charges was already substantially higher than median in-network rates for doctors who can surprise bill without arbitrators tacking on an average increase of 8%. As seen in Figure 3, the median in-network rate in New York for an emergency room visit is $320, while the 80th percentile of billed charges is $1,211. For a radiologic chest exam, the median in-network rate in New York is $36, while the 80th percentile is $128.

Figure 3: In-Network Rates vs. 80th Percentile of Billed Charges in New York, 2018-2019



Critics of H.R. 3502 also point out that the New York law uses the term "usual and customary" to describe the 80th percentile of billed charges. They suggest that many providers may have reasonably assumed that "usual and customary" meant something like the median, or 50th percentile, of in-network rates. As word gets out about arbitrators' decisions, providers might realize that "usual and customary" means a payment several times higher than they expected.

Consequently, opponents suggest, more providers are taking claims to arbitration to obtain these higher payments.

H.R. 3502 opponents suggest that the data on significantly increasing submissions to IDR, the data that arbitrators' payments are 8% higher than the 80th percentile of billed rates, and the discovery of the meaning of "usual and customary" in New York may mean that the 5% payment increases described in the CBO email may just be the beginning.

IDR: H.R. 5826 – The Consumer Protections Against Surprise Medical Bills Act

 **Independent Dispute Resolution (IDR)**

Summary of What it Does

Ends Surprise Bills for:	
Emergency Services	Yes
Ancillary Services	Yes
Ground Ambulance Services	No
Air Ambulance Services	No, but study
Post Emergency Inpatient Stabilization	No
Benchmarks for Out-of-Network Payment Standards	Doesn't Apply
Arbitration considerations	Arbitrator considers: ● Insurer's Own Median In-Network Rate for 2019, indexed to inflation in subsequent years ● Information parties provide relating to their final offer, except for Billed Charges

Details of What It Does

House Bill 5826 (H.R. 5826) eliminates surprise medical bills for emergency and ancillary services. It does not eliminate surprise bills for air or ground ambulances, though it has a provision to study eliminating surprise bills for air ambulances. It also does not eliminate surprise bills for post-emergency inpatient stabilization (see Table 1).

Like H.R. 3502, H.R. 5826 takes an Independent Dispute Resolution (IDR) approach rather than mandating a payment standard. H.R. 5826 allows insurers and providers to negotiate the out-of-network payment appropriate to each case. In cases in which the insurer and provider are unable to agree, either can submit their case to an IDR "final offer arbitration" process, like in H.R. 3502.

H.R. 5826 differs from H.R. 3502 primarily in the benchmarks it establishes for the arbitrator to consider when determining which of the final offers is most appropriate. The biggest difference is that H.R. 5826 does not give the arbitrator the 80th percentile of billed charges as a benchmark. Instead, the arbitrator is directed to consider two benchmarks. First, the arbitrator considers the insurer's own median in-network rate for similar items or services in the same geographic area. Specifically, the benchmark is the insurer's 2019 median in-network rate

indexed to inflation. Second, the arbitrator can consider other information the parties provide related to the final offer they submit to the arbitrator, except that the arbitrator cannot consider a provider's billed charges.

Representative Richard Neal (D-MA), the chairman of the House Ways and Means Committee, and Representative Keven Brady (R-TX), the committee's ranking Republican, sponsored H.R. 5826. It is co-sponsored by 16 Democrats and 20 Republicans. On February 12, 2020, the House Ways and Means Committee passed the bill overwhelmingly on a voice vote.

Arguments For and Against

Because it is also an IDR-only approach, many of the same arguments are made for and against H.R. 5826 as H.R. 3502.

In response to H.R. 5826 the White House cautioned against an IDR-only approach, saying that President Trump "is concerned that a push to overuse arbitration will raise healthcare costs."

H.R. 5826, however, does address one of the chief criticisms H.R. 3502. Opponents of H.R. 3502 argued that by including the 80th percentile of billed charges as a benchmark for the arbitrator would lock disproportionately high payments to emergency and ancillary providers into federal law. Most agree that H.R. 5826's elimination of that benchmark means that it wouldn't maintain, or even increase, already high prices as much as H.R. 3502.

By benchmarking to the insurer's 2019 median in-network rate indexed to inflation, H.R. 5826 raises two arguments that cut in the opposite direction of each other in terms of prices. First, the 2019 benchmark means that insurance companies can't manipulate the data to calculate the median. Many agree that data less prone to manipulation is an advantage over S. 1895's benchmark of the insurer's own median in-network rate for the prior year. Providers argue that this keeps insurance companies from unfairly reducing the payments they receive for their services.

Second, since healthcare costs tend to rise more rapidly than inflation, some argue that the indexed 2019 median should help hold down costs over . Insurer's tend to like that consequence more than providers.

The Evidence

A CBO cost estimate confirms that H.R. 5826 would reduce prices, in contrast to their findings that H.R. 3502 would increase them. CBO estimated that H.R. 5826 would reduce payments to those who can surprise bill enough to reduce overall insurance premiums by between 0.5 and 1 percent. That is less than the 1 percent reduction in premiums that CBO estimated S. 1895's payment-standard only approach would produce.

Combined: H.R. 2328 – The No Surprises Act

 **Combined**

Summary of What it Does

Ends Surprise Bills for:	
Emergency Services	Yes
Ancillary Services	Yes
Ground Ambulance Services	No
Air Ambulance Services	No
Post Emergency Inpatient Stabilization	Yes
Approach for Applying Benchmarks	**Combined:** ● Mandated Payment Standard ● Cases over $1,250 can be appealed to IDR (Final Offer Arbitration)
Benchmarks for Out-of-Network Payment Standards	Insurer's Own Median In-Network Rate for 2019, indexed to inflation
Arbitration considerations	On appeal, arbitrator considers: ● Median In-Network Rate of All Insurance Plans ● Severity of case and provider training

Details of What It Does

House Bill 2328 (H.R. 2328) eliminates surprise bills for emergency and ancillary services. It also eliminates surprise bills for post-emergency inpatient stabilization. It does not eliminate surprise bills for ground or air ambulance services (see Table 1).

H.R. 2328 combines a payment standard approach like that found in S. 1895 with an IDR system like that in H.R. 3502 and H.R. 5826. It establishes the insurer's own median in-network rate as the payment standard for out-of-network providers. Specifically, like H.R. 5826's arbitrator benchmark, H.R. 2328 establishes the insurer's own current median in-network rate in 2019 for a given service or item in that geographic area, indexed to inflation.

An insurer or provider who is dissatisfied with this payment standard rate for a particular case can appeal that case to IDR as long as the contested charge is more than $1,250. Like H.R. 3502, H.R. 2328 uses "final offer" arbitration. The arbitrator's decision is binding. The losing party pays for the arbitration.
H.R. 2328 establishes two benchmarks for the arbitrator to consider when determining which of the final offers is more appropriate. First, the arbitrator can consider the median in-network rates of all insurance plans in that geographic area for that service or item. Second, the arbitrator can consider distinguishing factors such as the severity of the case and the education and experience of the provider.

House Energy and Commerce Committee Chairman Frank Pallone (D-NJ) sponsored H.R. 2328. Ranking Member Representative Greg Walden (R-OR), along with Representatives Ann Wagner (R-MO) and Rashida Tlaib (D-MI), co-sponsored the bill. The bill was originally introduced as H.R. 3630. It was then included as part of H.R. 2328 which passed the House Energy and Commerce Committee on July 17, 2019. H.R. 2328 also includes provisions for funding community health centers, increasing Medicaid funding for U.S. territories, and increasing the federal medical assistance percentage.

We do not have the breakdown of Democratic and Republican votes for H.R. 2328 because it passed out of committee on a voice vote. We also don't know whether committee members' support or opposition was related specifically to the surprise medical billing provisions. However, like the other three bills, the surprise billing provisions in H.R. 2328 enjoy broad, bipartisan support.

Arguments For and Against

Proponents of H.R. 2328 argue that it realizes the strengths of both the payment standard and IDR approaches while avoiding the problems each presents as a stand-alone solution. This, they argue, is why H.R. 2328 draws broader support from across the insurer and provider divide than either S. 1895 or H.R. 3502.

Proponents of H.R. 2328 argue that it will realize the strengths of both the payment standard and IDR approaches while avoiding the problems each presents as a stand-alone solution.

H.R. 2328 proponents agree with payment standard supporters that establishing the median in-network rate as the payment standard significantly reduces the disproportionately high payments that providers who currently surprise bill receive. They also agree with S. 1895 proponents that the insurer's own median in-network rate is a good approximation of a fair market rate because it reflects negotiations between the insurer and many other regional providers.

Proponents of H.R. 2328 also agree with IDR supporters who believe that paying the insurer's own median in-network rate in all circumstances for that service in that geographic area will sometimes yield the wrong outcome is some cases. They argue that some circumstances require IDR's responsiveness to their exceptional characteristics.

For IDR to play this limited role effectively, H.R. 2328 proponents argue, it's important to establish the right benchmarks for arbitrators' use. In the interest of reducing the

disproportionately high payment rates currently collected by emergency and ancillary care providers, H.R. 2328 does not allow arbitrators to consider the 80th percentile of billed charges. In the interest of protecting against a given insurer manipulating their own median in-network rate, H.R. 2328 directs arbitrators to consider all insurers' median in-network rates in that geographic area. In the interest of recognizing exceptional circumstances, it directs arbitrators to consider the severity of the case and the providers' training.

H.R. 2328 proponents also argue that two features of the way it incorporates IDR addresses the criticism of the IDR-only approach that it creates a cumbersome government-run bureaucracy to arbitrate potentially thousands of claims. First, by establishing IDR as an appeal of a payment standard for exceptional circumstances, proponents argue, H.R. 2328 likely reduces the number of claims made to IDR significantly compared to the IDR-only approach. Second, H.R. 2328 supporters point to the limit that only cases over $1,250 can be taken to arbitration. This is a sensible additional step to keep the cost and bureaucracy of IDR down, proponents suggest, and to only use it when the stakes are high enough to warrant it.

Most payment-standard-only supporters agree that H.R. 2328's combined approach is significantly better than an IDR-only approach. Similarly, most IDR-only supporters agree that H.R. 2328 is meaningfully better than the payment-standard-only approach. Still, H.R. 2328 draws some opposition from both payment-standard-only and IDR-only supporters.

Opponents of H.R. 2328 attack the bill from both sides. Providers argue that the payment standard is simply government price fixing while insurers argue that the inclusion of IDR introduces needless expense and uncertainty.

We start with the criticisms of H.R. 2328 that some insurers and payment-standard only supporters make. Many who prefer the payment-standard-only approach agree that H.R. 2328 is a smarter approach to IDR than the IDR-only approach in H.R. 3502. Nevertheless, some payment-standard only supporters still argue that H.R. 3502's improved IDR mechanism is ill-advised. Their main argument is that the inclusion of IDR, even as an appeal process without the 80th percentile billed rate benchmark, introduces uncertainty about whether it can deliver on the core need to reduce the disproportionately high rates that providers who can surprise bill are charging. In short, they argue, it gives providers who already charge too much another opportunity to charge unjustifiably high rates. Some payment standard-only supporters consider cost reduction such a critical function of surprise billing legislation that they believe that adding even limited IDR is not worth it.

Proponents of H.R. 2328's combined approach respond to the criticism from payment-standard-only advocates by arguing that H.R. 2328 actually has a provision that gives

it an advantage over S. 1895 in reducing disproportionately high payments to providers who surprise bill. Like supporters of H.R. 5826, H.R. 2328 supporters point out that medical costs increase over time much more than the costs of all goods and services. Because the median in-network rate is calculated for 2019 and then indexed to inflation, H.R. 2328 will reduce payments more over the long run, some proponents argue, than S. 1895.

H.R. 2328 proponents also argue that the calculation of the median in-network rate each year, as S. 1895 would do, is prone to manipulation. Like H.R. 5826, H.R. 2328 avoids this problem, proponents argue, by calculating the current median in-network rates, before either insurers or providers have much opportunity to manipulate it, and then indexes it to the Consumer Price Index, which they can't manipulate.

We now move to the criticisms that proponents of the IDR-only approach and providers raise. Unsurprisingly, their criticisms of H.R. 2328's combined approach are generally the opposite of those raised by proponents of payment standards and insurers. Many IDR-only supporters and providers argue that H.R. 2328 will decrease payments too much. As with S. 1895, they argue, access to high quality emergency and ancillary care will be jeopardized and less emergency and ancillary care will be provided on an in-network basis.

The California Medical Association (CMA) warns that the combined approach specifically, not just the payment-standard-only approach, creates these access problems. In a letter to Members of Congress, the CMA advised against following California's combined approach law. They claim that under that law, "insurance company physician networks are diminishing, patient access to in-network physicians is declining, patient access to emergency physicians and on-call physician specialists is in jeopardy".

Proponents of the IDR-only approach also criticize H.R. 2328's requirement that only cases above $1,250 may be appealed to IDR. The IDR remains useful even for cases below $1,250, they argue. They also argue that the $1,250 threshold is especially inappropriate for some specialties whose services are less expensive. Particularly since the losing side pays for the arbitration, they also argue, the cost isn't a major factor.

The Evidence

The CBO estimate for H.R. 2328's combined approach largely confirms claims that it would significantly reduce the disproportionately high payments for providers who can surprise bill. In fact, at least over the long run, H.R. 2328 would reduce payments by about the same amount as S. 1895's payment-standard-only approach. According to CBO, three provisions will have the most significant impacts on payment levels. The first, and biggest effect, is the median in-network payment standard that it shares with S. 1895. As with S. 1895, CBO estimates that this specific provision will lead to a 15% - 20% reduction in payment rates to providers who can surprise bill.

The other two provisions in H.R. 2328 that would meaningfully affect payment levels differ from S. 1895. The two provisions unique to H.R. 2328', CBO estimates, will have offsetting effects

on payment levels. First, CBO estimates that the IDR appeal provision would have a payment increasing effect. The IDR provision would increase costs because, CBO reasons, it allows arbitrators to take into account factors like the severity of the case and the level of provider training. Many cases appealed to IDR will be those for which a case can be made that a payment higher than the in-network median is appropriate. CBO estimates that this effect would offset the 25% of the reduction in payment levels due to setting them at the median in-network rate.

CBO estimates that H.R. 2328's second unique provision would, over time, further reduce payments who can surprise bill. Under H.R. 2328, the current median in-network rate would be calculated and then indexed to overall inflation in subsequent years. CBO estimated that in the long run this provision would further reduce payments because general inflation rises more slowly than medical costs.

Over the long run, then, the unique provisions in H.R. 2328 mostly offset each other. The net effect on payments to affected providers would be about the same 15% - 20% reduction as CBO estimates for S. 1895. Also like with S. 1895, CBO estimates that net reductions in overall health insurance premiums would be about 1%.

The surprise billing law that California passed on September 26, 2016 provides another source of evidence about the likely effects of H.R. 2328's combination of payment standards and IDR. In fact, H.R. 2328 largely draws on the California model. California's law, which went into effect on July 1, 2017, sets a payment standard for out-of-network ancillary charges at either the "average contracted rate" or 125% of Medicare, whichever is higher. It gives either side the opportunity to appeal that result to arbitration. Like the other IDR mechanisms, the arbitrator chooses between the insurer and provider's "final offer" and the losing party pays for the arbitration. Under the California law, arbitrators may consider any relevant information, including payments made by other private insurers and by public payers like Medicaid and Medicare. Like H.R. 2328 and H.R. 5826, the California law does not include the 80th percentile of what providers bill as a benchmark for arbitrators to consider.

There has not yet been a rigorous study examining whether the California law reduced payment amounts to those it prohibits from surprise billing. We do have relevant data, however, about the effect the California law has had on how much care is available in-network and about how the IDR system in California is working.

The evidence from California contradicts the California Medical Association's claims that it would cause a reduction in the number and quality of in-network services. In fact, the evidence indicates that California's combined approach has actually increased the amount of care available through insurers' networks, a result that is consistent with economic theory.

The strongest evidence comes from two recent studies. One study was conducted by the USC-Brookings Schaeffer Initiative. It examined more than 10.3 million claims for ancillary services affected by California's surprise billing legislation, including anesthesiology, diagnostic radiology, pathology, assistant surgeons, and neonatal-perinatal medicine (the California law did not affect surprise bills for emergency services because an earlier California Supreme Court ruling had already prohibited them). The study found that as of December 2018, California had experienced a modest 3.5% increase in the proportion of those ancillary services that are

delivered in network (from 79.1% of those services being delivered in-network before the law to 82.6% after the law) since the law went into effect.

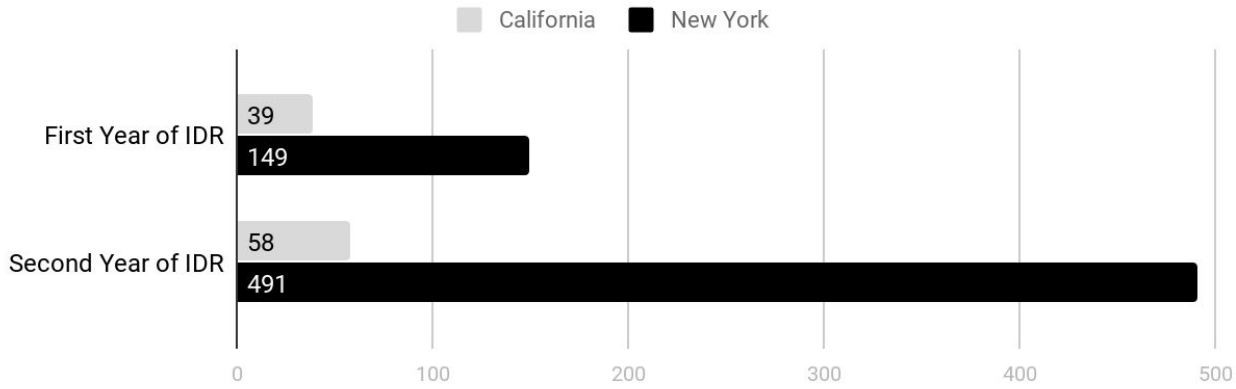
A study reporting more recent data published in the American Journal of Managed Care also found an increase in the number of in-network ancillary providers in California since the law went into effect. It found that as of July 2019, the number of in-network anesthesiologists increased 18%, diagnostic radiologists increased 26%, and pathologists increased by 1%.

Some opponents have criticized these studies, including noting that the USC-Brookings study has not been published in a peer-reviewed journal and that the study published in the American Journal of Managed Care was conducted by American's Health Insurance Plans (AHIP), who have a conflict of interest on this question.

Recognizing the limits of the available data, many knowledgeable observers who are neither insurers nor providers nevertheless conclude that there is more evidence that a combined approach like the California law increases access to in-network care than that it decreases it.

Recent evidence about how the IDR appeal mechanism is functioning in California also supports some of the arguments made by supporters of H.R. 2328's combined approach. Although we do not yet have data about the payment levels from arbitrators' decisions, we do have evidence that, at least early in the California experience, very few claims are being taken to IDR. The IDR appeal mechanism in California first became available September 1, 2017. According to data recently released by the California Department of Managed Healthcare, no cases were appealed to IDR during the last four months of 2017 that it was available. As seen in Figure 4, 39 claims were appealed in 2018, compared to 149 in the first year (2015) IDR was available in New York, a difference of 280%. In first half of 2019, 29 claims have been appealed in California. At that rate, 58 claims will be submitted for all of 2019, the second full year IDR has been available there. At 491 claims, New York had 747% more claims submitted to its IDR in its second year (2016) than California did.

Figure 4: Number of Cases Appealed to IDR in California and New York



The remarkably small number of claims being taken to IDR, supporters argue, suggest that very few providers believe that they have a sufficiently strong argument that the severity of the case or the training of the provider would justify a payment above the medium in-network rate. With

such small numbers, they further argue, it's difficult to imagine the 25% offset to the 15% - 20% reduction in payments that CBO estimates.

Opponents respond that while the number of cases is low, we only have 18 months of data to go on. Furthermore, they argue, those data show that the number of IDR cases is increasing. Consequently, they suggest, it's too early to know the impact of the California IDR mechanism.

Supporters of H.R. 2328 also argue that the IDR system that it would establish would more quickly achieve a stable state in which few cases are arbitrated than in California because it gives a narrower and clearer set of benchmarks than the California law. While the California law allows arbitrators to consider any relevant information, H.R. 2328 requires the arbitrator to only consider the median in-network rates of all insurance plans and factors such as the severity of the case and level of provider training.

Combined: H.R. 5800 -
The Ban Surprise Billing Act

 **Combined**

Summary of What it Does

Ends Surprise Bills for:	
Emergency Services	Yes
Ancillary Services	Yes
Ground Ambulance Services	No, but study
Air Ambulance Services	Yes
Post Emergency Inpatient Stabilization	Yes
Approach for Applying Benchmarks	**Combined:** ● Mandated Payment Standard ● Emergency, ancillary, and post emergency inpatient stabilization cases over $750 can be appealed to IDR (Final Offer Arbitration) ● Air ambulance cases over $25,000 can be appealed to IDR (Final Offer Arbitration)
Benchmarks for Out-of-Network Payment Standards	Insurer's Own Median In-Network Rate for 2019, indexed to inflation
Arbitration considerations	On appeal, arbitrator considers: ● Median In-Network Rate for all Insurance Plans ● Severity of case and provider training ● Market share of parties

Details of What It Does

H.R. 5800 eliminates surprise bills for emergency and ancillary services. It also eliminates surprise bills for post-emergency inpatient stabilization and air ambulance services. It does not eliminate surprise bills for ground ambulance services. It does, however, mandate a study to investigate how to protect patients from surprise bills for ground ambulance services (see Table 1). This source of surprise bills is complicated because many ground ambulance providers are public entities like cities or counties.

Like H.R. 2328, H.R. 5800 combines a payment standard approach with IDR. It establishes the insurer's own median in-network rate as the payment standard for out-of-network providers. Specifically, H.R. 5800 also establishes the insurer's own current median in-network rate in 2019 for a given service or item in that geographic area, indexed to inflation.

An insurer or provider who is dissatisfied with this payment standard rate for a particular emergency or ancillary care case can appeal that case to IDR as long as the contested charge

is more than $750, in contrast to the higher minimum of $1,250 under H.R. 2328. In cases specifically involving air ambulance services, the contested charge must be more than $25,000. Like the IDR provisions in other bills, H.R. 5800 uses "final offer" arbitration. The arbitrator's decision is binding. The losing party pays for the arbitration.

H.R. 5800 establishes three benchmarks for the arbitrator to consider when determining which of the final offers is more appropriate. First, the arbitrator can consider the median in-network rates of all other insurance plans in that geographic area for that service or item. Second, the arbitrator can consider distinguishing factors such as the severity of the case and the education and experience of the provider. Third, the arbitrator can consider the market share of the insurer and the provider. This third provision allows the arbitrator to take into account circumstances where the insurer or provider may have disproportionate bargaining power because they have a large share of the market in a particular geographic area.

The outline of H.R. 5800 was announced by Senator Alexander (R-TN) and Representatives Pallone (D-NJ) and Walden (R-OR) on December 8, 2019. That announcement was the result of negotiations among the three leaders to build on the insights gained from the various efforts to find a commonsense, bipartisan solution to surprise billing. Senator Alexander is the chairman of of the Senate HELP Committee and a co-sponsor of S. 1895's payment-standard-only approach. Representative Pallone is the chairman, and Representative Walden is the Ranking Member of the House Energy and Commerce Committee. Together, they co-sponsored.R. 2328's combined approach.

President Trump released a statement supporting Alexander, Pallone, and Walden's December 8th announcement, praising their efforts to address the concerns of both Republicans and Democrats and the Senate and the House.

On February 7, 2020, Representative Robert "Bobby" Scott (D-VA), chairman of the House Education and Labor Committee, and Representative Virginia Foxx (R-NC), ranking member of the committee, introduced as H.R. 5800 what Alexander, Pallone, and Walden had outlined on December 8. On February 11, 2020, the House Education and Labor Committee passed H.R. 5800 on a 32 - 13 bipartisan vote.

Arguments For and Against

H.R. 5800's combined approach is very similar to H.R. 2328. Consequently, most of the arguments for and against it are the same.

H.R. 5800's main distinguishing feature is the limit it establishes that only cases over $750 can be appealed to IDR. Insurers still prefer no IDR, for the reasons described above. If there is to be IDR, insurers would prefer the $1,250 limit. Most providers remain opposed to any approach with a payment standard, for the reasons described above, even if there is an IDR appeal. If

there is an IDR, providers would prefer that even cases for even very small amounts could be appealed .
Most Republicans and Democrats and insurers and providers support H.R. 5800's unique provision to study how to address surprise bills for ground ambulance services. None of the prior bills prohibited ground ambulance surprise bills because they present unique complexities. Many who provide these services are public entities like counties and cities. Still, most believe a way to address these surprise bills should be explored.

Most also agree with the provision that arbitrators can consider insurer's and provider's market share. In many geographic areas, a few insurer's and/or a few hospital systems can own most of the market share. The lack of competition can give them increased, and potentially unfair, bargaining leverage.

The Evidence

The evidence cited for H.R. 2328's combined approach is also relevant for H.R. 5800. A CBO estimate finds that HR 5800 would provide similar cost savings as H.R. 2328 and result in roughly a 1 percent reduction in insurance premiums overall.

Questions

1. Do you support or oppose the surprise billing provisions for S. 1895?
2. Do you support or oppose H.R. 3502?
3. Do you support or oppose H.R. 5826?
4. Do you support or oppose the surprise billing provisions for H.R. 2328?
5. Do you support or oppose H.R. 5800?
6. Do you support or oppose limiting IDR to cases over $250?
7. Do you support or oppose limiting IDR to cases over $500?
8. Do you support or oppose limiting IDR to cases over $750?
9. Do you support or oppose limiting IDR to cases over $1,250?
10. Do you support or oppose using the insurer's own median in-network rates as a benchmark?
11. Do you support or oppose using all insurers' median in-network rates as a benchmark?
12. Do you support or oppose calculating the median in-network rate each year?
13. Do you support or oppose calculating the median in-network rate for the first year and then indexing it to inflation in subsequent years?
14. Do you support or oppose using factors such as severity of case and provider training as a benchmark?
15. Do you support or oppose using the 80th percentile of billed charges as a benchmark?
16. Do you support or oppose using the market share of insurers and providers as a benchmark?
17. Do you support or oppose ending surprise bills for emergency services?
18. Do you support or oppose ending surprise bills for ancillary services?
19. Do you support or oppose ending surprise bills for ground ambulance services?
20. Do you support or oppose ending surprise bills for air ambulance services?
21. Do you support or oppose ending surprise bills for post-emergency stabilization?
22. What are the most important reasons for the positions you've taken? (Optional) [Open-ended text box answer]
23. Any other comments you'd like to make about surprise billing legislation? (Optional) [Open-ended text box answer]
24. How would you rate the quality of this brief?: Poor, fair, good, excellent. (Optional)
25. Any comments or suggestions for how we do these briefs? (Optional) [Open-ended text box answer]