MEMORANDUM

Date: April 30, 2019

To: Capitol Hill health care staff

From: The ERISA Industry Committee (ERIC), National Retail Federation

Re: Surprise Billing – Frequently Asked Questions, Clarifications, Legislative Options, and Stakeholder Priorities

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It has come to the attention of employer groups, who represent the companies currently sponsoring health benefits for more than 181 million Americans, that more information is needed for Hill staff engaging on the issue of surprise medical billing. Employers are committed to ending (or at least drastically curtailing) surprise medical billing, and have a very simple proposition for Congress:

Employers are willing to take responsibility, and agree to pay surprise medical bills on behalf of our plan beneficiaries.

This comes with several critical caveats: The amounts we pay must be reasonable, based on amounts that providers can realistically expect in a functioning market, and cannot undermine our ability to use provider networks to drive quality and affordability.

As such, we are heavily engaged with congressional staff on developing proactive solutions to protect our employees, retirees, and their families (our beneficiaries), ensure that their benefits provide them with access to high quality health care, and eliminate the financial woes caused by defects in the current system. We offer the below information to help Hill staff continue policy development and create and pass a proposal to permanently solve this completely solvable problem in health care.

Executive Summary

Unexpected or "surprise" medical bills are a big problem for many employees and their covered families. These bills most often come from treatment at an in-network health care facility by an unexpected out-of-network medical provider. Others come from emergency treatment at an out-of-network facility or by an out-of-network provider. Employers often intervene to protect employees, but in other cases, these bills threaten to financially impoverish families.

Employers are willing to take responsibility for these out-of-network bills, provided that the amounts we pay are reasonable and do not undermine our ability to use provider networks to drive quality and affordable care. State action has been mostly lacking in this area (only nine state have enacted comprehensive protections) and completely fails to protect the third of Americans covered in ERISA plans.

Employers reject the idea that providers must increase charges to employer plans (a.k.a. cost-shifting) to make up for shortfalls in reimbursement from public plans, like Medicare or Medicaid. Health care costs are still critically important and simply shifting responsibility for massive surprise medical bills to employers will only exacerbate the problem. Employers stand ready to support reasonable solutions to surprise medical billing.

Table of Contents

What is a surprise medical bill?	4
Who generates surprise medical bills?	5
What are the best, most straightforward ways Congress can address surprise medical bills?	5
If most providers already participate in networks, why are surprise medical bills a big deal?	6
Would Congress meddling in the health care market lead to “big government” and violate conservative principles?	6
Didn’t the ACA already regulate out-of-network emergency care services and costs?	7
Why does Congress need to act – can’t states solve this themselves?	7
What exactly have states done so far? Has the problem been solved in those states?	8
Won’t limiting providers’ surprise bills cause them dire financial harm?	8
Can’t many surprise bills be avoided simply by consumers making better choices?	9
How exactly do medical bills work? What is a patient responsible for?	9
How are responsible patients still being seen by out-of-network providers?	10
Why can’t Congress just mandate that the plans pay the surprise bills? Or just ban providers from sending balance bills?	10
Why do plans need provider networks?	11
What is a “joint venture,” and how are they contributing to surprise medical billing?	11
What can Congress do about these joint ventures?	12
Can transparency alone solve the surprise medical billing problem?	13
Some provider groups say Congress should just hold the patient harmless, and the providers and insurers will work it out between themselves. Can this approach work?	13
What about implementing binding arbitration – can this solve the problem?	14
Some provider groups claim a benchmark will lead to Medicare-for-All. Is this true?	14
Should Congress should stay out of surprise billing because it could give some parties an advantage?	15

Q: *What is a surprise medical bill?*

A: Surprise bills are generated primarily by out-of-network providers. They are bills sent by providers (e.g., doctors) to patients, outside of their health insurance plans, which patients do not expect, cannot meaningfully foresee, or avoid. Surprise medical bills are charged directly to the patient (and thus their health insurance is not obligated to pay). Most providers who participate in an insurance carrier's network agree not to send additional bills to patients beyond the patient's copay or coinsurance – the providers are paid by the patient's insurer or plan sponsor, and their agreed upon network payment is considered payment in full.

Surprise bills are generated primarily in two situations:

- When a patient goes to an in-network facility (such as a hospital), and at some point during the course of care (without the patient's knowledge, or without presenting the patient with a meaningful alternative), the patient is treated by an out-of-network provider; and

- When a patient requires emergency care, and goes or is taken to a facility or provider outside of the patient's insurance network.

The following situations **are not surprise medical bills**, despite irresponsible rhetoric that muddies the issue and confuses unrelated health policy issues with the surprise billing debate:

- When a patient goes to an emergency room, despite the terms of their insurance plan stating that emergency care in a given situation is inappropriate and will not be covered. This is an unrelated debate over a measure in the Affordable Care Act (ACA) called the "*prudent layperson*" standard. Certain provider groups are using the surprise billing debate to propose that insurers - pay them for unnecessary or inappropriate care;

- When a patient receives medical care, and that patient is enrolled in a high-deductible health plan (HDHP), but has not in fact met their deductible and expected first-dollar coverage. Opponents of consumerism, Health Savings Accounts (HSAs), and HDHPs are using the surprise billing debate to delegitimize the movement toward value-based insurance design, which incentivizes high-value care, while disincentivizing unnecessary and low-value care;

- When a patient knowingly schedules treatment with an out-of-network provider, or at an out-of-network facility.

The key issue here is that a "surprise" medical bill is defined as a bill that is generated with the patient lacking knowledge that the bill would come, or lacking meaningful choice to avoid the out-of-network provider. In any case when a patient knows, or should have known that they were obtaining unnecessary or out-of-network care, or care defined in the terms of their plan in such a way that the patient is informed they will pay, this is not a surprise bill – it's an affirmative choice by the patient. Congress should focus on real surprise bills and not be distracted by these other efforts.

Q: *Who generates surprise medical bills?*

A: Most providers do not generate surprise medical bills. They participate in networks, form agreements with insurance companies, agree to reasonable compensation, and are paid in full, promptly, by insurance carriers' automated systems. However, a small number of medical professions have adopted out-of-network strategies that maximize their profits at the expense of patients. These providers (dubbed "PEAR" as an acronym) primarily include:

- **P**athologists;
- **E**mergency physicians (including private-equity-owned "staffing firms");
- **A**nesthesiologists; and
- **R**adiologists.

There are also a couple of other medical provider professions that generate devastating surprise medical bills, although they have been less a focus of the debate so far. These include:

- Ambulances;
- Air ambulances (protected by a legal loophole, they avoid state regulation);
- So-called "free-standing emergency rooms" (often disguised to appear like clinics or urgent care centers); and
- Kidney dialysis facilities.

You'll notice that these providers all have some common traits: the first group (the "PEAR" providers) are primarily hospital-based doctors, who treat patients who are not choosing to see them in particular. In most cases, a patient who needs the services of these doctors lacks the ability or time to avoid them, becoming a "captive audience" forced to pay unreasonable amounts far beyond what any insurer would in good conscience pay.

The second group consists of providers who either engage in questionable business practices, are immune to reasonable state regulation (which almost all other providers are subject to), are unavoidable for patients and cannot be "shopped for," or exercise monopoly-like control of their markets.

Obviously there are other situations in which a patient will receive a surprise bill – numerous reports cite surgeons, assistant surgeons, and other hospital-based providers, or even the hospitals themselves levying large "facility fees" on unsuspecting patients. However, a solution to the first and second groups of providers described above is likely to eliminate the vast majority of surprise bills.

Q: *What are the best, most straightforward ways Congress can address surprise medical bills?*

A: Two simple policy changes could wipe out the vast majority of surprise medical bills, without raising health insurance premium costs for patients, and without causing financial instability to providers:

- **In-Network Matching Rate Guarantee**: If a provider chooses to practice at an in-network facility, the provider must accept the in-network rate at the facility; and

- A **benchmark backstop** for emergency care at an out-of-network facility: If a patient needs emergency care, and the care they receive is at an out-of-network facility, policymakers can specify a payment rate that the insurer or plan sponsor must pay if no agreement is reached. We suggest using 125% of Medicare rates, or considering a market-based rate such as 80% of

the median contracted in-network rate for the same or similar services agreed to between plans and providers in a given market or geography.

While these two solutions will not address all the problems causing surprise bills, they would eliminate the vast majority of them. Further, both guarantee that providers would be fairly compensated, because the reimbursement is based on rates that the vast majority of providers already agree to accept.

Q: *If most providers already participate in networks, why are surprise medical bills a big deal?*

A: While many families may be able to absorb unforeseen medical costs, that simply isn't the case in the rest of the country. You've likely seen statistics such as 78% of families live paycheck to paycheck, or less than 40% of Americans have the money to cover a $1,000 emergency. For these Americans, an unforeseen and unavoidable medical bill is a disaster scenario. It can lead to devastating consequences on their credit, or even force them to make choices between paying their bills, and affording necessities like food and housing. The fact that the current system makes it impossible for these people to adequately plan ahead for the costs of medical care is simply unacceptable.

But many families who are on financially sound footing also struggle with surprise medical bills. Many of America's largest employers offer generous health benefits. If those plans were offered on an ACA exchange, they would be considered "Platinum" plans. And yet, these families are still worried about surprise medical bills. This concern causes them to forego care, and not to make the best use of the benefits that they have. Given that employers pay such a large percentage of the medical costs of our beneficiaries (generally 80%), we are deeply concerned that surprise bills are undermining the value of these benefits.

Q: *My boss believes in free markets. Wouldn't Congress meddling in the health care market lead to "bigger government" and over-regulated markets?*

A: **No.** It's important to start by recognizing that health care is already one of the most highly regulated markets in existence, with a very large amount of government participation. The largest payer in the U.S. health care market is the federal government (Medicare – whose beneficiaries are protected from surprise bills!), and virtually all rates paid in health care markets are based on the government's version of a "living wage" for health care providers – Medicare rates. Most doctors accept Medicare patients, and virtually all hospitals accept payments from the government to offset costs for low-income and uninsured patients. So, accusations of "big government" hardly make sense when talking about a limited intervention to protect beneficiaries in the U.S. health care markets.

Perhaps more importantly, the U.S. health care system has existed largely in its current form since World War II. In the intervening **75 years**, the free market has not solved this problem. In fact, the problem of surprise medical bills is getting worse, with more patients reporting receiving these bills, and more providers adopting out-of-network strategies to maximize their revenues. Economists refer to a situation like this as a "market failure," and even the most ardent free-market economists acknowledge that sometimes markets do not function optimally, and lead to sub-optimal results. While some argue that market failures show the need for big government, conservative economists prefer the creation of guardrails and frameworks that allow the free market to continue to operate, but steer actors toward better outcomes. That is what employers are advocating for on surprise medical bills.

Q: *Didn't the ACA already regulate out-of-network emergency care services and costs?*

A: It is true that the authors of the ACA saw the problem of emergency services leading to financially devastating surprise medical bills, and sought to address the issue. However, the ACA falls short, because of a critical gap in the legislation.

The ACA specifically regulates the minimum amount that a plan must pay out-of-network emergency providers. It also specifically regulates the amount that a plan can charge a patient for their copay or coinsurance. So, what's the problem?

The ACA does not speak to, after the patient has paid their copay and the plan has paid their out-of-network amount, whether a provider may send a balance bill asking for more money – or how much money they can ask for. Providers who participate in Medicare are expressly forbidden from balance billing Medicare patients, and the tiny percentage of physicians who do not participate in Medicare are severely restricted in how much they can balance bill Medicare patients. But for some reason, the ACA did not provide these same protections to non-Medicare beneficiaries.

This is why Congress must address surprise billing by emergency care providers: because ACA limited two of the three avenues in which money changes hands in such a situation, which has led some providers to massively increase the amounts they demand via the third avenue – demanding money directly from insured patients.

Q: *Health care services are regulated on the state level, and some states have already passed laws to address surprise billing. Why does Congress need to act – can't states solve this themselves?*

A: States can regulate health care providers. They are also able to regulate fully-insured plans, state government plans, Medicaid plans (to a degree), and certain other types of insurance (for instance, a MEWA). However, a state cannot regulate self-insured plans, or plans governed by federal law under the Employee Retirement Income Security Act (ERISA). So how big a deal is this?

Of the more than 180 million Americans who receive insurance through their employer, about 100 million of them are in self-insured plans. That's about 1/3 of the U.S. population. So, from a state perspective, you already begin with about 1/3 of Americans that cannot be protected from surprise bills.

Next, many states have taken little to no action to protect those consumers they could help. An analysis by the Commonwealth Fund in January of 2019 found that only 9 states have enacted comprehensive protections for surprise medical bills. Some of these states have done great work, but even if they completely protected their residents, that would still leave more than 40 American states and territories unprotected.

Additionally, some of the actions taken by states have not been sufficient, or worse, have simply enshrined the irresponsible out-of-network strategies of providers that hold sway in a state capital. Some state laws force insurance companies to pay providers' "billed charges" – a fake price tag, invented by providers, for how much they would like to be paid. No insurers or plan sponsor acting of their own free will, or acting as a responsible fiduciary of the plan funds, would ever agree to pay billed charges. And as a result, all plan beneficiaries will suffer, because plans will have to raise health insurance premium costs, in order to account for the big new unreasonable bills they will have to pay.

In summary, some states have taken action. **But many states have taken no action, some state actions actually made things worse, and no state is able to help the 1/3 of Americans in ERISA plans**.

Therefore, it makes sense for Congress to act, and create uniform protections for Americans who otherwise could fall victim to destructive surprise medical bills.

Q: *What exactly have states done so far? Has the problem been solved in those states?*

A: Click here for the Commonwealth Fund's analysis (scroll down to the chart!) of the 9 states they consider to have taken a comprehensive approach, and the 16 states that they consider to have taken a limited approach. Note that many of these states have failed to protect enrollees either from surprise bills generated by emergency care, or from surprise bills generated by out-of-network providers at in-network hospitals.

Some states have created complicated binding arbitration regimes. Others have mandated that plans in some circumstances pay unsustainable rates to providers. Still others have failed to specify what happens when a (now banned) surprise bill would otherwise have been generated… leading to litigation and incineration of funds that would be better spent on patient care.

It is clear that some states have done the best job they could on addressing the problem. However, many have not acted, and some that have acted, have settled on incomplete, insufficient, or counter-productive solutions.

Q: *I've heard from providers that they have to charge very large amounts to some patients, because so many other patients are uninsured and cannot pay, or are on government programs like Medicaid and Medicare, and providers lose money treating them. Won't limiting these providers' surprise bills cause them dire financial harm?*

A: Providers often report that Medicaid rates, and to a lesser extent Medicare rates, do not adequately compensate them for the services they perform. In order to make up for these low reimbursements, as well as the small or nonexistent amounts some providers obtain from uninsured individuals, providers then demand higher rates from insured individuals. Health policy wonks refer to this as cost-shifting. Some well-respected economists do not buy this explanation of the higher costs charged to private payers.

The Medicare program has a series of formulas that are used to determine on an annual basis, how much Medicare will pay for various medical services. The AMA lays it out pretty clearly: these amounts are aimed at covering a provider's costs, including the work the provider does, the costs to the practice, malpractice insurance costs, and other factors. Few would argue that Medicare reimbursements will make a provider rich. However, Medicare payments are designed to ensure that providers can do their job and keep their doors open – such that treating Medicare patients will not send a provider to the poor house.

It's true that Medicaid rates tend to be lower than Medicare rates. So, some providers could lose money on Medicaid patients. And other providers (especially emergency care physicians and hospitals) treat lots of uninsured patients – they're required by federal law to stabilize those patients, whether or not they can pay. Certainly, this leads to losses. But the federal government offsets these costs, spending tens of billions of dollars per year paying providers for treating poor and uninsured Americans.

That's a long way of saying, the argument that providers have to charge disproportionately large amounts to insured patients in order to keep the lights on, is questionable at best, at least for most providers. But have you ever heard of any proposal to simply force providers to treat patients, and not

pay them any more? Of course not. Employers are proposing to pay new, market-based rates to providers, to more than offset any losses they might experience from a ban on surprise bills.

One more point – remember the statistics above, about the financial situation of many American families? What this means for providers is, they can send a massive surprise bill to a family. And it might well ruin the family's credit. But that doesn't mean the provider will ever actually get paid. In fact, the provider may well end up selling that debt to a debt collection agency, collecting only pennies on the dollar. Some providers, so weary of this, have begun investing in their own debt collection agencies.

Q: *Can't many surprise bills be avoided simply by consumers making better choices?*

A: Health insurance plans, and employer plan sponsors, go to great lengths to inform patients about health care costs and quality. They provide transparency tools, provider directories, hotlines, and other resources that beneficiaries can use to find and access in-network care. More can, and should, be done – and hospitals have a big role to play, which we will discuss under the transparency section. But even if patients have and use all this data, many surprise bills are simply unavoidable.

Most of the surprise bills we are focused on are produced by providers who have a captive audience. If you're in an ambulance on the way to the hospital, in serious need of care, it's not reasonable to expect that you pick up the phone, find and call the nearest appropriate hospital, and quiz them about the network status of their providers. Likewise, when a patient does the right thing and goes to an in-network facility, they often have no way of knowing which exact ancillary providers will be on duty, and whether those providers will, or will not, accept their insurance.

This is the fundamental problem that needs to be addressed: The system has developed in such a way that patients don't have access to all this data… and even if they did, often times there is nothing they could do about it. Most of the people reading this FAQ will be aware that the network status of a facility does not guarantee the network status of the providers who practice there. But is this a reasonable thing to expect your constituents to know? Is it reasonable to expect them to navigate a health system in which at best, they must roll the dice and hope the providers on duty at a given hour will accept their insurance, and at worst, they must accept that nearly entire medical professions have simply excluded themselves from the insurance system, to make more money?

Q: *How exactly do medical bills work? What is a patient responsible for?*

A: Medical billing is definitely complicated, and can vary drastically depending on the plan, the provider, and the situation. However, at its most basic level, there are three types of payments that generally stem when a medical service is provided:

- **The patient's responsibility**, usually a copay or coinsurance, set by their insurance plan;
- **The insurer's payment** to the provider. This generally is the amount the insurer has negotiated with an in-network provider, or an amount based on other payments in a given market for an out-of-network provider, minus the patient's responsibility.
- **The provider's balance bill**. Most of the time, an in-network provider agrees not to send a balance bill. But for an out-of-network provider, they will compare the amount they've been paid by the insurer and the patient, vs. the amount they want to be paid – and send the patient a balance bill for the difference.

So, what is the difference between a balance bill and a surprise bill? If a patient knowingly chooses and goes to an out-of-network provider, they generally know that their insurance will not cover all the costs. The "surprise" element comes in when the patient lacks knowledge, or choice, in seeing out-of-network providers. Whether surprise or not, a balance bill is not a binding contract; rather, it's the beginning of a negotiation. Many insurers and employer plan sponsors offer special services to help patients with these negotiations. However, many times these bills are very unfair – and that's where Congress should focus.

Q: *Many media stories about surprise medical bills talk about patients who "do the right thing" – they choose an in-network doctor and facility, call ahead to confirm, and try to stay within the bounds of care that their insurance will pay for. How are they still being seen by out-of-network providers?*

A: Imagine you pick up the phone and call the local hospital. "*Hello, I am an XYZ Insurance Company patient. I will be getting surgery on my leg 3 weeks from today, at 2pm. Can you please tell me whether the anesthesiologist, the assistant surgeon, all nurses and orderlies, or any other providers who might see me, will be covered in-network? And if something goes wrong and I need emergency care, will that be in network?*"

Chances are, you will not get a satisfying, or satisfactory, answer. Patients can do a lot to reduce costs by staying in-network, but the business practices of certain providers have become impossible for patients to navigate. The push to regulate surprise billing comes in part due to the difficulty for even the most proactive patients in avoiding encounters with out-of-network providers during the course of care.

Q: *How do surprise bills affect patients enrolled in large-group plans like those offered by major employers? Why can't Congress just mandate that the plans pay the surprise bills? Or just ban providers from sending balance bills?*

A: Here's the conundrum – if Congress forces insurers and plan sponsors to pay balance bills, providers now have an incentive to send even more of them, at even higher rates. This will cost the employers and insurers money, and they in turn will be forced to cut benefits or wages or raise patients' health insurance premiums to offset those additional costs. So, requiring the balance bills to be paid might eliminate the surprise bills, but at a serious cost – including higher health insurance costs for everyone.

Conversely, Congress could just ban balance bills, and require the providers to treat whatever amount they get from insurers as payment in full. Provider groups say that this would cause them to be severely underpaid and put them at a disadvantage in negotiating with insurers. They would react by refusing to treat patients in a given market, which would mean the patients would lack access to medical services.

Unfortunately, neither of these solutions is comprehensive enough – both would have significant negative externalities that could make things even worse than the status quo. That's why employers are asking Congress to consider solutions that create a fair backstop to ensure that providers are paid a reasonable (but not excessive) amount, in those cases when a network agreement cannot be reached. The goal is to eliminate as many balance bills as possible by getting all parties to the table and creating a new incentive to hammer out reasonable network agreements.

Q: *Some providers say that surprise medical bills are caused by insurance companies and plan sponsors, who won't pay providers enough, and who have networks that are too narrow. Is that true? Why do plans need these restrictive provider networks?*

A: The creation and maintenance of networks is one of the most important things an insurer does for patients. The insurer (or in the case of a large employer's plan, their third-party administrator) negotiates with providers, agreeing on payment amounts that are low enough to keep health insurance premiums affordable, and high enough that the provider will agree to see patients with that insurance, accept the payment, and not send a balance bill. Importantly, plans use networks to drive patients to higher quality providers.

Without these networks, the costs of insurance would drastically increase, and the protections afforded by the insurance would be jeopardized. Sometimes networks are narrow because it's hard to find providers willing to accept reasonable payment amounts. If the networks agreed to pay higher amounts, they might include more doctors – but at the cost of increasing health insurance premiums. Most employers and insurers would like to add more providers to their networks, but they need some of those providers to agree to more affordable rates that are in line with market and industry norms. And some doctors are just not interested – they make more money under the current scheme, and don't want to participate in a network. This is not a secret as provider group representatives have shared their strategy at congressional meetings and negotiating sessions.

Q: *What is a "joint venture," and how are they contributing to surprise medical billing?*

A: One of the trends that is contributing to higher health care costs, is growing consolidation of providers. Sometimes this means hospital systems are purchasing provider practices and other medical services in the area. Other times it means doctors are giving up their independent practices and going to work for medical companies or groups. And sometimes private equity or hedge funds purchase medical practices and redesign the businesses.

Traditionally, a hospital would be staffed by doctors who wish to perform services there. The hospital allows these doctors to work there, performs administrative services (such as scheduling), and the like. But what can a hospital do, when the doctors in the area are all working for a private company owned by investors? The hospital strikes an agreement with the company to staff the hospital – sometimes creating a "*joint venture.*" This is not inherently problematic – provider staffing firms can bring an economy of scale, streamline scheduling and reduce gaps in coverage, and leverage other efficiencies.

The problem arises when these joint ventures operate in a way that takes advantage of patients. One of the worst arrangements is when a hospital staffing firm seeks out hospitals with steady supplies of in-network hospital patients, and then the staffing firm refuses to accept in-network insurance. We know of a number of emergency department staffing firms that use this business model.

To make matters worse, some of these staffing firms will strike up deals with the hospitals they staff that seriously harm patients. It is widely reported that one of the biggest emergency department staffing firms has an ongoing relationship with a very large for-profit hospital chain. The hospital itself is in-network for many patients, while the staffing firm is out-of-network. But the staffing firm has agreed to share profits with the hospital – meaning that a patient who is in-network for the hospital, can receive a massive surprise bill from the emergency department within that very hospital… and then the hospital benefits from the surprise bill. Any reasonable outside observer can see that this presents a host of problematic, perverse incentives.

Q: *What can Congress do about these joint ventures?*

A: Congress has a host of options when it comes to ensuring that joint ventures cannot undermine networks, take advantage of patients, or incentivize bad behaviors that harm consumers. Here are some examples:

- **Outlaw profit-sharing agreements between hospitals and provider staffing firms, unless all parties are in-network**. Congress has already outlawed many kinds of inappropriate kickback schemes, self-dealing, and bribe-like incentive arrangements, specifically in the health care industry. The current effort to change incentives in the pharmaceutical and PBM industry, for example, is centered in antitrust law. Congress has the authority to put an end to these practices.

- **Ban kickbacks to a hospital from providers and firms operating in a hospital, or delivering patients to or from the hospital.** This solution would fix the incentive for hospitals. Under current law, hospitals can actually profit by engaging in this behavior. At least banning the hospitals from profiting from these arrangements would eliminate the bad incentives for one of the parties.

- **Regulatory reporting and oversight**. There are several agencies that are responsible for ensuring that consumers are protected from anticompetitive business practices, coercive monopolies, and other anti-consumer activity. Congress could require the reporting, approval, and oversight of this kind of health industry joint venture, and empower the Federal Trade Commission, the Consumer Financial Protection Bureau, or another appropriate government entity, with the responsibility to protect consumers as appropriate.

- **Require public reporting of revenue from joint venture arrangements**. Congress may feel that they do not have enough information to advance substantive policy solutions to the joint venture problem. One way to close this information gap would be to require hospitals, and the joint ventures and hospitals doing business with hospitals, to publicly report the amount of money changing hands. For instance, how much money did a given staffing firm make in year 2019 by running the emergency department in hospital X? How much of this money was then passed back to hospital X? What percentage of this money was collected from patients that the hospital considers in-network? This information could then be posted online for patients, researchers, and Congress to examine.

- **Require hospital disclosure.** If Congress won't stop this abusive behavior, they can at least ensure that patients are fully informed. Congress could stipulate that a hospital engaged in a joint venture must disclose this up front to patients, with a prominent disclosure statement on the front page of their website. Here's an example:

  "*This hospital has a profit-sharing agreement with an out-of-network emergency department staffing firm. Although the hospital accepts United, Blue Cross, and Aetna insurance, our emergency room does not.* ***Patients with this insurance who receive emergency care here should expect significant surprise medical bills.***"

Q: *Can transparency alone solve the surprise medical billing problem?*

A: Patients have a right to know whether they are likely to see out-of-network providers in the course of an episode of care. Employers support new transparency and accountability requirements to further this cause. However, **transparency alone will not solve the surprise medical billing problem**, because often times patients lack any meaningful choice. With that caveat, here are several transparency and accountability rules that Congress should consider:

- When possible, **match in-network patients with in-network providers**. Hospitals should have a responsibility to schedule patients to see providers in their networks, whenever possible. Doing so would not require Congress to delve into provider reimbursement but would eliminate some surprise bills before they happen.

- **Require hospitals to post, prominently, on their website information about the network status of practicing providers**. The most important information that is currently not obvious to consumers is that all (or a large percent) of providers in a given area of practice (such as anesthesiology) who practice at the facility, do not participate in major networks. This disclosure will not likely be helpful in emergency situations, but it could at least help patients who are planning care. Here's an example:

  "***Surprise Billing Alert****: Although this hospital participates in most insurance networks, the anesthesiologists and neonatologists who practice here largely do not. Patients who receive anesthesia or neonatology care here are likely to receive* ***significant surprise medical bills****."*

- **Require informed consent for referrals and handoffs**. When a provider or hospital recommends or transfers a patient to another provider, it should be the referring provider's responsibility to ensure that the patient knows if this new provider is in-network. This cannot simply be another in the large pile of forms a patient is required to fill out; rather, the patient must be fully informed and be able to demonstrate as much to a reasonable person.

Q: *Some provider groups say Congress should just hold the patient harmless, and the providers and insurers will work it out between themselves. Can this approach work?*

A: It is true that Congress could pass a law that simply says a patient does not have to pay surprise medical bills without addressing who (if anyone) does pay, and how much that payment would be. This would protect some patients, to a degree. However, it is likely to have significant negative externalities.

For one thing, providers are unlikely to simply accept whatever money is furnished, in the absence of a network agreement. They will likely either refuse to treat out-of-network patients, creating an access problem, or they will look elsewhere for payment. If the providers seek payment from insurers or employer plan sponsors, the plans are unlikely to agree to the providers' demands. What then?

Litigation will follow. When insurers refuse to pay, and providers feel they are owed payment, they will take the plans to court. Sometimes the providers will win these cases, and sometimes the plans will win. But the lawyers will win every time. Unnecessary medical litigation creates vast amounts of administrative waste, funneling money that would otherwise be spent on the provision of medical care, instead into paying court fees, attorneys, investigators, and other related expenses.

And neither plans nor providers will simply absorb the costs of this litigation. The result will be providers demanding ever-higher payments from plans and patients, while plans will have to increase health insurance premiums to offset litigation costs – both experienced and projected. This solution will appear

to solve the problem without taking on entrenched medical interests, but it will raise costs for patients and could potentially jeopardize their access to some kinds of medical care.

Q: *What about implementing binding arbitration – can this solve the problem?*

A: It is true that Congress could choose to implement binding arbitration, without determining exactly who is liable to pay exactly how much. However, the results would be similar to proposals that simply hold patients harmless. Costs could shoot up, waste would be created, and in the end some providers would continue their practice of maximizing profits by staying out of networks. The only difference is, we will pay mediators and the like, instead of lawyers and court fees.

Arbitration is a way of punting, kicking the can down the road without addressing the underlying problems and practices that have led to the surprise billing crisis. Employers might accept a binding arbitration regime, if that arbitration was imbued with strong guardrails that prevent insurers or plan sponsors from being forced to pay outrageous amounts, and don't incentivize doctors to stay out of networks. But if Congress does this, it will be fundamentally the same as setting a benchmark rate – just with an added layer of administrative waste on top.

Q: *Many employer, insurer, and consumer groups have asked Congress to set a "benchmark" backstop rate, to establish what a provider must be paid if the insurer and provider could not come to an agreement. But some provider groups claim this will lead to Medicare-for-All. Is this true?*

A: The single largest problem in health care is the cost of medical care and prescription drugs. Whether one is for or against a single-payer or a "Medicare-for-All" plan, the problem of health care costs still must be solved. Under the current system, many Americans who have robust private health insurance are still suffering – be that from increasingly higher deductibles, the vast costs of certain prescription drugs, or fear of surprise medical bills. Inaction or half-measures on this critical issue are likely to do more to increase support for single-payer than any purported solution opposed by the medical professionals profiting from the status quo.

Consumers are protected in an array of transactions by backstop rates and amounts, not in order to advance big government, but rather to incentivize fair and equitable commerce between parties. Employers are open to backstop rates based on market prices agreed to between insurers and providers, but rates based on Medicare (such as 125% of Medicare) would be cleaner, and simpler to administer.

Note that the vast majority of providers already participate in Medicare, meaning that they accept Medicare rates for some or many of their patients. They provide Medicare with all kinds of quality reporting and undertake practice decision (such as implementing health information technology) under the auspices of Medicare rules. And the rates paid to providers by private insurance carriers are based on a percentage of Medicare. In other words, Medicare rates and rules are pervasive throughout the system, and despite being around since 1965, Medicare hasn't taken over.

The idea that a benchmark backstop rate, to be used only when a network agreement cannot be reached, and when a surprise bill is generated, and when that bill cannot be negotiated down to a reasonable amount… that this would somehow lead to Medicare for All, is not a convincing argument. Many consider it a scare tactic designed to prevent conservatives from supporting a reasonable, proactive policy solution to surprise medical billing.

Q: *Some provider groups have accused Congress of picking winners and losers, upsetting the delicate balance that currently exists between providers, insurers, and patients. They say the health care system is so complicated, legislation is sure to have unintended consequences. Doesn't this suggest that Congress should stay out of it?*

A: To say that the current system is in a delicate balance is an interesting perspective. The surprise medical billing debate begins with the understanding that most patients are at an extreme disadvantage, lacking meaningful transparency of information, much less any choices among providers were they to have the information they would need. Insurance carriers are negotiating on these patients' behalf, sometimes in the individual or small group market, and sometimes representing large plan sponsors.

Recent media stories have chronicled how even the nation's largest plan sponsors, those with the absolute greatest amount of leverage, are at an extreme disadvantage, and cannot adequately negotiate with local, concentrated, monopolistic hospital systems. This does not represent a balance, and if ending surprise medical bills means increasing the leverage of patients and the plan sponsors negotiating on their behalf, while ensuring that providers will still be reimbursed adequately, then this is a trade-off Congress should be willing to consider.

Conclusion

Surprise medical billing is an area ripe for Congressional intervention. Congress can take targeted, limited action that will have a meaningful impact on patients. Bad choices (which might be easier, due to pressure from the medical industry) could lead to higher costs for patients, and enshrine the current provider behaviors that have led to many surprise medical bills. But adopting reasonable, fair solutions could lead to improvement in the lives of patients, put the reins on at least one aspect of out-of-control health care costs, and end a practice that is currently undermining the most important benefit that tens of millions of Americans say they want and need from their employers.