Surprise Billing Myths vs. Facts:
Benchmark-based Payment vs. Arbitration

The Blue Cross Blue Shield Association (BCBSA) shares Congress' goal of protecting patients from crippling out-of-pocket costs stemming from "surprise" medical bills. These bills happen when patients receive care at an out-of-network (OON) emergency room or by an OON provider during a visit at an in-network facility and are balanced billed for the amount that exceeds their health plan's reimbursement level.

A payment methodology that is simple, transparent and fair to all parties is the most meaningful way to address surprise billing. Below is a fact check on the two payment methodologies under consideration: a benchmark-based payment and arbitration.

Myth: A benchmark-based approach would establish a precedent for government rate setting.

Fact: Establishing a payment benchmark replicates the market rate for each individual insurer and does not rely on a government benchmark. This approach, as proposed by Congress, would give authority to HHS to develop the calculation methodology to promote transparency, but would not give HHS the authority to determine specific payment amounts. Plans would still be responsible for using their own data to calculate rates specific to individual markets, specialties and lines of business. This is not rate setting or "Medicare for all."

Typically, surprise billing happens when patients access care in an emergency or from an OON provider in an in-network facility that the patient did not know they would need. In these non-elective situations, the patient has limited opportunity to choose his or her providers. Furthermore, due to factors such as market consolidation, these bills occur in situations where the market is not functioning effectively. It is important to correct market imbalances in these instances, and a payment benchmark would be the cleanest, least disruptive solution.

Myth: A benchmark-based approach would reduce payments below what providers and facilities need to stay in business.

Fact: In a 2017 study published in the Journal of the American Medical Association[1], researchers indicated median physician charges (i.e., billed amounts) were 2.5 times (or 250 percent) higher than

[1] Bai, Ge and Gerard F. Anderson. "Variation in the Ratio of Physician Charges to Medicare Payments by Specialty and Region." Journal of the American Medical Association. January 17, 2017. https://jamanetwork.com/journals/jama/fullarticle/2598253

what Medicare pays. The researchers further noted that physician charges were the highest for specialties where patients have the least ability to choose, notably the facility-based providers most commonly associated with surprise billing:

- *Anesthesiologists' median charge is 5.8 times (580 percent) what Medicare reimburses.*
- *Interventional radiologists' median charge is 4.5 times (450 percent) what Medicare reimburses.*
- *Emergency medicine physicians' median charge is 4.0 times (400 percent) what Medicare reimburses.*
- *Pathologists' median charge is 4.0 times (400 percent) what Medicare reimburses.*

Research shows providers would be able to operate under a median in-network amount approach. In fact, commercial health plans already pay well above Medicare for many of these providers:

- *Anesthesiologists are reimbursed a median amount of 344 percent of Medicare.*
- *Emergency physicians' average contracted rates are 306 percent of Medicare.*
- *Radiologists' average contracted rates are 200 percent of Medicare.*

An appropriate solution to address surprise billing, such as a payment benchmark, can help contain healthcare costs for individual patients, all consumers and taxpayers without impairing the facilities' and providers' ability to be compensated fairly or consumers' access to care.

While not all providers engage in surprise billing, the ones that do often take advantage of the lack of transparency for patients and demand even higher prices than those highlighted above (e.g., 14 to 33 times what Medicare reimburses). As such, relying on charge amounts as a basis for resolution or for arbitration could doubly impact consumers through higher out-of-pocket costs at point of service and higher premiums at the outset.

Myth: A payment benchmark would deter health plans from contracting with providers.

Fact: Creating a benchmark payment will not erode networks. This argument runs counter to a core business proposition for health plans – to develop networks in order to ensure our members have access to high-quality, cost-efficient clinicians and hospitals. Health plans develop different types of network solutions based on client needs, and these range from narrow to broad types of solutions. Health plans would need to continue to contract with these provider specialties regardless of how surprise billing is addressed. Most, if not all, states have extensive network adequacy laws that require insurers to maintain robust networks based on provider type and/or time and distance standards. Furthermore, a year after implementation of the California surprise billing law, which establishes a payment benchmark of the average in-network rate, at least one health plan has seen a 6 percent increase in the percent of providers it contracts with at acute care facilities.

Myth: Arbitration would not raise healthcare costs.

Fact: Arbitration, or independent dispute resolution (IDR), requires expensive new infrastructure. At least one judge who represents a District Court in Massachusetts has raised concerns on the cost of arbitration

generally, citing a $1,900 filing fee per case, a $750 care management fee and the arbiter's time. One Blue Cross and Blue Shield company estimated that the cost of an arbiter would likely be a minimum of $1,000/hr. This would be in addition to the legal costs incurred by both entities to prepare for, and be represented in, these cases. In many cases, these costs could quickly exceed the cost of the bill itself and will ultimately be passed on to consumers through higher premiums and to taxpayers through federal subsidies and other consumer support mechanisms.

It also does little to constrain costs. Regarding New York's surprise billing law, stakeholders (including issuers) raised concerns that the process may incentivize providers to increase their charges. For example, a pattern could develop where an arbiter considers a percent of charges (e.g., 80 percent) a reasonable concession on the part of providers. This could incent providers to raise their charges since they are not tied to market forces. When Major League Baseball (MLB) implemented a best-and-final offer arbitration approach to setting players' salaries, which has been the model for the IDR proposals to address surprise billing, the MLB saw players' salaries increase overtime as a result.

Finally, arbitration would be extremely costly and burdensome for many small and mid-sized businesses. Based on the way self-insured plans are structured, employers would often be the entity responsible for going to arbitration if a provider contests payment. This would mean that small companies could be forced to either accept provider pricing or hire external legal support, both of which could be extremely costly.

Myth: Arbitration will only be used to resolve a small number of cases.

Fact: State laws have been enacted too recently to assess the long-term impact of arbitration as a solution. We have already seen that the use of arbitration, and subsequently the burden, will increase over time. The volume of cases going through independent dispute resolution in New York has been increasing since implementation. In 2015, there were 207 emergency service surprise bills and 36 non-emergency surprise bills that went through the process. As of 2017, the use of the process had increased 450 percent (645 and 451 cases, respectively). In addition, when Texas established an arbitration system for surprise medical bills, the number of cases increased significantly - from 43 requests preceding the law to more than 600 a year later. Four years later, there was a backlog of more than 4,000 cases waiting for resolution, and this backlog is expected to be even larger this year.

Concerns around a possible backlog are exacerbated if the arbiters do not review cases in a timely fashion, similar to what is happening with the Medicare appeals process. For example, at the peak of the backlog in 2017, there were 650,000 cases pending, and significant federal resources were needed (more than $182 million) to make modest reductions in the volume of outstanding cases.

The increased use, and burden, would be further exacerbated if extended to employer-sponsored insurance through federal action as the number of claims eligible would expand considerably given the size of this patient population.