

BRIEF

Teasing Apart the Threads to the Surprise Billing Debate

Understanding Policy Choices through the Lens of Independent
Data

A FAIR Health Brief, March 2019



Executive Summary

With almost all stakeholders in agreement on protecting consumers from surprise or balance bills that exceed their in-network responsibility, this brief focuses on the current debate on how to determine the amounts that plans should pay to compensate providers. Based on our experience consulting with policy makers and stakeholders and on data from our repository of private healthcare claims, FAIR Health outlines the varying approaches under consideration by federal and state policy makers and includes data visualizations that help reveal the implications of those approaches.

One option often considered by legislators and regulators is to mandate a value for reimbursement based on a clear benchmark. Generally, four types of benchmark have been proposed: a percentile value based on the range of providers' charges (nondiscounted fees) for a service in the relevant market; a formulation based on allowed amounts, which are the in-network fees paid under a plan to a provider for a service; a "hybrid" blend of benchmarks for billed charges and allowed amounts; or Medicare fee schedule rates or a multiple thereof.

The principal alternative to a mandate is independent dispute resolution (IDR). IDR either may occur in the context of articulated guidelines for reimbursement, or it may have no specific guidepost for reimbursement.

The most efficient method for evaluating the implications of the various reimbursement models under consideration is reference to an independent, objective database. Such data provide several advantages, including access of all parties to the same information; protecting payors' proprietary information relating to in-network rates; avoidance of potential provider distrust of payors' reports of their rates and payors' distrust of providers' reports of their fees, and elimination of any need for audit/investigation of payors' and providers' practices.

Introduction

Surprise or balance billing has become a prominent issue in healthcare policy debate. Surprise billing occurs when consumers receive out-of-network emergency services or unexpectedly receive services from an out-of-network provider, either because the option of in-network care is not available or because the out-of-network provider delivers care in an in-network facility without the consumer's knowledge. Consumers are often billed by the out-of-network provider for the full amount or, if they are members of a plan that covers out-of-network care, for the balance of the bill that insurance does not cover. The amounts can be substantial, leaving consumers to face sizable healthcare costs for unintended out-of-network services.

In such cases, there is widespread consensus that consumers should be held harmless to their in-network responsibility and that surprise billing for unanticipated out-of-network services should be prohibited. Policy makers at every level of government and stakeholders throughout the healthcare sector generally agree that insured consumers¹ should be protected from surprise bills when they obtain necessary out-of-network emergency care and when they receive unanticipated out-of-network care.

But the method for determining appropriate payment by plans to providers for such care is intensely debated. For years the states have acted as legislative "laboratories" crafting solutions to the challenges of protecting consumers from surprise billing. Surprise billing legislation has passed already in several states—including New York and Connecticut, which have enacted laws that reference FAIR Health data. New York uses a FAIR Health benchmark as the standard for comparative reimbursement disclosures and a guideline for independent dispute resolution (IDR). Connecticut uses FAIR Health data as an

¹ Current surprise billing laws generally do not address individuals who are uninsured, receive healthcare through government programs such as Medicaid or affirmatively choose out-of-network services. New York law, however, permits uninsured individuals to contest their bills in the state's independent dispute resolution process.

official benchmark for provider payment rates for emergency services.² California generally requires that plans pay providers for nonemergency surprise bills at the greater of the average in-network rate or 125 percent of Medicare; requirements for payments with respect to out-of-network emergency services are less specific.³ However, most state proposals are still in various stages of the legislative process. Recently, a bipartisan group of US senators has proposed federal legislation to protect patients against surprise bills.

The implications of various approaches to surprise bills are both fascinating and complex. One option is to mandate a value for reimbursement based on a clear benchmark. Generally, four types of benchmark have been proposed, each with its own defenders:

- a percentile value based on the range of providers' charges (nondiscounted fees) for a service in the relevant market;⁴
- a formulation based on allowed amounts, which are the in-network fees paid under a plan to a provider for a service;⁵
- a "hybrid" blend of benchmarks for billed charges and allowed amounts; or
- Medicare fee schedule rates or a multiple thereof.

The principal alternative to a mandate is IDR. IDR either may occur in the context of articulated guidelines for reimbursement, or it may have no specific guideline for reimbursement.

In crafting and debating the various legislative proposals, legislators have sought to find ways to establish an appropriate compromise among the various stakeholders. One means of doing so is to use objective, third-party standard rates, such as FAIR Health benchmarks or Medicare rates, in establishing or evaluating reimbursements for surprise bills.

FAIR Health is a national, independent, nonprofit organization dedicated to bringing transparency to healthcare costs and health insurance information. As a tax-exempt public charity, we do not lobby nor do we take positions on the specifics of proposed policies. Our charitable mission, however, includes sharing information based on our resources and experience. Over the past four years, FAIR Health has been invited to meet with legislators, agency heads and governors' and commissioners' offices in more than 20 states as well as with federal executive branch officials and members of Congress—all seeking to protect consumers from surprise bills while treating fairly the economic interests of insurers and providers. Possessing the nation's largest repository of private healthcare claims, we have brought to these discussions our data resources and technical expertise and have acquired a deep understanding of the nuanced issues faced by legislators and stakeholders alike.

In this brief, we tease apart the threads to the surprise billing debate with the intent of increasing clarity about the implications of various legislative choices. To that end, we include data visualizations that use our independent data as a lens to illuminate those choices.

² With respect to nonemergency surprise bills, Connecticut consumers are held harmless to their in-network liability and, absent agreement between the parties, plans must pay providers the insured's in-network rate.

³ It should be noted, however, in a separate California law pertaining to emergency services generally, a ceiling on the amount that can be charged to certain low-income patients is set at a specific FAIR Health benchmark.

⁴ A charge is the amount billed by a provider as the standard price for a service, i.e., the full, nondiscounted fee. It is the amount usually billed for a service that is provided out of network or to an uninsured individual.

⁵ An allowed amount is the total in-network amount negotiated between an insurer/plan and a provider for a service. It includes both the amount paid by the insurer/plan and the amount paid by the member.

Present Laws

Currently, states addressing surprise bills have enacted a limited patchwork of laws.⁶ This brief focuses on legislation addressing how to determine pricing for out-of-network care provided to insured individuals in a surprise bill situation.⁷ Some require the out-of-network providers to deal with a patient's insurers but still allow the providers to balance bill the patient. Others limit patients' responsibility for surprise out-of-network bills to the amount they would be responsible to pay if the service had been in network. In these situations, the plan and the provider must resolve the payment issue on their own, while some states provide for IDR.

With the passage of the Affordable Care Act, federal law now requires plans to cover out-of-network emergency services rendered to members without additional cost sharing beyond what the patient would have paid for in-network emergency care. But federal law does not set a specific payment standard for such care, nor hold patients harmless against additional costs incurred for emergency services.

Standards for Provider Payments

Despite widespread agreement that consumers should be insulated from surprise billing, how to determine the amount that an out-of-network provider should be paid in such situations remains a difficult and complicated question. One solution is for states to mandate values for reimbursement. States may mandate specific values for different circumstances. Connecticut enacted a mandated specific rate for emergency services; New York, a guideline for both emergency and other surprise bills; and California, the "greater" of two prescribed options for nonemergency surprise bills.⁸

As noted in the introduction and detailed below, the four different standards generally considered for mandated values are providers' charges, allowed amounts, hybrids of charges and allowed amounts, and Medicare fee schedule rates or a multiple thereof.

The most efficient method for compiling and determining charges, allowed amounts and payments for healthcare services is collecting and analyzing healthcare claims data. Generally claims provide the full, accurate amount of charges and in-network rates. Policy makers have often sought to rely on objective, third-party standard rates, whether FAIR Health benchmarks or the rates of the Centers for Medicare & Medicaid Services (CMS). Such reliance has several advantages:

⁶ A 2019 report by the Commonwealth Fund stated that only nine states have comprehensive balance billing protections that (1) cover both emergency and other surprise bills, (2) apply to all types of insurance, (3) prohibit balance billing and hold consumers harmless for charges in excess of their in-network liability and (4) provide a payment standard or dispute resolution process for providers and insurers. Jack Hoadley, Kevin Lucia and Maanasa Kona, "State Efforts to Protect Consumers from Balance Billing," *To the Point* (blog), Commonwealth Fund, January 18, 2019, <https://doi.org/10.26099/G10E-A246>.

⁷ We do not address some of the other complexities of this type of legislation, such as whether or when services should be covered by surprise billing laws. For example, most current laws and proposals apply to emergency services, but may offer different definitions of what constitutes an emergency. Moreover, many existing laws addressing emergency care were enacted contemporaneously with the introduction of HMOs, and do not apply to PPOs or EPOs. To date, fewer than half the states have sought to address surprise bills in the context of PPOs and EPOs. While some current proposals cover only emergency bills, others include protections for patients who seek in-network care by choosing an in-network surgeon and hospital, but receive out-of-network care that could not be anticipated or was not available from in-network physicians. A few bills also would address situations where a patient has no available alternative to out-of-network care, such as patients in remote areas with only a single hospital. There are also policy questions as to whether IDR provisions in this type of legislation, or relevant regulations and official memoranda, should apply to both professional providers and facilities.

⁸ The regulations and/or official governing memoranda pertaining to the New York and Connecticut laws expressly reference FAIR Health benchmarks. For nonemergency surprise bills in Connecticut, consumers are held harmless to their in-network liability and, absent agreement between the parties, plans must pay providers the insured's in-network rate.

- All parties have access to the same information.
- It protects payors' proprietary information relating to in-network rates.
- It avoids potential provider distrust of payors' reports of their rates and potential payor distrust of providers' report of their fees.
- It eliminates any burdensome and expensive need for audit/investigation of payors' and providers' practices.

When policy makers have adopted a payment rule based on one of these standards, they often have prescribed a particular level of, or made adjustment to, the standard.

Providers' Charges

Traditionally, private healthcare insurance reimbursed plan members for fees by reference to the usual, customary and reasonable rate (UCR). The meaning of UCR, if defined at all, was determined by the plan at the insurer's discretion, or in some circumstances by law or regulation. Typically, UCR was described as the usual rate charged by similar providers for the same service in the same community. In some cases, for example in New Jersey auto liability regulations (PIP) and Pennsylvania workers' compensation regulations, databases have been referenced.

In a number of jurisdictions, the payment standards for provider services in a variety of programs are set according to charge benchmarks determined by FAIR Health on the basis of the recent, actual billed charges of providers in the particular geographic area where the service was rendered.⁹ The charge benchmarks are based on providers' nondiscounted billed fees for services, i.e., out-of-network rates. Because they are independent, based on 12 recent months of claims for actual charges in 493 local areas, they closely reflect the healthcare market economy in a particular area and time. In addition, because they are based on market information, the relationship among the percentile benchmarks for different procedures corresponds to the relationships in the specific market. By mirroring the market, the benchmarks reflect the differentials in fees and in-network rates for the different specialties. Accordingly, using percentile benchmarks facilitates flexibility in the level of a payment while still tying the overall system of payments to local market factors.

Depending on the program, a percentile benchmark may be the prescribed payment or one of several standards; different laws adopt different percentiles. For example, Connecticut prescribes payment for out-of-network emergency services at the highest of three values: (1) the in-network rate (allowed amount) under the member's plan; (2) UCR for out-of-network emergency services, with UCR officially set at the FAIR Health 80th percentile charge benchmark; or (3) the Medicare reimbursement for the service. In New York State, the statute codifies a term, "Usual and Customary Cost" (UCC), which it defines as the 80th percentile of a benchmarking database of a nonprofit organization unaffiliated with any insurer.¹⁰ Formal regulations define UCC to be tantamount to the 80th percentile of FAIR Health charge benchmarks. The UCC value does not constitute a mandate for payment to the provider but helps serve as a backdrop to reimbursement decisions. If the parties cannot agree on the amount of reimbursement and seek arbitration, the New York law requires that arbitrators resolving healthcare fee disputes between payors and providers consider UCC, among other factors, in reaching their decisions.

Many provider groups have urged adoption of a standard based on providers' billed charges for each specific service in a particular geographic area. Generally, they support the use of a specific charge benchmark from an independent data source that provides the range of benchmarks reflecting the distribution of charges for a service in an area. Some professional providers who would be affected by the rule have supported using an 80th percentile benchmark, i.e., the value at the point where 80 percent of

⁹ FAIR Health employs widely accepted statistical methodologies to help identify and exclude both high and low outliers, which are typically defined as the values in a distribution of data that are extreme and likely to be erroneous.

¹⁰ NY FIN Serv L §603(i).

the charges are equal to or lower than the particular value and 20 percent are higher. In a few states, some providers have proposed alternatives, including hybrid solutions averaging a charge percentile and an allowed amount percentile.

Allowed Amounts

An allowed amount or in-network standard, although generally a higher amount than a Medicare-based fee sought by some payors (discussed below), has attracted considerable attention.¹¹ Some payors have suggested using their own average or median¹² in-network rates as a standard while other stakeholders suggest that using an independent source of allowed information, such as imputed allowed benchmarks, would alleviate potential provider suspicion of payor-reported rates and forestall efforts to challenge or audit rates determined by the payors themselves.

FAIR Health creates benchmarks for insurers' allowed amounts in 493 specific geographic areas. FAIR Health provides percentile values from the 50th to the 95th percentile for imputed allowed amounts, which, similar to the charge benchmarks, are based on 12 recent months of validated claims data.¹³ The benchmarks for allowed amounts, although almost always lower than the charge benchmarks for the same services, nonetheless also reflect actual market dynamics; they indicate the range of payments negotiated between payors and providers in a specific area for specific services.

When providers contract with an insurer to participate in a network, the providers benefit from a listing in the payor directory and the opportunity to build practice volume based on the network's membership. In considering network compensation as a standard for payments to providers, it should be noted that for providers who cannot take advantage of that volume opportunity, such as certain hospital-affiliated specialists who tend to be "invisible to patients" and may be called upon by another treating professional, it may be appropriate to recognize the lack of a volume opportunity in determining the fee compensation. A draft bill offered for discussion by US Senators Cassidy and Bennet in 2018 appeared to reflect this consideration. It proposed a standard of 125 percent of the median (50th percentile) allowed benchmark value for the payment of out-of-network emergency and other surprise bills.

¹¹ Allowed amounts—the amounts negotiated between provider and plan—differ from "payments" or "paid amounts," which is what the plan ultimately pays for the service. Payments vary for reasons that make for a less satisfactory standard. First, most health plans require cost sharing by plan members—typically a deductible, the amount that a member must pay for covered services before the plan starts to pay; and a copay or coinsurance amount that the member must pay for a covered service. Once the deductible has been met, both the plan and the member pay their respective shares of the allowed amount. Accordingly, the amount paid by the plan may be nothing until the deductible has been met. In addition, most plans apply discounts to certain charges under policies that vary from plan to plan. For example, when a single treatment involves multiple services, the first service generally is paid at the full rate, while the additional services are paid at a discount.

¹² The median is the 50th percentile value in a distribution of values: the place in a range of values where half of the values are lower and half of the values are higher. It is distinct from the average or mean, the amount that results from the total (sum) of charges (or allowed amounts) for services designated by the same code divided by the number of services designated by that same code in the specified geographic area.

¹³ In order to protect contributors' proprietary interest in their in-network rates, all of FAIR Health's allowed benchmark values are imputed using a methodology that produces values with a high correlation to the range of actual allowed amounts. FAIR Health's charge benchmarks, however, are based directly on the actual charges for services in the specific area, provided there is a sufficient number of actual charges. Values for services with no, or an insufficient number of, actual charges are derived.

Hybrids

In some cases, a “blend” of averages of a percentile charge benchmark and a percentile allowed (in-network) benchmark has been proposed. An example would be the average of the 50th percentile of charges and the 50th percentile of allowed amounts for a service.

Medicare Rates

In some programs, the Medicare rate schedule has been adopted as the standard for payment, using either the actual Medicare payment amounts in a particular region or some multiple of the Medicare rate. Although Medicare rates, which are fixed by the federal government, are accessible and easily adjustable by some percentage, they can present serious challenges when being deployed in the general healthcare market.

As is widely known, Medicare was established to help pay for healthcare provided to the elderly, disabled and end-stage renal disease patients. Accordingly, Medicare is not designed to support the full range of medical services that necessarily include pregnancy, childbirth and pediatric care. Moreover, the Medicare fee schedule does not cover the full range of services as coded in the official CPT^{®14} codes that federal regulation requires be used in billing and record-keeping. Even if the official Medicare schedule is adopted, the gaps in that schedule must be filled by other means. (In some programs, laws and regulations have filled these gaps by mandating payments based on FAIR Health benchmarks.)

Another complication is that Medicare rates are adjusted and readjusted, often annually, to promote specific federal policy goals and budget limitations. For example, the Medicare fee schedule has been adjusted to encourage primary care rather than certain specialized services. In addition, Medicare fees are subject to a ceiling—i.e., the amount of funds allocated for the program—which is not related to the market. Indeed, in some cases, Medicare may pay less than cost. Accordingly, because of the special, nonmarket factors that affect Medicare rates, the use of Medicare rates as standards in the general healthcare market may require complex adjustments if different professionals are to be compensated fairly and providers’ expenses in some high-cost markets are to be covered.

Medicare rates are tied to local markets that in some cases are too broad to reflect the significant differences in healthcare economics within the Medicare region. To insure that local conditions are adequately factored into standards, a more granular data source, based on market rates in more numerous geographic areas, has been considered preferable in some discussions. As noted, some providers, particularly hospitals, have reported that Medicare rates do not cover their costs for the related services and that they rely on commercial insurance payments to make up the shortfall in revenue attributable to patients covered by Medicare and other government programs.

¹⁴ CPT © 2018 American Medical Association (AMA). All rights reserved.

Data Visualizations of Standards for Provider Payments

The following data visualizations are intended to illustrate the implications of the varying approaches under consideration by federal and state policy makers. In each of the following seven figures, seven values are presented for a specific CPT code in a specific state: the 80th percentile of charges, the median charges, the median allowed, 125 percent of the median allowed, the average of median charges and median allowed, the average of the 80th percentile of charges and median allowed, and the CMS rate. All but the CMS rate are benchmarks from the suite of FAIR Health benchmark modules, FH Benchmarks, which are based on private insurance claims data in the FAIR Health repository. The charge data are from the November 2018 FH Medical module and the allowed data from the February 2019 FH Allowed Medical module. The CMS rate is based on 2019 data from the Medicare Physician Fee Schedule.

Figures 1 to 4 present values for four codes in New York State. The codes are selected from service areas that are often contested in surprise billing disputes: emergency care, radiology and pathology. (CPT code 12011, simple repair of superficial wounds of face, ears, eyelids, nose, lips—2.5 cm or less, is often performed in emergency departments, though it can be performed elsewhere.)

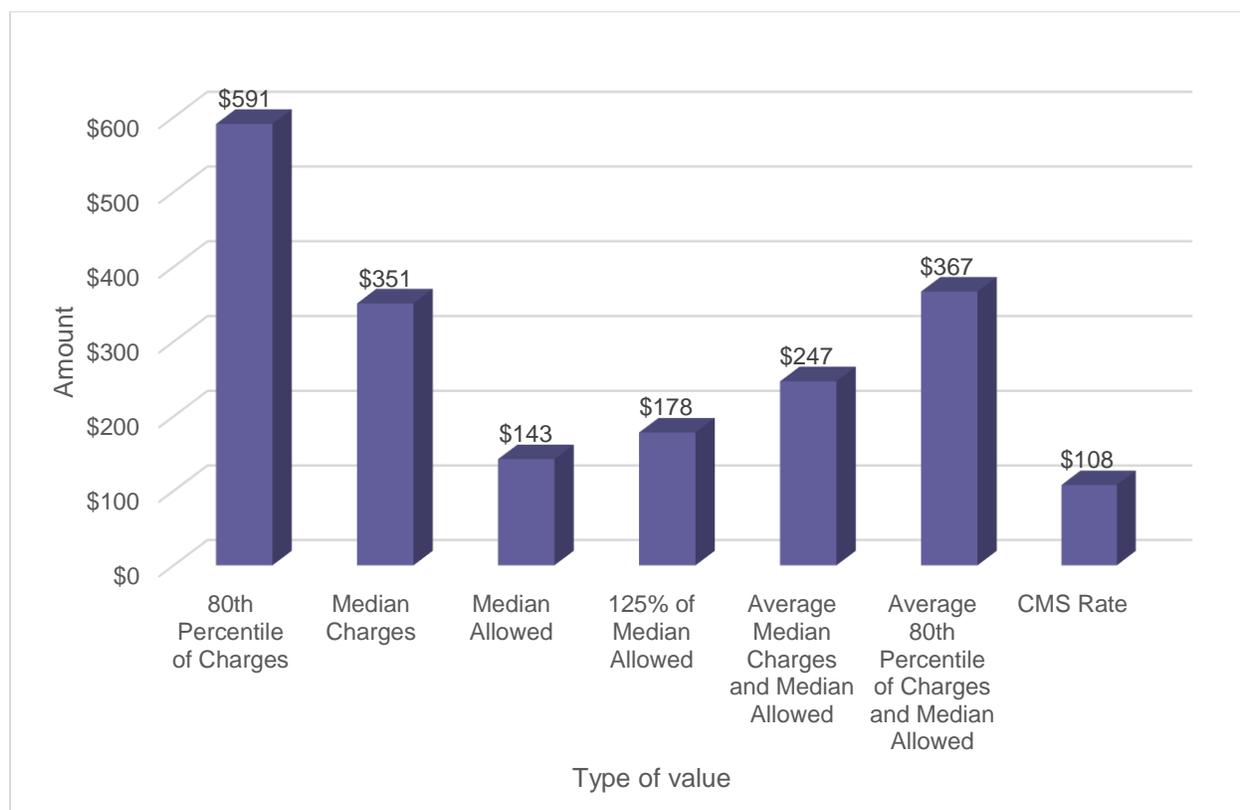


Figure 1. Varying types of value for CPT code 12011, simple repair of superficial wounds of face, ears, eyelids, nose, lips—2.5 cm or less, New York State, 2018-2019

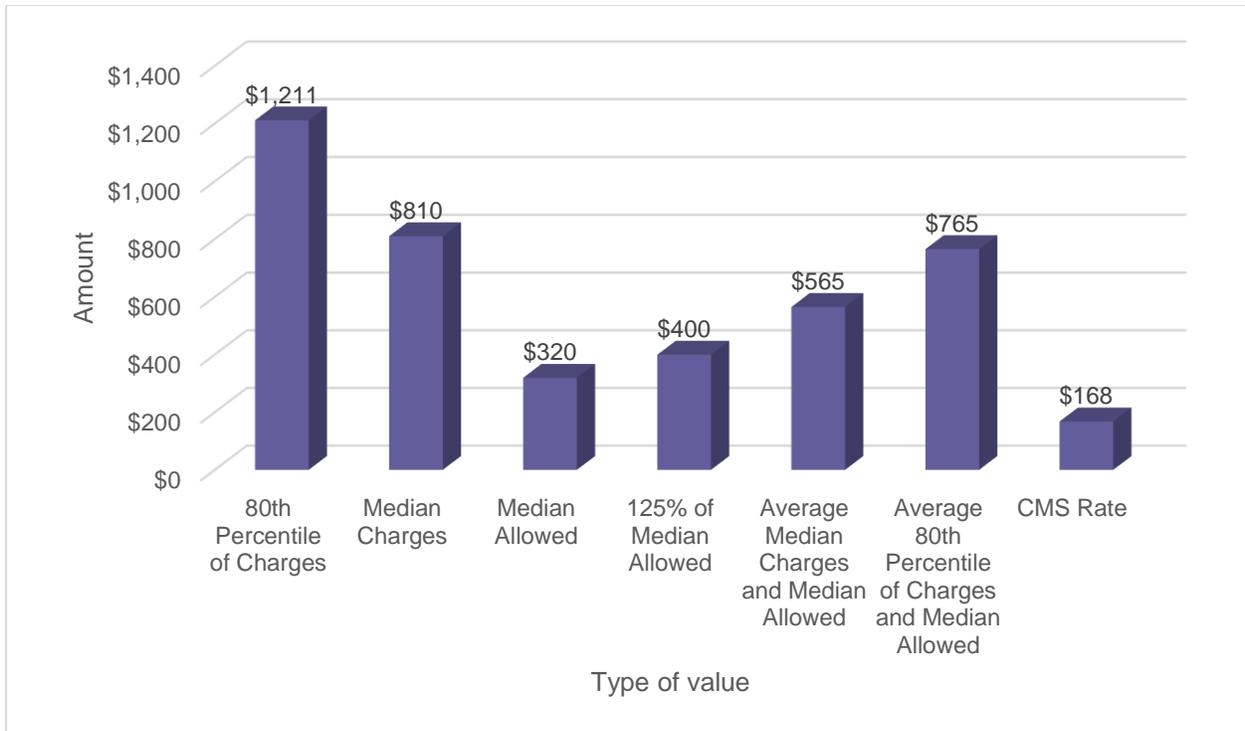


Figure 2. Varying types of value for CPT code 99285, emergency department visit with high severity and threatening function, New York State, 2018-2019

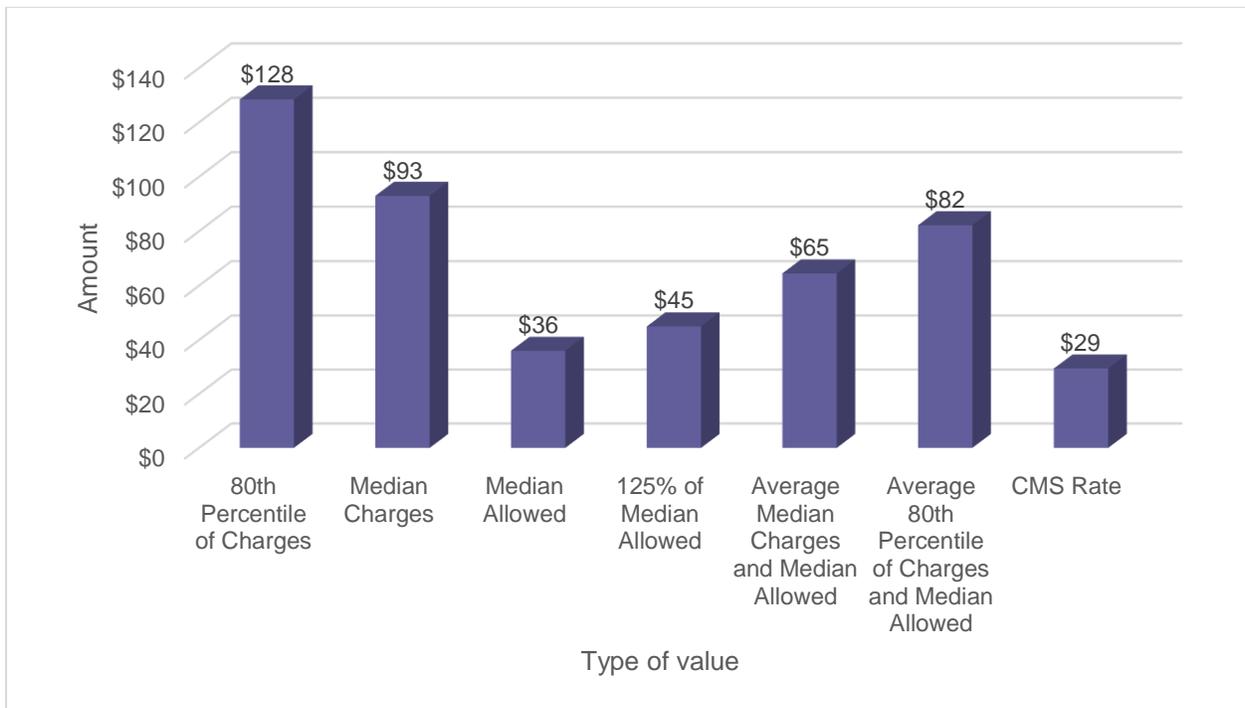


Figure 3. Varying types of value for CPT code 71046, radiologic exam chest—2 views, New York State, 2018-2019

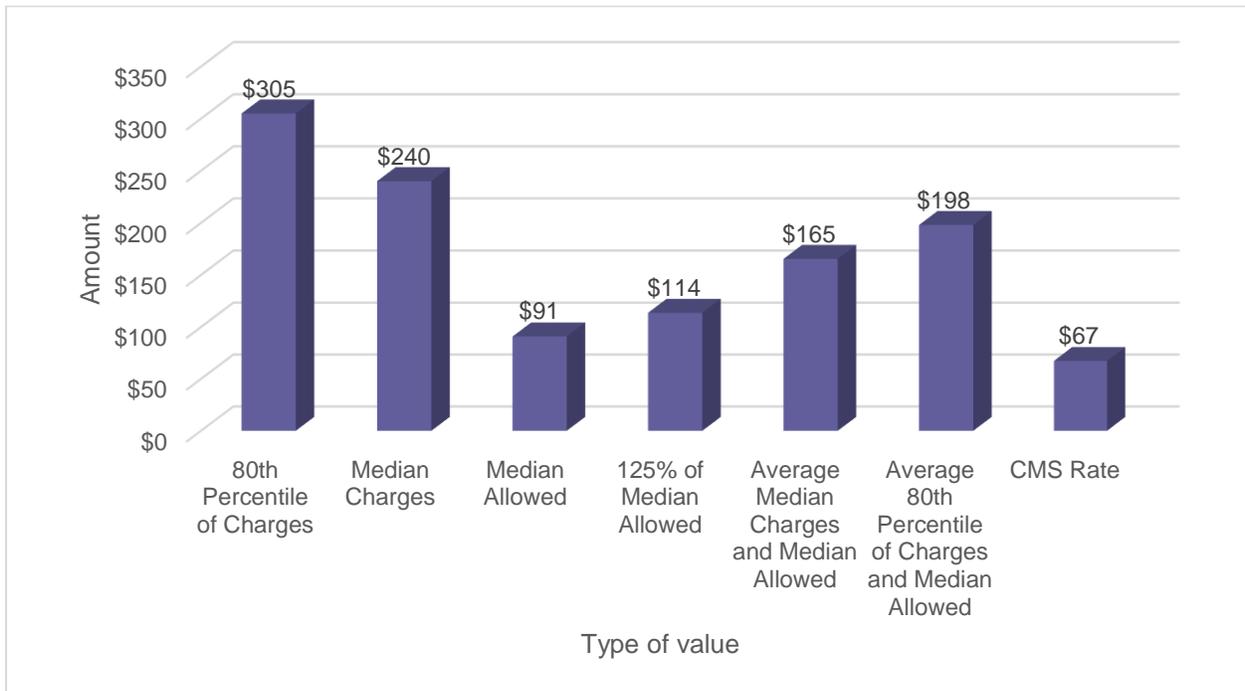


Figure 4. Varying types of value for CPT code 88305, level IV surgical pathology, gross and microscopic examination, New York State, 2018-2019

Figures 5 to 6 present a point of comparison of different states' values for a single code, CPT code 12011. Values for that code in New York State were shown above in figure 1; they are shown for New Mexico in figure 5 and for Nevada in figure 6.

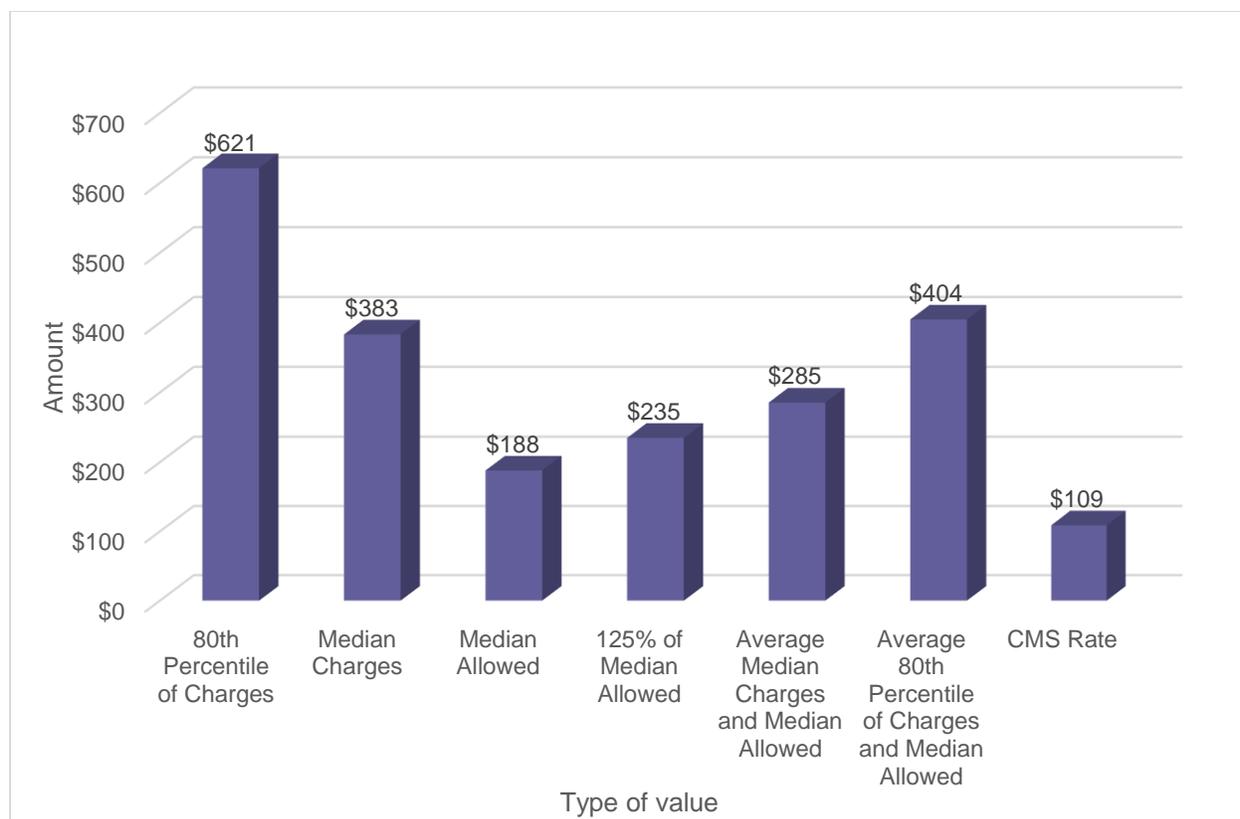


Figure 5. Varying types of value for CPT code 12011, simple repair of superficial wounds of face, ears, eyelids, nose, lips—2.5 cm or less, New Mexico, 2018-2019

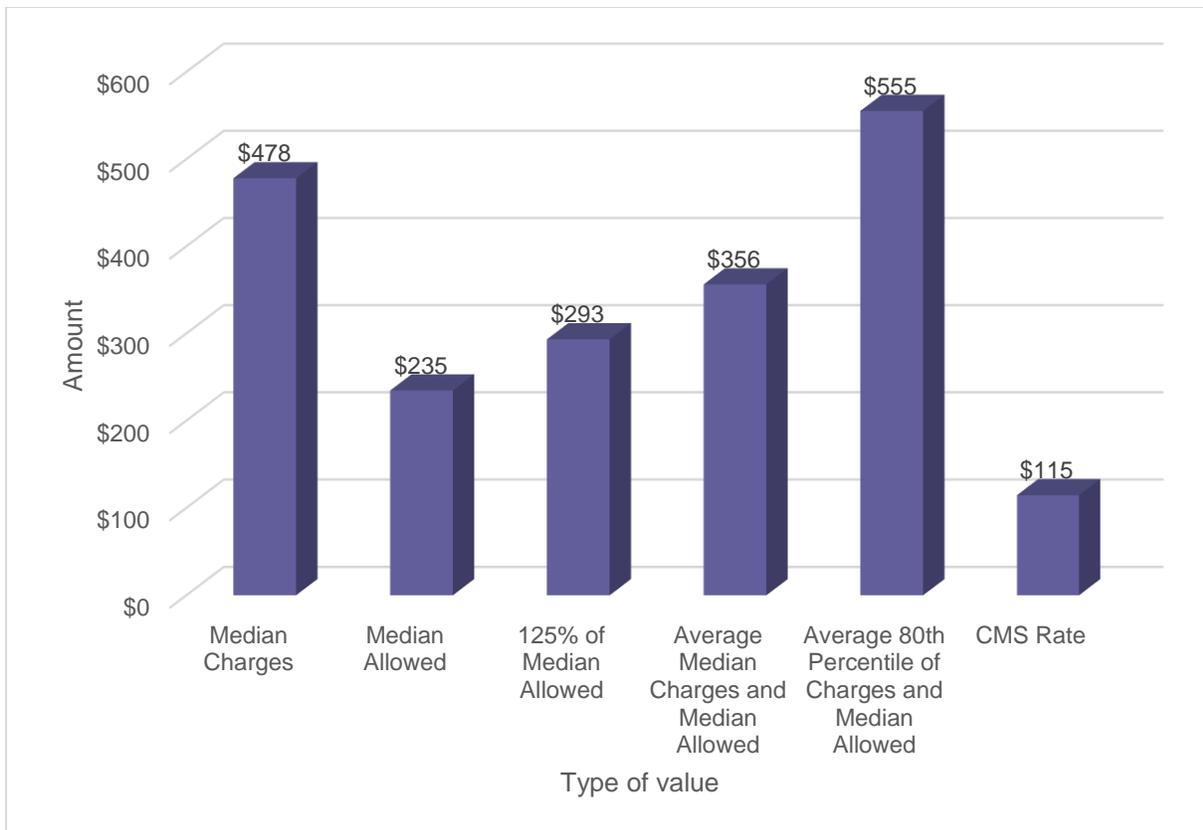


Figure 6. Varying types of value for CPT code 12011, simple repair of superficial wounds of face, ears, eyelids, nose, lips—2.5 cm or less, Nevada, 2018-2019

Within a state, charges and allowed amounts can vary greatly from one locality to another. FAIR Health benchmarks include geographically specific data for 493 geozips nationwide, which tend to track with the first three digits of a zip code. Each of the following figures shows the variation for a particular code in a particular state across four types of value: median charges, median allowed, 125 percent of median allowed and the CMS rate. The variation is shown for selected geozips in Florida (figure 7), Tennessee (figure 8) and California (figure 9).

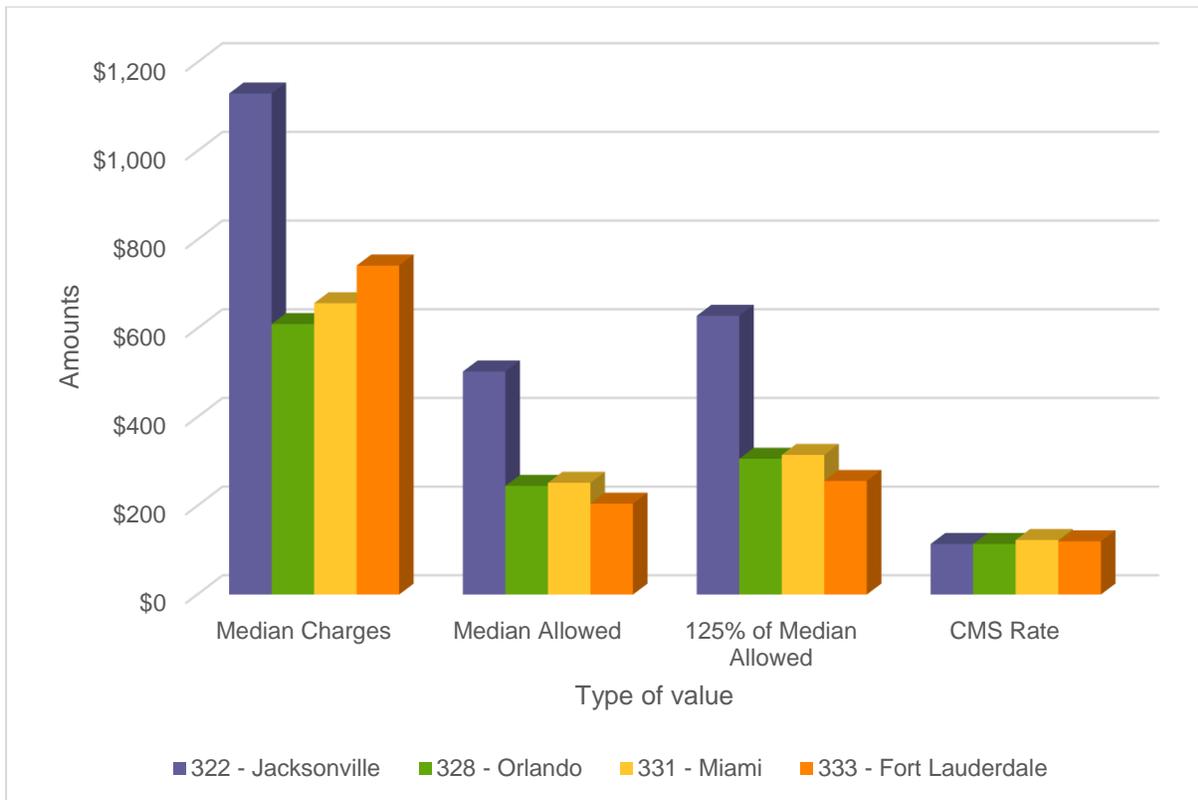


Figure 7. Varying types of value for CPT code 70450, computed tomography head/brain without contrast material, in selected geozips in Florida, 2018-2019

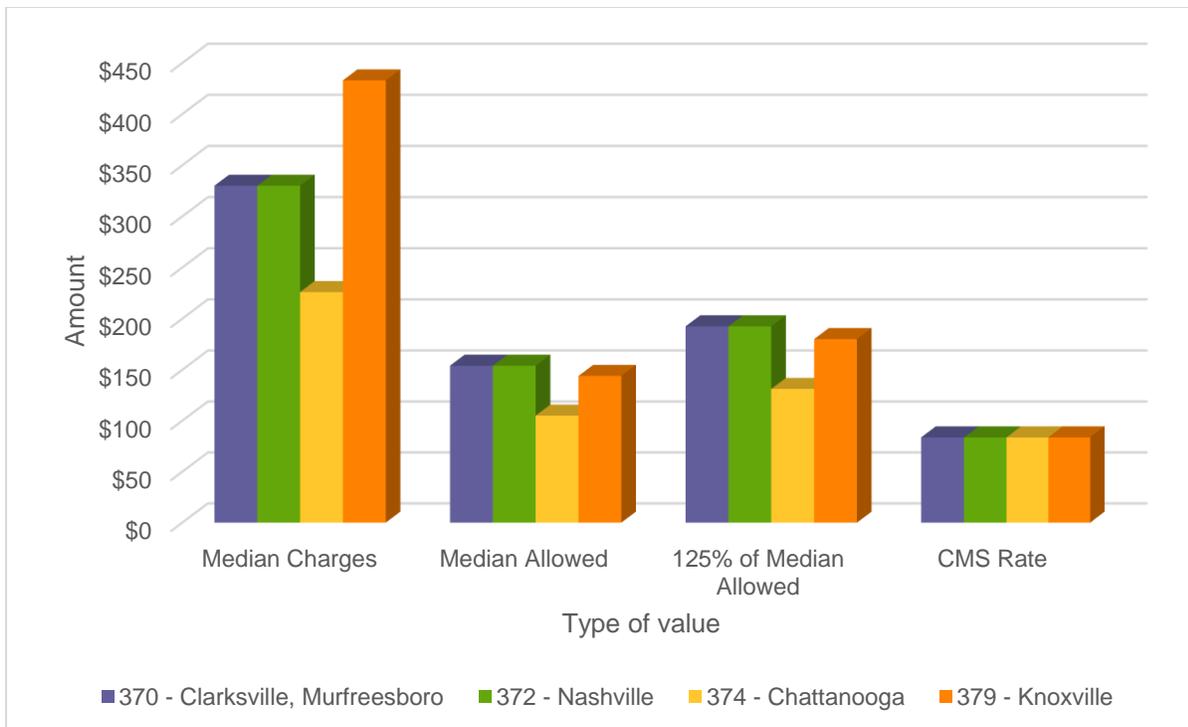


Figure 8. Varying types of value for CPT code 12001, simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet)—2.5 cm or less, in selected geozips in Tennessee, 2018-2019

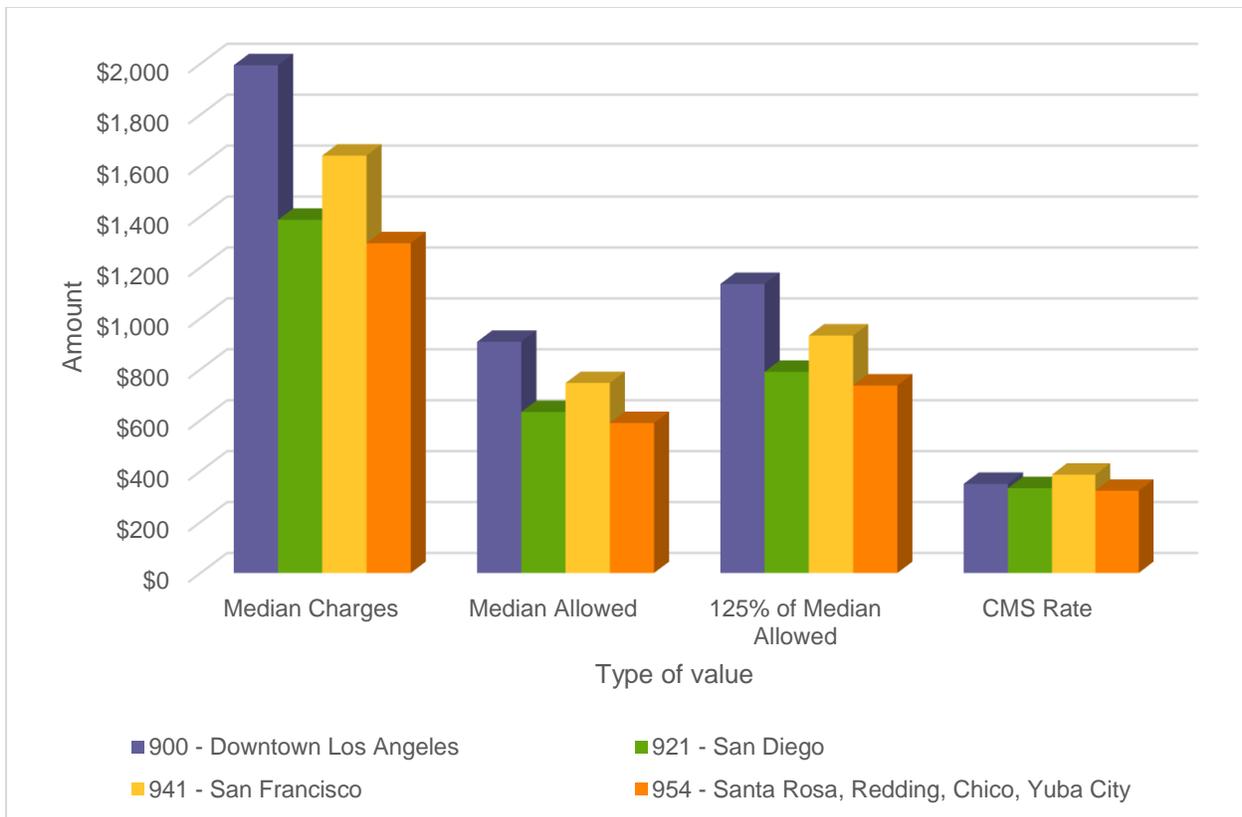


Figure 9. Varying types of value for CPT code 71275, computed tomography angiography chest with contrast/noncontrast, in selected geozips in California, 2018-2019

Addressing Concerns about the Potential for External Manipulation and Incomplete Data

In considering specific payment standards for out-of-network services in surprise billing situations, some officials and stakeholders alike have expressed concerns about prevention of external manipulation of values and ensuring that data are representative.

Indexing to Prevent Manipulation

One concern of some officials and stakeholders is that if a charge benchmark or an allowed benchmark is designated as a payment standard, providers and payors, respectively, might attempt to influence future values by increasing billed charges or altering approaches to network negotiations.

A review of charges since the adoption of a benchmark charge guideline in New York and a mandated charge benchmark in Connecticut reveals no unusual trends in billed charges. Figure 10 shows how a single value—the FAIR Health 80th percentile of charges for CPT code 99284, emergency department visit high/urgent severity—varied from 2015 to 2018 in three states, Colorado, Connecticut and New York. Although charges for the code increased in all three states, the overall percentage increase was greatest in Colorado, which had no surprise bill legislation; there the increase was 86 percent, from \$473 to \$880. In Connecticut and New York, which had surprise bill legislation, the increase was smaller. In Connecticut the increase was 14 percent, from \$832 to \$946; in New York 21 percent, from \$664 to \$806.

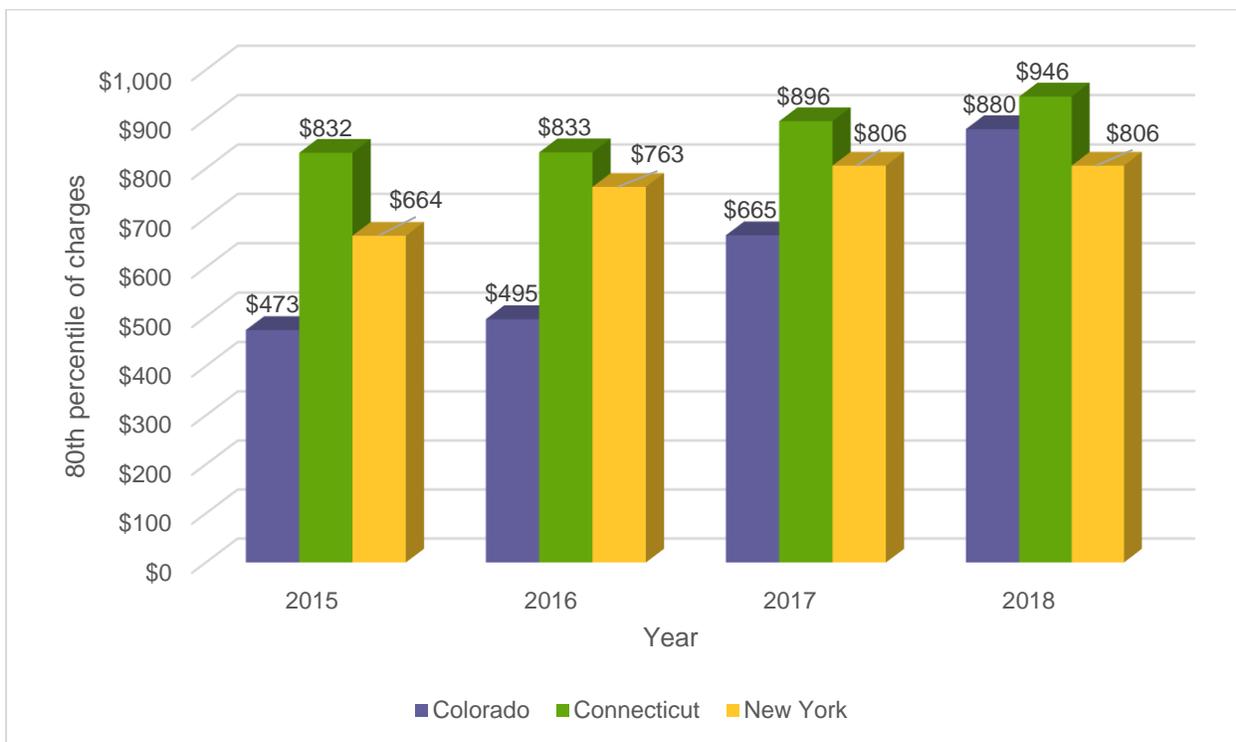


Figure 10. 80th percentile of charges in Colorado, Connecticut and New York for CPT code 99284, emergency department visit high/urgent severity, 2015-2018

Nevertheless, the fear of manipulation, even if unwarranted, can create a barrier to a solution. This perceived barrier, however, can be addressed legislatively. For example, a specific benchmark issued prior to enactment of legislation, whether charge or allowed, can be established as the standard for a year; in the following years, the benchmark values can be adjusted by a medical price index. After a reasonable period, say three to five years, the values can be reevaluated and updated. For example, a more recent base year benchmark can be adopted to recognize changes in treatment protocols, such as new medications or new technologies that have increased or decreased the cost of providing a service.

Representative Data

Some officials and stakeholders have expressed a preference for a standard based on underlying data that are representative of the population and plans in the particular regions. Several of the fewer than 20 states that have created or will create state All-Payer Claims Databases (APCDs) are considering using

APCD data to determine standards for their own surprise billing rules. Because APCDs are not permitted to mandate the contribution of claims data by self-insured ERISA plans, they are dependent on voluntary claims contributions from such plans. As a result, they may lack information about the economics of the self-funded plans that cover approximately 60 percent of the country's privately insured population. In addition, at this time, some APCDs lack the financial and technical capacity to generate a current average, median or other standard value of charges, in-network rate or other factors from their claims collection to serve as a requirement or guideline for payment of out-of-network services.

Alternative Approaches

In surprise billing debates, officials have considered several alternatives to mandated standards for out-of-network payment. Although the principal alternative is IDR, increasing price transparency and mandatory network participation have also been discussed.

Independent Dispute Resolution

If stakeholders cannot agree on a specific standard, they may find an IDR system, particularly one that involves consideration of relevant clinical and economic factors, a satisfactory alternative. Surprise bill consumer protection laws in several states leave the resolution of payment disputes between providers and payors to IDR, generally some type of binding arbitration or mediation.

Representatives of certain stakeholder groups, however, have expressed concerns about leaving the determination of payment for surprise bills to IDR, due to the cost and time involved. Some providers also note that IDR results in delays in payment. Some payors view the uncertainty of IDR decisions as hindering their business planning.

Moreover, a number of states with IDR have imposed no standards for the selection of arbitrators, and provide little guidance to arbitrators as to what is an appropriate payment. Thus, the arbitrator may receive little or no information about pricing for services. An arbitrator who lacks a background in healthcare costs and various billing regimes may be ill-equipped to render decisions.

An IDR system that requires arbitrators or mediators to consider factors relevant to the compensation appropriate for a particular service, including information about fee regimes, may result in decisions that are generally satisfactory to diverse interests. The New York State IDR system, for example, which includes consideration of a specific guideline, provides a model that has been operating since 2015.

Although the New York law requires the arbitrator to choose between the payor's and the provider's "final" bids, so-called baseball arbitration, the arbitrator first is required to take into account all relevant factors. The statutory list of considerations includes the severity of the problem, the condition of the patient, provider expertise, fees paid to the provider by other plans for the same out-of-network service and fees paid by the payor to other providers for the same out-of-network service.

Significantly, as noted earlier, the New York arbitrator must also consider the "Usual and Customary Cost" (UCC) for the service, determined by law and regulation to be the 80th percentile charge benchmark for the specific service and the geographic area where the service was rendered, as reported by FAIR Health. State officials have indicated that the required cost guideline has likely helped to promote direct resolution of disputes by the parties and to keep the number of actual IDR proceedings lower than originally expected.

The New York experience suggests that an IDR process that takes into account independent fee data, fee information provided by the parties and other relevant factors could help resolve disputes. The

independent information could be based on specific charges or allowed amounts, or could consist of a range of such rates.

Transparency

While most proposals to provide consumer protection from surprise bills include measures to increase price transparency for healthcare services, it is generally recognized that transparency alone cannot solve the problem. Healthcare emergencies do not provide time and opportunity to compare costs. And there are situations where in-network care may not be available at all.

Some proposals rely on requirements that patients receive advance notice of possible out-of-network care from a facility. While there are time periods attached to the advance notice requirements in some cases, in other cases, no time period is prescribed or the period is very short. If the time period is inadequate, the “transparency” probably serves little practical purpose.

Moreover, some proposals are silent about situations where there is transparency but no available alternative to out-of-network care. A lack of an alternative might occur in a remote area with only a single hospital or, in cases of networks, particularly narrow networks, or where an in-network facility might staff some services with only out-of-network staff, such as ER physicians. Because plan networks generally do not include all facilities and professionals in an area and facilities and professionals generally do not participate in every plan to which their patients belong, some network gaps are inevitable even in areas of high plan participation.

A large portion of out-of-network surprise bills is attributable to hospital-affiliated physicians who do not participate in plan networks. This group includes emergency and laboratory physicians, pathologists, radiologists and anesthesiologists, as well as “on-call” specialists, such as psychiatrists and plastic surgeons, who are less commonly required on an emergency basis.

Mandatory Network Participation

Another suggestion has been to require that all providers belong to networks. There are legal questions about the ability of legislators to force individuals and entities to enter contractual relationships. And, there also are significant practical aspects of the present healthcare system that conflict with this approach. Even if all providers belonged to one or more networks, it is unlikely that they could belong to all networks in a particular area. Furthermore, plans are unlikely to be willing to contract with every provider—in fact, the development of narrow networks suggests the opposite trend. Even if there were overlapping network coverage in a region, consumers traveling elsewhere may need healthcare that likely will be out of network.

Conclusion

There are various approaches to consider in determining the amounts that plans should pay to compensate providers in surprise billing situations. One is to mandate a value for reimbursement based on a clear benchmark, whether that is based on billed charges, allowed amounts, a hybrid of billed charges and allowed amounts, or Medicare fee schedule rates or a multiple thereof. An alternative to a mandate is IDR, either with or without articulated guidelines for reimbursement.

Designing the best solution for every jurisdiction requires a nuanced evaluation of different options and a realistic appreciation of the implications of different legislative paths. Toward that end, it is critically

important to use real-world data, reflecting actual healthcare economics in local markets, as a flashlight to shine in the corners of legislative discussions.

About FAIR Health

FAIR Health is a national, independent, nonprofit organization dedicated to bringing transparency to healthcare costs and health insurance information through data products, consumer resources and health systems research support. FAIR Health's activities involve the use of a variety of data sources, including nondiscounted fees for services reported by providers in private claim records, the allowed amounts that are the in-network fees that insurers negotiate with providers under network contracts, and Medicare fees, as well as Medicaid and workers compensation fee schedules in many jurisdictions.

FAIR Health's own database of over 27 billion privately billed medical and dental claims is the largest collection of private insurance healthcare claims in the country. The claims are contributed by both fully insured and self-insured employer (ERISA) plans. FAIR Health uses this database to power an award-winning, free consumer website and to create data products and custom analytics serving all healthcare stakeholders, including government officials, researchers, consumers, providers, insurers and other businesses.

FAIR Health's private claims data serve as the official data source for a variety of state health programs, including workers' compensation and personal injury protection (PIP) programs, as well as state consumer protection laws governing surprise out-of-network bills and emergency services. FAIR Health also has consulted with a number of jurisdictions as they consider revisions to Medicaid and workers' compensation fee schedules with a view to ensuring access to care for individuals insured under those programs. In addition, a number of federal agencies, including the Government Accountability Office (GAO), the Centers for Medicare & Medicaid Services (CMS), the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention (CDC) and the White House, have consulted FAIR Health. Currently, FAIR Health data are among the resources used by the Bureau of Labor Statistics (BLS) in developing its medical price index.

Separately, FAIR Health holds extensive Medicare data. FAIR Health has been certified by CMS as a Qualified Entity (QE), and thus now holds all claims under Parts A, B and D of traditional Medicare for all beneficiaries from 2013 to the present; FAIR Health houses data on Medicare Advantage enrollees in its private claims data repository.

As part of the requirements for QE status, FAIR Health demonstrated to CMS that FAIR Health's private claims data were representative of the populations in each of the 50 states and the District of Columbia.

FAIR Health, Inc.
530 Fifth Avenue, 18th Floor
New York, NY 10036
212-370-0704
fairhealth.org
fairhealthconsumer.org
fairhealthconsumidor.org

Copyright 2019, FAIR Health, Inc. All rights reserved.