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EMERGING POLICY SOLUTIONS TO SURPRISE MEDICAL BILLS

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P R O C E E D I N G S

MR. GINSBURG: Good morning. I'm Paul Ginsburg and I want to welcome you to Brookings. Thank you for braving the weather to get there. (Laughter) I guess I have the wrong notes. I gather some of you were planning to come February 20 as well. I'm glad we could get together today and glad that so many of our panelists were able to make it today as well.

So my colleagues and I have been working on the issue of surprise billing since the beginning of the Schaeffer Initiative in early 2016. And it's been striking how much interest in this issue among policy makers has grown since then and how many states have enacted policies to address it. And this continues to accelerate.

A grant from the Laura and John Arnold Foundation made last year has enabled us to substantially expand our activities on surprise billing and has led to directly to this conference and the paper on policy options for states that was released in February around the original meeting dates. We're grateful for their support.

I think everyone who is dealing with the issue is focusing on the subset of services for which patients cannot choose a provider. And of course this undermines the potential for having a competitive market. So if the patients cannot choose, the only motivation for providers to be in-network is the challenge of collecting from patients instead of billing an insurer. The result is very high network rates and large balance bills for unlucky patients. And while this is a bad situation, especially for patients, a silver lining is that it's been conducive to bipartisan, or more actually, non-partisan efforts to find a solution both in states and more recently in congress.

The conference is going to begin with Loren Adler presenting the paper that was released in February and taking questions from the audience. Loren is Associate Director of the USC Brookings Schaeffer Initiative for Health Policy, and he did an outstanding job in leading the preparation of the paper and navigating the challenge of having six co-authors (laughter) all affiliated with the Schaeffer Initiative and all of whom

made substantive contributions.

After Loren takes questions from the audience we'll turn to Mark Hall, who is a Nonresident Senior Fellow at Brookings and the Fred D. and Elizabeth L. Turnage Professor Law at Wake Forest University and a co-author of the paper, to moderate a panel of policy makers who have been working on this issue, three at the state level and one at the federal level.

And, finally, after a break, I will moderate a panel of stakeholders that expect to be impacted by policies to address surprise billing and to try and influence the policy process.

Loren?

MR. ADLER: Hi, everyone. Thank you for the introduction, Paul. I think he covered the basics of what we did. And, obviously, thank you to all the co-authors on the paper as well. It would not have happened without everyone's work on this issue.

So today I'm basically going to kind of walk through really kind of why these surprise bills happen, what they are -- although Paul mostly touched on that already -- and then I'm going to kind of talk through what the different policy solutions look like and sort of where we come out in our paper for recommendations, and also thinking through what the impacts of different policies addressing surprise billing might be.

So just to take a first look -- Paul sort of touched on this -- we kind of define -- it's useful to kind of define what is a surprise out-of-network bill. This isn't any out-of-network bill you get, this isn't any surprise you get, we're really kind of focusing in on sort of three main types of examples. So one is -- this one gets written up a lot -- you have a heart attack, you get hit by a car, you call 911, the ambulance is dispatched and takes you to the hospital. It turns out the hospital you get taken to is out of your insurer's network and they can hit you with a large bill, or the ambulance that took you there is not in your insurer's network.

And then there's sort of the more common cases that get talked about here

where most people actually, even in emergency situations, are choosing in-network emergency departments, in-network hospitals, but then the emergency physicians who work there or the surgeons on call, whatever doctors might be on call in the emergency room, they are out network. So those doctors are negotiating independently with health plans from the hospital, so it is very possible, and it is not uncommon, that you have a hospital that is in-network but the emergency doctors, emergency medicine physicians who practice there are not in those same networks.

And then the last example here is that this can even happen with elective care. So I'm getting a hip replacement surgery, I call ahead to make sure the hospital is in-network, to make sure the surgeon who's going to be doing the operation is in-network, but I go get my surgery and it turns out after the fact that the anesthesiologist or the radiologist hits me with a surprise bill and they were out-of-network. And I had no plausible way -- and I think it's sort of impossible people actually choosing their anesthesiologist beforehand and honestly go ahead and try to do this. I've tried before. My wife gave birth and I tried to call the hospital and it took me eight calls to figure out -- and even then, I was like I gave -- I was given like a 90 percent sure answer. And so I think it's useful.

Mostly in this presentation I'll mostly reference sort of as the examples, emergency medicine physicians and anesthesiologists, just because that's really where the overwhelming sort of surprise balance bills are kind of coming from. But really this is also at least somewhat common among pathologist, radiologists, definitely ambulances, both ground and air. And also, less commonly, for kind of any other types of physicians who are working in the emergency department, and more occasionally for certain neonatologists. So right after a birth you need a neonatologist instantly who might not be in-network.

I know recently there's been some private equity activity buying up hospitals, physician groups, or sort of -- the doctor who my wife -- during your hospital stay the doctor who kind of works at the hospital who comes and checks up on you. More sort of a primary care type who you typically don't choose as well. So that hasn't been a problem

much to date, but I am somewhat nervous that that will become a problem in the future.

We've read a lot about anecdotes of these and there are a lot of great stories in Kaiser Health News and Vox on sort of individual examples. But it's worth looking at. This is actually a pretty somewhat common, if common, phenomenon. This isn't really just a few one-off anecdotes from (inaudible) and the few research studies that have been put out there. Looks like about one in five emergency department visits result in the potential for a surprise out-of-network bill, and that means you went to an in-network hospital but one of the doctors who treated you is out-of-network. And even in the one in ten times that you do that elective procedure or you prescheduled everything, there are one in ten times you are seen by an out-of-network anesthesiologist, radiologist, et cetera.

And then the ambulance case is kind of an interesting one. So about 50 percent of ambulance rides in the one study that's looked at this, with a pretty large insurance data set, found that about half of ambulance rides were out-of-network. And a GAO report, I think yesterday or the day before, found that 69 percent of air ambulance rides were out-of-network. And referring ambulances, it's just really hard to fathom how there could plausibly be a market for these pretty rare events that are pretty much mostly emergencies.

So I think the first thing I kind of want to do is take a step back and which I kind of -- it gets lost in some of the discussions here, is why does this happen. What is going on that allows surprise bills. Why does this happen here and not in any other industry. And so really there is a market failure going on here in my opinion.

For your typical physician, your cardiologist, neurologist, whoever it might be, they go to an insurance company and the insurance company says look, I'll steer my enrollees your way if you give me a price concession. That's sort of the standard price volume trade off that exists throughout the economy, not just in healthcare. And that works. You know, your cardiologist can't practice without being in insurers' networks. If they don't sign up with health plans they see zero patients and they make zero dollars.

But we just flip around. When we talk about anesthesiologists or emergency doctors, that's simply not the case. So there's no real price volume trade off here because the health plans aren't the driver of volume for them. Any anesthesiologist, if they don't contract with a health plan, they still see roughly the same number of patients, because patients are choosing the hospital and not the emergency or ancillary clinicians. And as a result of that, they have this potentially lucrative out-of-network billing option of these sort of captive patients that no other provider type has. And as a result, this is why, as Paul kind of hinted at, we see very high in-network rates for these physicians as well, and also very high bill charges, which I'll kind of get to in a minute.

And they still might go in-network; it's still sort of a pain colleting from patients. Most doctors don't like surprise billing patients and going after them, so that's why you still see some, but that's really the only thing stopping surprise billing. And, in my opinion, that's why you've seen sort of bigger companies come in here and who maybe are more efficient at collecting from patients and might have less qualms about collecting from patients also. And they can then more efficiently sort of drive up rates.

I think it's also worth talking about here, the hospital actually plays a very big role in these negotiations. That's really where the actual market is here. The real market here is between the hospital and the anesthesiologist rather than the health plan and the anesthesiologist. So it's the hospital who drives volume to the anesthesiologist. They pick the hospital, they get a surgery, and then because they're at that hospital they see that anesthesiologist. And the hospitals obviously need anesthesiologists also. You can't be giving surgeries without having anesthesia. So there's just a very natural market where there's a price volume trade off there. And there's already a lot of money flowing between the hospitals and these types of doctors, there's contracts right here as well. Hospitals are typically trying to pressure these physician types to join the same networks that they're in. It doesn't always work. Almost every hospital I've talked to at least says that they are trying to sort of pressure these docs. And the reason they do this is because they suffer -- hospitals -

- all is equal, doesn't like surprise billing happening at their hospital either. That looks bad for them.

There was a study recently that basically said women who give birth at a hospital and get a surprise bill are much more likely to choose a different hospital the next time around. So there's at least some impact on the hospital and that's why when you see sort of the emergency doctor balance billing, surprise billing patients at a hospital, typically they are sort of compensating the hospital to allow that to happen. So the typical case that I've seen written up a lot of times and that I've heard just a lot of times is a sort of staffing company or like Envision, the poster boy for this, will basically go to the hospital and say look, I know you're currently paying a $300,000 subsidy to your emergency doctor to kind of get them to practice here, look, you don't have to pay me anything, but just don't tell me how to bill patients and I'm going to go surprise bill them. And they're sort of -- so there's already a little bit of money changing hands to kind of allow this today.

So that's sort of the theory behind why this has been a problem and why you expect this to happen. I think it's worth now kind of returning to the data to see why that does happen. So given that they do have this lucrative out-of-network billing option, it's no surprise that these types of specialists really lean into that leverage and bill really high amounts. So this table here, you see that the exact types of physicians that we're talking about, your anesthesiologists, emergency doctors, radiologist, are billing -- anesthesiologists are billing 5 1/2 times the Medicare rate on average, the 80th percentile. So that means only 20 percent of anesthesiologists bill above that amount and 80 percent of anesthesiologists bill less than that. So that means that 20 percent of anesthesiologists have billed charges at 11 times Medicare or higher. That is a very -- it's a pretty jarring amount. And you can see right down below, you know, take every other specialist, they're almost all in the sort of 2-2 1/2 times Medicare rate. And you can look through the entire list of specialists, there's no one up at these levels other than these specific types of doctors.

This may be hard to read from where you're sitting, but this is just to put a

little bit of numbers to this and kind of look at how big these balance bills can actually be, especially when you're talking about emergency medicine and anesthesiology. These bills can often be in the thousand-dollar range or more. In the emergency setting you're often also getting seen by not just an out-of-network emergency doctor, but an out-of-network surgeon who might be billing you $10,000. So that's the cases where you're getting like the really large bills. But even the anesthesiologist, the 80 percentile charges here, that's $1,300 rather than the maybe $300 that the insurer would pay. That leaves a pretty large amount of money that you're trying to outlay. And these are just sort of chosen to be the most common procedures for these plan types.

The other thing here is this isn't just a -- this gets kind of lost I think sometimes in the discussion is this isn't just a problem for the people who get the surprise bills themselves. Obviously it sucks to get the surprise bills, but because of this leverage to surprise bill patients, we see that these physician types get paid more money when they do g in-network. And as a result of that, that means that the insurance companies are paying more and we are all paying higher premiums as a result. You see anesthesiologists getting paid 350 percent of Medicare on average, emergency doctors are up around there too. And so when you look across other types of specialists, they're much more in the -- pretty much every other specialist is somewhere in sort of the 125 percent of Medicare to 150 percent of Medicare range. So these are just very large outliers.

And the natural sort of contradiction to this is Medicare rates are not perfect, and I'm not trying to say that the Medicare rate for each of these specialties is dead right, but they have budgetary constraints, et cetera. But they are a best estimate of costs of delivering these services. They're not really trying to say that the Medicare rate got it exactly right, but it's just too coincidental that we see crazy high rates for these exact types of specialists and charges for these exact specialists that you would expect that an economic theory would predict and literally no one else. I think that coincidence is too grand. So maybe the market rate for anesthesiologists isn't 130 percent of Medicare like other

specialists, but I'm pretty darn sure it's not 350 percent of Medicare.

So now I think I've established this as a problem -- or I hope so. The next question is how do we solve it. I think I'm going to walk through a few options here, but I first sort of wanted to touch on just sort of the overview of what we kind of see as some of the keys to addressing this issue.

First, I think it's important to take patients out of the middle when these happen. I think it's unrealistic to expect patients to be selecting their anesthesiologist or their emergency doctor. I think that's too unrealistic. So I think when you're talking about a solution you kind of want to take them out of it and leave it between insurer, hospital, and provider. I also think it's important to be comprehensive. So a number of states, especially older laws on this issue, really only address the situation for emergency services. I think it's important -- this is clearly a problem not just in the emergency setting -- to be broader than that. Similarly, some older state laws only address this in HMO plans, so a narrow network type plans. The data that I've seen, it seems the prevalence is pretty similar across PPOs and sort of broader network plans as well. There's really no reason to kind of narrow this in to just HMOs.

And then something I'm going to harp on a bit is that the even states do have a lot of authority to protect folks in self-insurance plans as well, so I just sort of find myself insured as. So most large employers basically handle the risk of their health costs themselves. I mean they self-insure, so they're kind of on the hook for the health cost of their employees even though they're using an insurer to kind of administer the benefit. But that's about half of the commercially insured lives in this country. And the law known as ERISA prevents states from telling those plans what they can pay, or telling them sort of to regulate those plans themselves. But you can still regulate providers. And I think the solutions we're focusing on allow you to kind of focus some of the regulations on providers to basically provide that protection to everyone in your state rather than just half of your state.

And then I think this last one is -- the other thing I will harp on a lot is please, just please avoid policies that increase health spending. I think we want to avoid solving one problem while just creating another.

So I think I want to start with -- we have two broad swaths of solutions here. The first one that I'm going to talk about here is what we term "billing regulation". This is what every state who had addressed this issue to date has done some form of. The typical way this happens is it's basically -- most states this is a three-part thing where you basically prohibit the provider from balance billing in the surprise cases. You tell the insurer to treat the service as in-network, and then you set some sort of minimum payment standard that the insurer sort of has to pay to the provider. What we're kind of talking about here is it's equivalent if the federal government was doing this, this is exactly the same thing, but just flipping that slightly where you put a cap on the physician's charges, so that out-of-network charge rate. If you put a cap on that at a reasonable rate, that largely solves the problem for everyone in your state, because even for folks in self-insured plans if the anesthesiologist can only bill 200 percent of Medicare, the insurer all of the sudden now actually has an incentive to take care of that. There is some harm to insurers when they're enrollees get surprised bill. It's just sometimes it's not worth it for them to pay 10 or 12 times Medicare rates to get that way, but if it was 2 times Medicare, I'm confident you would see insurers juts sort of treat this and the problem would pretty much go away for everyone in your state. And that avoids the ERISA preemption issue. You'd combine this still with requiring your fully insured plans to treat the service as in-network, so you kind of do close the loop entirely for the plans that you can address. And at the federal level, obviously, you can do that for all plans and it sort of doesn't really matter which one of these you do.

So I think the next question is how do you set this limit or how do you set this payment standard. That's kind of the fundamental question here. And in particular I like to kind of frame this as sort a question of too high versus too low when you're setting this. So if you set a high payment standard, if you set a rate above what doctors are currently

getting paid as sort of the out network payments standard, you know, ever doctor can basically just go out-of-network and get that rate. And you'll see rates climb up to that level, premiums go up, costs go up, et cetera. That one is a pretty straightforward mechanical thing if you set a very high payment standard.

The flip side, however, is not equivalent. So if you set a payment standard that is too low in some sense, or that is actually below whatever kind of their normal market rate is -- which I think is probably a good amount below what they're getting paid today -- if you set a payment standard that's sort of on the low end, there's a natural market here between the hospital and the physician, so in that case the hospital still needs the anesthesiologist to practice. So if you set a payment standard at 100 percent to Medicare, the hospital goes, okay, they go to the insurance company and say, okay, look, we need our anesthesiologists to actually practice so here, insurance company, as sort of part of the negotiation with us just offer our anesthesiologists 150 percent to Medicare, that's probably closer to the market rate and then that will be part of our kind of agreement. Or the alternative is the insurer refuses to do that and the hospitals just sort of pay the anesthesiologists directly something like 50 percent of Medicare and sort of top the off effectively. And then they build those costs into their negotiations with the insurance company.

And I know this sort of sounds unusual, but this really happens today on a smaller scale. It is very common right now for a hospital that has a high share of Medicare or Medicaid patients, for instance, to basically because -- an anesthesiologist who works at a hospital that has a lot of Medicare patients is effectively getting paid less money by plans, because Medicare is paying a third of private payers. And in those cases we see hospitals paying those anesthesiologists extra money to practice at their hospital rather than the one that has mostly privately insured patients. That's really the same dynamic on a smaller scale, but I have no fears that this would happen in practice.

Getting into more of the specifics of kind of the actual benchmarks that

people tend to choose, our huge caution is please do not base anything on physician bill charges. This is a completely made up rate that has no basis and is completely untethered to the market. It is sort of the provider's wish price. It's not a list price, the MSRP on your car, it's something that no one actually pays. I mean uninsured patients are liable for it and surprise bill patients are liable for it, but there's basically no control on it, and these tend to be -- I mean we looked at those slide earlier -- these tend to be 10 times Medicare, 5 times Medicare, and at least double contracted rates when we're talking about these. They're just very high numbers.

I also think ideally we'd avoid basing this on current contracted rates also because they are already way too high. So if you base something on current contracted rates, you are basically baking in the high costs that we're already paying for these services and sort of rewarding the types of specialists that have sort of been benefitting from the market failure status quo. So ideally you would set something lower, and we'll kind of get into recommendations in a slide or two.

I just wanted to touch on, I think some of my authors more than me are somewhat uneasy about using the sort of -- the other approach to setting a rate it to sort of kick this to arbiters to kind of make the decision of what the rate should be. In some ways like the same considerations apply. As long as you tell them to kind of consider low rates and don't tell them to consider charges, it will end up pretty similar. There are some extra administrative costs, but there's also just some lack of transparency and kind of risk of -- there's no reason to think that arbiters are better at picking kind of the appropriate rate than lawmakers are. Obviously, there's a political expediency to not having to choose the exact rate, but that's sort of the key. And I think just to kind of drive home the do not base anything on bill charges. Fair Health released this data recently from New York data basically look at here is what the 80th percentile of charges and here's what the median in-network rates are in New York for a few of the sort of very common surprise billing cases. The incentive is blatantly clear. If you are an emergency doctor making $320 currently in-

network, you just go out-of-network, go to the arbiter -- the arbiters are basically told in New York to consider the 80th percentile of charges, this very high rate. My understanding is that arbiters almost always pick whoever is closer to that number. So you can just go out-of-network and get paid $1,200. So, you know, my rate or 4 times that rate. It's a pretty straightforward incentive there and I am -- there are some things in a state law that kind of prevent it from spiraling too far, but if you did this at the federal level you would see rates climb up pretty close to those high levels and have premium impacts, budgetary impacts, et cetera.

So the other type of recommendation that we walk through here is what we term "contracting regulation". But this is basically you would prohibit emergency and ancillary clinicians from billing independently to either health plans or patients for their services. So right at that point they would contract for payment with the facilities rather than the health plans and then the services would then -- the hospital would then bundle that in when they're negotiating with the health plan to get paid. The analog here is nurses. Right now hospitals pay nurses and then they build those costs into their negotiations with health plans. And this also has the benefit of -- because it is exclusively regulation on providers, there is no ERISA constraint, so this could -- if a state enacted something like this, it would apply across the board.

The vision for this is that you're actually creating a real market where a kind of broken market exists today. This sort of creates something much more approximating a real market. Markets can still have other issues of high market power, but that's sort of a separate issue.

Walking through our kind of recommendations, so we have two main recommendations if you actually think work out pretty much the same. The first is that you would regulate -- do the sort of billing regulation approach and tie a payment standard to what other specialists get paid relative to Medicare. So I was saying earlier, other physician types tend to get paid 125-130 percent of Medicare, if you just tied the payment standard to

that I think it's a much more reasonable thing to do. This is something that I think is a very reasonable argument. You can vary that by state and markets still. And just given what I was talking about before, there's really no risk to setting a rate below their market rate. We would sort of err on the low side of that. So we recommend sort of setting a rate at 125 percent of Medicare. And, similarly, if you're going with an arbitration approach you can give policy makers the same guidance. You should consider what other specialists, or maybe name a list of specialists, get paid relative to Medicare in your market.

But the problem with this is that this only -- sorry, and then jumping into the next one is talking about this contracting regulation, I think you would want to -- is sort of the same thing, you apply that to all your facility-based services. The problem is that can't apply -- that doesn't help you for those few cases of -- the first ones I talked about of the out-of-network emergency department or the ambulances. So in those cases you would still need the billing regulation approach just because there's no facility at play to kind of -- it wouldn't help you at that point.

And then sort of lastly, just sort of wanted to walk through a -- obviously we're in Washington, DC right now, there are probably federal policy makers watching this. Most of the paper was kind of focused on states, but honestly, like the same considerations basically apply. There's not a whole lot of difference in how you want to think about this. The main thing is you can just ignore all the things I said about ERISA. If you're talking about a federal law maker it's very easy to regulate self-insured plans at the federal level. I think the other big one is states are prohibited by FAA regulation from touching what we pay for air ambulance services. So at a federal level you can much more easily just sort of fix this problem on the air ambulance side, which seems to be pretty jarring problem -- 69 percent out-of-network, $10,000 balance bills we're talking about. And really the same solutions we've been talking about the billing regulation side. Same thing you'd apply to ground ambulance should be applied to air ambulance.

And, lastly, there's a question at the federal level of what do you do with

existing state laws, when do you preempt them and stuff like that. This is kind of an open discussion to our own preferences. I think my view is you would preempt anything that you don't consider a particularly strong law, so maybe you'd even pick a few states that have laws or say, you know, we're going to allow anyone who has a payment standard less than 150 percent of Medicare can keep their -- that law still hold, and if not, it's preempted by federal law. But obviously that one is a little bit more of an open question.

And, on that note, that's sort of the presentation. And I wanted to open it up to audience Q&A for five minutes or so.

MR. LESTER: Hi, David Lester, a consumer. Not in the business, but I do own a small business and I struggle with paying for insurance and how much to pass on to my employees. Every year it goes up, et cetera.

But I have just a couple of comments. One area that you didn't discuss were these free-standing surgical facilities. And I know from experience, you sign up for a colonoscopy with an in-network doctor and they do all their colonoscopies at this free standing facility, which they may or may not own part of, and afterwards you find out that it's out-of-network -- not the doctor, but the facility, and you get walloped with that fee. And when you get an out-of-network -- I mean you've talked about how much higher it is, but the other problem is that typically you're out-of-network deductibles are much higher, so you may end up paying 100 percent, not just the excess over what the insurance company covers, because they're not going to cover any of it.

The other point I wanted to make was another recent experience. My wife had surgery at a local hospital, MedStar. I think a bigger problem are the hospital facility fees. The facility fees for her surgery were absolutely outrageous and they were in-network. And the discounts off the facility fees negotiated by the insurance company were negligible. So if the hospital, for example, has to pay a doctor because your plan ends up have the doctor fees limited, the hospital has other ways to generate income, and that's through much, much higher facility fees. And I think that's as big a problem as this.

And the final question I have for you is in a lot of regulatory settings, when you fix a problem, you're fixing the problem, the loophole that somebody found or the way around regulation somebody found. You have to test these solutions to find out whether the doctors and facilities are going to find a way around your new fix and just find another way to jack up their charges.

Thank you.

MR. ADLER: Thank you for that. No, I should have mentioned -- I kind of glossed over by just using the word facility without ever defining it. But certainly this is a problem in free standing emergency departments as well as free standing as ASCs, or the ambulatory surgical centers. So that is certainly something you want to be looping into these protections.

On the hospital side, I agree that is a problem of hospital market power, and we pay very high rates to hospitals in general. To me that is somewhat of a separate -- I think it is a very important policy topic, it's just somewhat separate from the direct surprise billing situation. And I mean, obviously, there's going to be -- I'm sure when we pass this there will be some small loophole that we missed, but I think that's sort of -- there's always sort of a game of whack a mole to some degree. I think that this catches the 99 percent of the cases at least. I'm much better in that situation that with 100 being there.

MR. STEINWALD: Bruce Steinwald. To make sure I understand a surprise bill, if I'm hospitalized and I get a surprise bill from the anesthesiologist and it's high, I'm still covered for at least some percentage of what the insurance company would have paid an in-network anesthesiologist. So if it's $10,000 and then they would have covered $2,000, on the one hand I have to pay the bill and then submit to the insurance company. They're only going to reimburse me for some fraction of the in-network amount. Is that true? So what actually happens? What does your data say about what people who are confronted with these surprise bills actually do? Do they pay them always? Sometimes?

MR. ADLER: That's a good question. That's a good question that sadly we

do not have good data on at all. I mean I've talked to a lot of people at this point. Look, most of the time that these potential surprise bills are showing up, the patient -- most of the time the insurer -- or a lot of the time -- I mean not most -- the insurer and the physician are kind of working something out. A lot of times the insurer just -- a surprising amount of time the insurer just ends up paying the full bill charges because the complaint is too loud and that's why we see even higher premiums. But a lot of times this does get worked out before, but in that case the anesthesiologist -- you were liable for probably 30 percent of that $2,000, and then on top of that the anesthesiologist can legally bill you the remaining $8,000 balance and you have no actual legal recourse. Well, some people argue you do, but you don't want to spend $10,000 on lawyer fees to do that recourse.

But they can bill you, and I think the fact that they can bill you is why they get paid so much in-network. So the fact that it gets resolved half the time or something, or maybe probably more than that actually, doesn't absolve that the problem exists.

Let's do one more question.

MS. FRIEDEN: Hi, Joyce Frieden, MedPage Today. You were talking about negotiating a cap as one of the options, and you said if you negotiate it low enough that the insurer would have an incentive to pay that. Can you expand on that a little? Why wouldn't they just let the patient it if it was low enough?

MR. ADLER: Sure. So I think our view is that right now, often when this happens, when a patient gets these sort of surprise bills from the anesthesiologists, often the insurer is paying the full, even like crazy high bill charges. I think the point is, right, it is -- through an insurance company it's worth something to not have your enrollees be balance billed because otherwise you'll lose customers to other insurance companies. It just might not be worth paying 10 times the Medicare rate for these types of services. But in the markets where -- there are a few markets where these doctors are paid much more normal levels, then you don't see this issue happening.

The insurer, all else equal, does want their anesthesiologist in-network at

the hospital, it's just if they could just pay a normal market rate for it they'd be happy to do that. And I just think the downside from allowing your enrollees to get surprise billed is worth paying that much more reasonable cap. It might not happen 100 percent of the time, but at worst you've at least limited the surprise bill also. At least the surprise bill is more reasonable. But my theory would be that almost all the time the insurer would kind of take care of it at that point. I think the insurer is sort of taking care of it the large majority of the time now, so I think in that case they would almost always take care of it.

Well, that's it for me. And then I wanted introduce and bring our next panel up to the stage. They have to get my sort of introduction as they walk up there. Mark and folks, if you want to kind of walk up.

Paul already introduced Mark Hall briefly, but Mark is a law professor at Wake Forest University and a Nonresident Senior Fellow with us at USC Brookings Schaeffer Initiative for Health Policy. And then we have Jessica Altman there, who is the Commissioner of the Insurance Department in Pennsylvania. We have Jane Beyer, who is a Senior Health Policy Advisor in Washington State's Insurance Commissioner's Office, and a state that is working very actively on legislation this session. And we have Lauren Block, who is the Program Director for the Health Division at the National Governor's Association. And then we have Mary Moody on the end, who is a health policy advisor for Senator Bill Cassidy, who obviously is working on this issue at the moment.

And I will -- well, they are still getting mic'd up, but I will walk off the stage anyway.

MR. HALL: You were very efficient with those introductions. Lauren, are you ready?

MS. BLOCK: I think so, I don't know. I was passed.

MR. HALL: They have much more extensive resumes than that. Okay, great. All right. So we're just going to go down the panel. We're going to start with sort of a broad overview of variety of things states are doing. We're going to hear from two states

that have been struggling with this issue for a while and then we're going to hear from the federal government what's brewing there.

So, Lauren.

MS. BLOCK: Thanks, Mark. So again, I'm Lauren Block. I work for the National Governors Association, the Center for Best Practices. Just a little bit of context about why I'm here. So NGA actually has two parts. There is NGA Advocacy where the interests of governors are represented before the administration and congress, and there's a lot of activity and a lot of interest among governors with regard to cost and value and controlling costs.

In addition, there's the Center for Best Practices. And that is where I work. And we function as something between a think tank and a consultancy for states, really helping them learn from one another and identify best practices.

States truly are the laboratory for innovation, as we've seen with surprise billing. The states are taking so much action right now and we're seeing how the federal government is learning from some of what states have been doing in introducing new bills and considering discussion drafts. So that's really exciting. Our work has focused a lot in recent years on controlling costs in Medicaid, building more efficient Medicaid programs, working with high needs, high costs populations, using data to inform policy, and also addressing costs broadly with regard to pharmaceuticals. And currently we're seeing a lot going on in the private market with regard to surprise billing and a real growing interest.

So I just wanted to briefly talk about some of the trends that we are seeing in states and where we think things might be going. So we've seen just in last few years, since 2017, at least seven states have passed laws that address surprise billing, and we've seen many more bills introduced. And there are a lot right now. Some states are even beginning to think about changes to the existing laws that they have.

I think where we know that everyone agrees is that this is a problem. Where there's a lot of variability is how different stakeholders view the problem and what

they see as the solutions. So fundamentally what's happening is that consumers, as Loren mentioned, are having challenges where it's a situation they can't control. They're either going to the emergency room or they're going to an in-network facility and seeing an out-of-network provider that they didn't expect. So really what we're seeing in regard to state solutions in the trend is that really states are moving more towards billing prohibitions where providers just are not allowed to bill patients for the services. This is the biggest trend that we've been seeing, but it's been paired with other solutions.

I should note that some states that have laws that just address emergency rooms, some address the providers in the in-network facilities, the providers who are out-of-network, and some of them are even more specific than that, and only address specific provider types. Some say all providers, some say only specific provider types.

Along with the billing prohibitions, we often see states setting reimbursement rates. Loren did talk about this a bit. So we see everything from percentage of Medicare to the contractor, their negotiated rates. Sometimes we also see a percent of billed charges. Loren did reference Fair Health as one of those sources that's looked at. And then also we see greatest or least of multiple options. So sometimes there will be three different options presented and it will be the greatest or the least of those.

And this is really where we've seen a big sticking point among states where, when they've been trying to pass legislation there's been a challenge. I think you'll hear a little bit more about that from my colleagues when they speak about their experiences.

So sometimes what's used also is dispute resolution. And so that sometimes is paired with the billing prohibition and it's where a state would set up an independent arbitration process. Sometimes the arbiters are given specific data points to look at, so there might be an all payers claims database, they might be given a reference point like Fair Health. In some cases, like New York and New Jersey -- and this is a growing trend -- there is baseball arbitration. I didn't know what this term was before, what it means, but for those of you who don't know, it's when each party comes to the table with a number

and the arbitrator is picking between those. So that has become more common. And then sometimes they're given different reference points to consider along the way when they're making that decision.

So that is a trend that we're seeing, if you can't come up with the reimbursement amount that everyone agrees to, that is an alternative solutions. And often times we've heard that it doesn't get all the way through the process, so things get resolved you get to that arbitration process. There might be an informal process when it happens, but it can be a long process, and so they don't all get there.

Another strategy that we sometimes see is a hold harmless provision. This is a situation really where the consumer doesn't have to pay the bill, but the issue is they may not know. You have to have an awareness for this to be relevant and helpful. So technically what is supposed to happen is the consumer would get the bill, talk to their insurer, and the insurer will pay it. Sometimes the insurer, as Loren mentioned, would be paying the full amount, but we there is that risk that the consumer doesn't know, it stresses them out, they're attempting to pay. And that can be a challenge. But there are a couple of states where that is the policy in place.

Another common thing that we see are disclosure requirements. These are often times paired with some of the other strategies I've mentioned. There are at least one or two instances in states where there's disclosure, but there is not anything else. And so the issue there is you have a disclosure, you're being notified that you might be seeing a provider who is out-of-network, but what do you do? I mean first of all, if you're in an emergency this is not going to be very helpful if you are finding out like when you're checking in that the assistant surgeon or the neonatologist or somebody else that you didn't know you were going to need in your procedure is out-of-network. What are you to do? And so there have been things going on where there are some bills that suggest upon stabilization you notify the person or other times, but I think it's important to notify the disclosure in and of itself when you're in an emergency situation or can't have anticipated

something really probably won't be sufficient.

So I did just want to also note, Loren did talk about ground ambulance, this is certainly an issue. Most states have not regulated on this. It's often seen as a local issue, but it certainly is a problem where there are a lot of out-of-network bills.

Also, when we talk a little bit, just briefly, about the federal role, certainly we have seen air ambulance is a big problem across states. There are some states who have attempted to regulate, but because of the Airline Deregulation Act, states are preempted from taking action. And I think there is broad interest in a federal solution.

Also Loren mentioned ERISA. This has been a challenge when it comes to self-funded plans and state regulation. There are a few states -- so far New York and New Jersey -- who have different types of opt-in provisions, where either the plan or the enrolled individual can take action. But it's not fully protective, states can't require. So there's also an opportunity there federally.

So that's sort of the playing field of what we're seeing. We've been excited and interested in what we've seen come federally in terms of discussion drafts and bills that have been introduced. I think states are interested in seeing what will happen, but there is also an interest in not being preempted and states being able to continue if they already have something in place that they like. But probably having a baseline would be something that many would appreciate.

MR. HALL: All right. Thank you -- we'll call you "Lauren with an A" to distinguish from "Loren with an O". (Laughter)

So, Jessica, Pennsylvania is never a dull place. How has this been playing out there?

MS. ALTMAN: Yeah, so a couple of years ago this issue really started coming to the Department's attention from a number of sources all at once. It was sort of an overwhelming -- we were hearing it from our own team of people who answers calls, assists with consumer complaints, we were hearing it from our legislature, we were hearing it from

consumer organizations and other stakeholder groups. And so we began to focus on it really quite some time ago.

One of the things that has always struck me about this is issue is that there's such a focus on these blockbuster high dollar claims that get the headlines. And there's a reason for that, and those are really severe cases. But our experience has been there's sort of high frequency low dollar versions of surprise bills and low frequency high dollar versions of these surprise bills. So we have a state senator who is coming to us and has been a lead sponsor and avid support of the legislation all along because women in her district were seeking mammograms, and mammograms under both federal law and state law are supposed to be at no cost to the patient. But these women were going to a mammography center that was in-network and then somewhere a scan was sent to someone who wasn't even on site, to a radiologist who was out-of-network, and they were getting a bill that they never should have gotten. Not, that wasn't a very expensive bill, it wasn't in the tens of thousands of dollars, but it was happening to a lot of women.

The other case -- and this is sort of on the other end of that spectrum -- the one that really has sort of been stuck in my craw from the beginning, was a gentleman who contacted us because he had needed heart surgery, he had gone to an in-network hospital and in-network surgeon, but there was an assistant surgeon who happened to be out-of-network who he had never met before the procedure, and he received a bill in the tens of thousands of dollars. The crazy thing about that case for us is he happens to live in the very northeast corner of Pennsylvania on the New York border and he happened to work in New York, have insurance in New York, go to a hospital in New York, and have his procedure on the very day -- I'm not making this up -- that New York surprise balance billing protections went into place. And so he was protected by that law. And from our position I think our response was why should we have to be grateful that a Pennsylvanian is going to New York for their care to have this type of protection.

And so we've been working on it ever since. It's been about three years of

legislative sessions. I think one of the nice things about this issue -- and there are not very many nice things (laughter) -- is that it's very bipartisan. There is nothing about this issue that is partisan, there is nothing about it that should be partisan. I think everyone is in this to find the right answer to help consumers and do it in a fair way.

So generally the goal is take the consumer out of the middle and create a fair process for the insurer and the provider to agree on reimbursement. The first part of that is actually quite easy, everybody agrees on that -- this is a problem. Consumers are doing the right things and being stuck in the middle, really falling through a crack in our healthcare system that is not fair to them. The second part is the hard part, and figuring out how you determine reimbursement in a way that is fair, the right way to do it.

And so in the couple of years that we've been working on legislation I think Pennsylvania has discussed every single thing under the sun, from arbitration to Medicare rates to usual and customary rate to in-network rates to the Fair Health database, everything that is out there. I think I come at it with three sort of principles. The first is to always remember that this is inherently supposed to be a consumer protection bill and perhaps not a fundamental shift in how our healthcare system is supposed to work, although some may have bigger picture goals. And that means not just having a way for the consumer to take care of this if they do their homework and understand everything that's happening, but really keeping an eye out for the process, how the consumer will experience that process. Lauren touched on sort of the differences between hold harmless and billing prohibitions and transparency. And I've been someone all along -- I think Lauren got the line from me of what is a consumer supposed to do. If you have a prescheduled surgery and you know your surgeon and two days before you get a piece of paper that says hey, by the way, your anesthesiologist may or may not be in-network and you may or may not be on the hook for all of that cost, what are you supposed to do? Cancel your surgery? Is the hospital supposed to help you find a different anesthesiologist, is the insurer supposed to help you find a different hospital? And so we have to create a process that is understandable and

manageable for the consumer.

The second principle is really not creating negative ripple effects in the market, trying to not disrupt the processes that we have in place, not creating -- for example there's a lot of discussions about disincentives for network participation. There are very good reasons why health plans have networks today and we don't want to undermine that process. I think we also hear about potentially creating disincentives for physicians to practice in certain -- either types of facilities or even in Pennsylvania altogether if the process goes too far in the other way.

And the third principle, which is really quite tied to the last one, is healthcare costs and trying not to do anything -- we are all desperately looking for ways to move the needle on healthcare costs in a way that we are bringing them down. We don't want to do something in this case where we take the cost that according to Loren are already really high and move them even higher because of the incentives that we're creating.

So that's sort of the overall principles that I come to this with.

In terms of where Pennsylvania is because of sort of natural transitions in our legislative body, we have some new chairs, we have some new sponsors, and that's brought some really great new energy. Our house of our general assembly has been holding hearings, both chairs are lead sponsors of the insurance committee of that bill, and they're really going through an extensive deliberative process with stakeholders. And I am hopeful that energy, as well as I think the attention coming from the federal level -- so thank you for that as well -- will help us get something across the finish line in Pennsylvania. But, if not, we'll keep trying and I'll see you back on a panel like this while we continue to work on it.

MR. HALL: Thank you, Jessica. So, Jane, you've been through many decades -- or several decades of many different kinds of health policy issues. So how is this one striking you?

MS. BEYER: This one is interesting. So first of all, Commissioner Kreidler

regrets that he was not able to be here today. So I wanted to say that. This is his fourth year trying to get surprise billing legislation through the legislature, and I think this year might be it. And I'm going to talk to you a little bit about the Commissioner's thinking behind it, the issues that have come up, how we have evolved over the course of thinking about this now for four years, and a few issues that haven't been discussed that I think are really important to keep in mind.

So I can say ditto to everything that Jessica said and Lauren said. Loren made me feel guilty about some of the things that I'm about to say (laughter), but this is the real world of working in a state legislature where it is very democratic (with a little "d"), and every opportunity for every stakeholder to clearly express their perspectives to legislators and other.

So our legislation has three major goals as we have gone into it. Prohibiting balance billing -- we totally agree that it should not be the consumer's burden to have to figure out oh, this is a right that I have, I guess I should exercise it. When any of us looks at the bills that we get, given especially the trend toward high deductible health plans and exclusive provider organizations, et cetera, et cetera, it's hard enough to figure out what your appropriate cost sharing is, let alone whether something is actually a surprise bill. So it is not okay to ask consumers to have to figure that out.

And in our bill, just as others have indicated, we're focusing on those situations where consumers don't have a choice. So emergency services and then services provided by out-of-network providers in in-network facilities, ambulatory surgery facilities as well, our legislation lists the type of providers that this would apply to. So radiologists, surgeons, ER doctors, anesthesiologists, hospitals, pathologists, and labs. And over and over again the issue that we have tried to stress is trying to come up with a balance between provider and insurer interests in all of this. And that's the hardest needle to thread. There's no question about it.

So with respect to payment standard, we tried for three years to have a

formula in the legislation and got nowhere. And the breakthrough literally this year is we shamelessly stole from the State of New Hampshire and the payment standard that's in our bill is commercially reasonable amount with a requirement -- and I'll talk to you a little bit about how we're going to use our all payer claims database -- but essentially with a requirement that the insurer and the physician try to work it out. They have to have a 30-day period of informal negotiations before either can pursue arbitration. As Lauren indicated, we're using baseball arbitration and both parties have to split the cost of the arbitration. So there is unquestionably an incentive to not have to go to arbitration, because it's expensive. So that's how we are addressing the question of the payment amount.

We are one of the few states that has an all payer claims database and so our plan through this legislation is to develop a database that pools information about claims in Washington State with respect to what the median in-network payments have been by insurers, what the median out-of-network payments have been, what the Medicare rate would be, and what the median bill charge would be. And the idea is to have the arbitrator have what would be thought of as the high end of what might be paid and the low end of Medicare. And each party is coming in with their final best offer and the arbitrator has to choose one or the other.

So that's how it's designed. I will say that if this bill is indeed enacted -- and the chances are looking very good because the bill passed the house of representatives with an 84-13 vote and is scheduled to be voted out of the senate healthcare committee next week. And again, the discussions have been completely bipartisan on this. But we have the opportunity through our all payer claims database to monitor once the bill is enacted what is happening and what trends we're seeing in terms of out-of-network payment rates, and also what trends we're seeing in terms of network participation.

So really, really quickly, in terms of a few other issues that I just wanted to point out, emergency treatment received in border state hospitals. This has been a big issue for us. We have two consumers, one of whom received $100,000 bill from a border state

hospital for emergency services and another who received a $200,000. And that's the surprise bill. That's over and above what was paid for the service. This is where federal legislation can be very, very helpful. The way we're approaching it in our bill is you can't just say to those consumers, too bad, so sad. So in our bill we're saying where it's emergency services that are provided by an out-of-state hospital the insurer does have to hold the consumer harmless from balance billing. But we would really like there to be a federal solution that says it doesn't matter where a hospital is, for emergency services you can't balance bill.

Then enforcement. If we are prohibiting balance billing by providers, there needs to be a mechanism to enforce that. And our legislation gives the insurance department the opportunity to reach out to the provider and say, you know, maybe you didn't know that this wasn't allowed, but it's not allowed, so do you want to take care of this and fix it. And if there is a repeated violation, the legislation in Washington State would make it unprofessional conduct for a provider to continue to balance bill where it's illegal and also for facilities to do that. So that's the linkage that involves a good relationship with whatever your regulatory agency is that regulates providers.

And, finally, with respect to transparency, the legislation has requirements, carriers, providers related to providing consumers information about what networks the providers participate in, it has the Office of the Insurance Commissioner developing a standard template, a notice for consumers, to explain their rights. And Washington State is one of the states that is providing in the legislation an opt-in option for self-funded employer groups. And what we would anticipate is, for example, there are many Taft-Harley plans that are self-funded, and so when those entities are going into collective bargaining, that's an opportunity for employees to come forward and say we want these protections as well.

So I'll stop there.

MR. HALL: Okay. Wow. All right. Impressive. So we have ERISA preemption, we've got aviation preemption, we've got cross-border issues, obviously

begging for some federal -- are the feds going to sweep in and solve all this for us? (Laughter)

MS. MOODY: Well, working on it. So thank you so much for having me here today. I'm really pleased to be here to speak about some of the work that my boss, along with others, are doing in congress to address this on a federal level as it's been so clearly demonstrated that there's a need for.

My boss is a physician. He is a gastroenterologist and represents the State of Louisiana in the U.S. Senate. So he is attuned to some of the issues that patients have raised I think others have mentioned how it just seems that this issue has reached this level of salience, much in part due to the reporting that's gone on on the issue, a lot of the activity on the state level. So it's given it this sort of great momentum that's enabled my boss to be sort of spearheading this effort in the senate together with five other members in the senate -- it's equally bipartisan -- to provide a federal protection for patients from surprise medical billing.

I think it was interesting to hear -- I liked how you talked about the low incidence of high dollar bills and high incidence of low dollar bills. And when you contextualize that in the economic reality of most Americans -- I know I've seen that 6 out of 10 U.S. families don't have more than $500 in a savings account. So when they get that $200 bill, I mean that's not just inconvenient, that's taking whatever it is, money to buy food for their family. And then when you get into those high dollar amounts, I mean that has potential to be financially ruinous for that family. So I think that is sort of the driving force for my boss and other to be able to protect that patient from what could be really devastating.

So in terms of our process, we're not quite as far along as some of you all. We released a discussion draft last October in which we sort of had a mechanism of capping the provider charges in greater to methodology, so sort of a combination of a couple of things that have been mentioned. It elicited a lot of feedback from some of you in this room. And we appreciate that. And it's been highlighted in some reporting lately about sort of the

level of acrimony between some of these stakeholders. And we hear from the providers about this is a function of narrow networks, of a growing trend of high deductible healthcare plans, of insurers not acting in good faith. And then from the plans we hear about some of these providers who might use it as their business plan to sort of stay out network and balance bill and then highlighting the really high level of charges by some of these folks. So there's certainly enough sort of blame to go around between different parties.

But we have taken this feedback and are trying to threat the needle on some of these issues. And there are the different frameworks that are being discussed. There's arbitration, there's capping provider charges, there is the bundling that Loren had talked about, there's network matching that's sort of an iteration of that. So we are trying to weigh the pros and cons of each of these. I think each come with their own set of strengths and weaknesses. And so we're still on the process of narrowing in on what our approach will be.

I think sort of to echo some of the comments Jessica made, you know, we're trying to keep a few things in mind and that of know that this is not -- in terms of being a chronic balance biller, it does seem to be concentrated a small number of -- you know, relatively a small number of providers. So how do you sort of target your approach to address what is the bad actions committed by a few? And so we're keeping that in mind, keeping in mind what undue implications there could be from some standard that we set. So particularly I feel the weightiness of that, knowing that we're putting in place a federal standard. So it's going to apply across the Nation where there are different healthcare markets, where there may be different asymmetries. You know, in some areas the plans maybe have greater sort of leverage over their providers and in other markets the providers might have greater leverage over the plans. And so how do you sort of establish a federal standard that balances that and doesn't sort of tilt it in one way or the other. So we're keeping that in mind.

And, ultimately, we're certainly cognizant of the impact that this will have on

costs and ultimately premiums, knowing that whatever we establish here can have downstream effects on that, which is really important.

So at the heart of this we know that it always comes back to protecting the patient. In his scenario we could end up with a solution that everyone loves, and that would be so wonderful. We could end up with a solution that everyone hates, and that is -- you know, sometimes you might be doing the right thing if you're at a place where everyone hates it too. (Laughter) But we're keeping that patient in mind and knowing that that is the heart of this.

And, frankly, I think I'm optimistic knowing that this is an issue that the Administration is interested in. The President held a roundtable at the beginning of the year in which he talked about surprise medical bills. We know there is interest across the congress, in the house, and in the senate. There have been different initiatives. And so, ultimately, surprise medical bills, this is one issue where there does seem to be some momentum behind -- really encouraged to see the level of interest and engagement by stakeholders, by patients, by everyone. I think it's also part of a larger set of reforms that need to happen getting at some of the -- there are so many things we need to do in terms of looking at what is driving cost, how are our incentives misaligned between different stakeholders that lead to increased costs.

So we're thinking about all of these things broadly and I think surprise medical billing fits in this picture, and I'm hopeful that it can sort of be the driving force to -- if I'm honest, in congress, where there can be a lot of discord, you know, this is an issue where there is bipartisan agreement that we need to do something. So I'm hopeful that surprise medical billing can sort of be the issue that can lead to agreements on other parts of our healthcare system, which also need addressing.

MR. HALL: All right. End on a positive note. (Laughter) So I'm going to take just a few more minutes to pose a couple of questions, maybe just one or two to the panel before we go to audience Q&A.

And direct your attention as panelists to the Brookings report, so I'm going to shift to Brookings rather than "Loren with an O" because it's just convenient. So we'll call it the Brookings report, which I think pushes the boundaries a bit more because it tries to dig down to the root of the market failure that causes the problem, as was presented, and brings more to the fore the role that the hospital plays in all of this, and so I think presents, too, pretty innovative ideas. And I want to get your reaction to them in terms of whether you would agree in principle. You can speak to the pragmatics, but also sort of does it make sense in principle or do you see problems with this either essentially requiring these key ancillary specialists, their services to be bundled with the hospital so that the hospital has to negotiate and bill for that on their behalf and contract. Or, number two, set the cap. You know, don't worry about setting the cap too low because if you do set it too low there's a market correction, which is the hospital can top off the payments to these ancillary specialists to bring it up to a level necessary to keep adequate supply.

So those sort of two potential functions of the hospital, does that grab you as plausible or an exciting new idea, or we'll never get out of the gate?

Loren?

MS. BLOCK: Sure. I start and I'll obviously defer to my state friends here to say what it would mean in their states. Certainly it would be beneficial to the consumer to have an assurance that whenever they go to a facility they are not going to have an out-of-network experience. Hands down, I think everyone can agree to that. I do think there's a question of the political palatability and whether or not states would be able to get the stakeholder buy in to be able to make something like that happen. I think there's also a question of could there be some sort of cost shifting that ultimately does happen, and we need to think about that.

I think just from an operational standpoint there -- and this isn't necessarily something that couldn't be overcome -- but there is a jurisdictional issue. Most of the laws that exist right now are out of the departments that oversee health plans as opposed to

those that oversee facilities or the boards of medicine who oversee providers. So that would probably be a new role and a new level of coordination that might need to exist across the DOI along with the facility oversight and the provider oversight.

MS. ALTMAN: So I agree with everything that Lauren said. I wanted to actually tease out that jurisdictional concern a little bit because this is something that's coming up in a lot of areas as we talk about what to do about cost. And when you come to the state level we are working within these existing regulatory frameworks where I regulate insurance companies, there's a long history of regulating finances and payments and sort of the financing side of the system. And then we have the state boards of medicine in Pennsylvania in our Department of State, we have facility regulation in Pennsylvania's Department of Health, and those functions for a very long time, and still today, are largely about public safety, largely about medical standards, largely really this health-related function. And there are not in most states entities that really oversee financing as it relates to the provider side of the healthcare system. And so I think from a pragmatic standpoint, but also certainly this gets to a political standpoint, when you're trying to fit a construct to fix this problem within the processes that we already have in the State, there isn't a natural home for something that would be overseeing how hospitals are being reimbursed, how hospitals are operating with independent physician that practice or have privileges at their facilities. And so it becomes -- there are serious operational challenges from a state oversight perspective. And it's also a bit of a mentality challenge in terms of the role states have historically played versus the role that some are looking for states to play in these broader conversations about cost. And I just think we should be cognizant of all of those dynamics.

MS. BEYER: So I would say a couple of things to be really concrete about what Jessica just said. States are purchasers, right. So our state Medicaid program covers almost 2 million people, and the legislature, without much difficulties years ago -- oh my gosh, maybe even 10 years ago -- passed a bill that basically said for purposes of the

Medicaid program, because were the purchaser, out-of-network providers have to accept the Medicaid rate. That's it. We're the purchaser, we're the 800-pound gorilla in the room. Taking that and translating that state as purchaser role into state as regulator role is challenging.

The other issue is -- there are two other issues. Political reality -- anything that has a state legislature setting rates is automatically very controversial and volatile. And even though we can say, but wait, but wait, it's only for surprise bills, the perception that others will have is camel's nose under the tent. So it's just a reality that we have to deal with all the time.

And then I would respectfully say that I don't think that having the hospital bundle all the payment and having that be the entity that negotiates the rates with the insurance companies is separate from the market dynamics that we have around market concentration in hospital systems, especially in rural communities. So I think it's the classic example of if you squeeze the balloon in one place it pops out in the other. I think those two are related and it -- I'm a little bit nervous of having that much more leverage in the hospitals' negotiating position when they're negotiating with insurers, especially in states like Washington that have really strong network access standards.

MR. HALL: Hasn't worked great for colonoscopies, I guess.

So, anyway. (Laughing) So any further comments, Mary?

MS. MOODY: Yes. I would just echo -- I took some notes this morning -- some of the concerns you expressed insofar as one thing as regards the bundling approach in particular. I think on the face of it, on the consumer side, it sounds great. You've sort of eliminated the possibility of being treated by an out-of-network provider at an in-network facility. And that is a great messaging point. I think practically, there are concerns about what the downstream impact could be, in particular, the concentration of power essentially.

I think my boss has concerns about, just generally speaking, the consolidation in our healthcare system right now. And that's among insurers, among health

systems, you know, the list goes on. But right now even there is a Health Affairs piece which came out which showed that the hospital facility fees have increased -- was it 42 percent over the past 10 or so years -- and I might not be getting that exactly right -- whereas the physician fees have been around 20 percent. And so if you concentrate the negotiating power within the hospital, how could that further sort of solidify that trend when they're able to negotiate on behalf of all the physicians in their facility, and how could they leverage that essentially with the plan. And so that's my concern, that that could be used as sort of a driver to increase costs in that way. I think the providers would also come up with their own set of issues with that insofar as just not having the ability to negotiate on their own behalf and things like that. I don't think it's well received by them.

So I would just echo some of those concerns and say that some also point to this is just really interventionalist within -- and could be very disruptive to the status quo. And so I sort of go back to that point I said in my initial comments about making sure our approach is sort of like proportional to the problem we're trying to address insofar as this would have broad implications for the entire healthcare system and could get outside the scope of what we're trying to address here.

MR. HALL: All right. Well, thanks for that reality check. Disruptive innovation at best. Anyway, so to the audience now. Whoever had the microphones and we have a few minutes. You decide. There's a hand here, a hand there. How about over there and the one in the back.

QUESTIONER: I'm Jack (inaudible) from Georgetown University. I appreciate all of these comments.

One of the things that I was interested in, several of you made reference to that scope of providers that might be included in these protections and, Jane, you in particular had a list of provider types. And I'm wondering about what limitation that creates. And one example I've heard about recently is plastic surgeons who might come in when somebody has had a facial injury. And that might not be on the list of providers. So how do

you think about sort of the consequences of limiting the categories of providers?

And I think it's also relevant to the bundling question, because it's one thing to think of bundling for the anesthesiologists or the ER doctor, but again, that doesn't necessarily extend to some of the other specialties, such as a plastic surgeon.

MR. ADLER: I'll just say on the second point that the paper was careful to say we're addressing principally just these hospital-based referral specialists and not the other kinds of physicians selected referrals.

QUESTIONER: That would be plastic surgeons.

MR. ADLER: Oh, right.

QUESTIONER: It would be.

QUESTIONER: If they're out-of-network in emergency service.

MR. HALL: Yeah, oh, in emergencies, yes. Yes.

True that. Okay, so it does get tricky. (Laughter) But other reactions to the sort of specificity of providers?

MS. ALTMAN: So I'll start and then Jane can jump in there since that's in their bill, which my preference is not have that specificity. I think as you sort of begin to collect the stories, which if you're in a role like mine, you are -- I've got to tell you, I bet if you ask three people on the street if they've had one of these, at least one of them will have, and you'll begin to hear the stories, right. And some of the specialties that we've come across were never named as sort of the common players when you first think about this. I think the one that really comes to mind and one where we've seen some incredibly high bills in neonatology. And out-of-network neonatology services following, in particular premature births where there's no way to anticipate prior to giving birth whether you will need neonatology services or not, and then depending on how premature the birth is, the length for which your child will need those services can often be quite long.

And then you get into that, what I said before, there's this focus on the high dollar claims and they are worse. There's no question it is worse to get a $200,000 balance

bill than a $200 balance bill, but to the point that you made about the savings and the impact, $200 is still $200 that fairly a consumer should not have to pay, and probably 100 consumers shouldn't have to pay. And so I in my discussions would strongly prefer to see a bill in Pennsylvania that really just says this is a systemic problem that deserves a systemic solution, and not limit it in that way.

But now I turn to Jane to say why they have that in their bill.

MS. BEYER: I mean, Jack, your point is really well taken. It's really well taken. And I'm going to go back and say, hmm, you know, should we think about, for example, adding neonatology. And then for those of us in the room, I worked for the state legislature for 20 years in addition to doing this in some other roles, and we frequently come back two years later, just like California is doing now and other states are doing, and say, hmm, we need to perfect this. So your point is really well taken.

QUESTIONER: Can I just add also that labs are also -- I know Jess talked about sometimes the low cost, but of them -- labs are another area where this is an issue. So it's not just the specific types of physicians.

MR. HALL: Mm-hmm, yeah. I'm going to move on because there are hands here, here, and here, and there, and somebody gets to decide where the microphone goes next.

MR. COMMON: Yes, good morning, David Common, JP Morgan. I think most everyone really gets the issue. I don't know if you accept the term cross-subsidization, but it seems like that's the common term to reference the disparity in payment rate. All of these solutions seem to have pretty significant implications for physician compensation. Has anyone actually done some numbers on what that would mean and does that have any unintended adverse consequences?

MR. HALL: I'm not aware of any really scoping to that extent. I would assume some of the specialist societies have taken a look at that. Whether it's public or not, I don't know.

Next.

QUESTIONER: Hi, I'm Christine; I'm a policy analyst with Capstone. I was wondering if you could comment a little bit more on the unique policy challenges to air ambulance. Yesterday in the GAO report they highlighted a law in Minnesota that goes after a hold harmless provision for air ambulance, so more so at the payment from the plan perspective than to get around the ADA exemption.

And then on the federal level there also just the appetite for doing something like that where you go after the ERISA approach as opposed to amending the ADA, because I know there are additional aviation challenges to the ADA perspective.

So any comments you or Mark Hall you may have on that air ambulance situation.

MR. HALL: I'm going to turn this to one person and one only. Who wants it?

QUESTIONER: Go ahead, Mary.

MS. MOODY: Okay. I will just say, this has been a focus in congress, particularly last year during the FAA reauthorization. There was sort of a push to -- there was some language that was considered that would enable states to use their regulatory authority to regulate air. It was not ultimately included in the bill. What came out of that was a task force, which is supposed to be jointly done by Department of Transportation and CMS, to look and advise on what would be the best path forward in terms of regulatory structure.

As you could imagine, folks can get really nervous when you talk about amending the ADA in terms of just broadly -- it might bring the airlines out, you know, others because if they think there are going to be changes to this. So I will say it's very complicated right now. I mean there is some uniqueness to air insofar as it is 30 percent of their transports are interstate. So that is different than other types of services perhaps where a -- might reinforce the need for a look at it federally. I think the exact policy details of

what the best solution is I think that's something I'm looking into, but I'm not sure exactly what that is at this moment.

MR. HALL: All right. In the back. Probably our last question. So make it a good one.

MS. ZOOK: A lot of pressure. Susan Zook, I'm with Mason Street Consulting. I just wanted to sort of reiterate -- I know we talked a little bit about the Medicare payment rates for a lot of these providers and that we don't have a lot of data. And as we see more and more people go into the Medicare program, taking more and more of that funding that might be set at what we might consider a lower rate, is that concerning that we don't have a lot of understanding about whether or not that's an adequate payment rate and what that would be while we go into this rate setting discussion?

MR. HALL: I'll chime in on that, unless Loren wants to take the last word? All right.

MR. ADLER: I mean I would just say, I agree, I think trying to get more data is helpful. It's not like we have no data. Like we've looked at this for a lot. There was a lot of man hours spent trying to get these rates right. And I think the key thing that we were kind of getting at earlier is if you set a low rate you're not actually setting a rate in this situation because the hospitals have a role here also and they are going to be involved here.

So the next step on that is if you actually wanted to rate set here and you actually wanted to say we really want to set the rates really low for anesthesiologists for whatever reason, you would need to not only cap the -- set a payment standard at 100 percent of Medicare, but you would also need to cap hospital payments at that point. Otherwise you're not actually rate setting here, you're really just sort of letting the market dynamic stay at play here.

So that's sort of my -- the main thing is I don't think we really have to -- you're not really setting a rate at Medicare, you're setting a rate at whatever the market rate ends up being, it's just the hospital is now getting involved in this negotiation.

But broadly to your question, I agree. I think it's worth looking more --

MR. HALL: You're helping cost shifting to happen, and this time it's fixing a problem.

MR. ADLER: Yeah. Well, I mean -- right. I'm the economist type, so I don't believe any of the cost shifting rhetoric. There's zero evidence that cost shifting is a thing that that relies on that hospitals are not profit maximizing now or providers are not profit maximizing now, which seems a little bit silly. Trying to tell me that anesthesiologists are not trying to get paid the most money they can now.

MR. HALL: I shouldn't say cost shifting --

MR. ADLER: Sorry.

MR. HALL: -- just before our break. (Laughter) Which it is break time. So to hear more on that, chat up Loren. But anyway, 10 minutes -- 8 minutes now because I took a minute and a half, so see you back at 5 after the hour.

(Recess)

MR. GINSBERG: Could people move to their seats. We are about to get started, and, I'm really pleased to be able to introduce four people who are affiliated with Stakeholders. You've heard about them in the previous panel, about the Stakeholders, and we have L. Anthony Cirillo, who is a board member of the American College of Emergency Physicians; we have Claire McAndrew, Director of Campaigns and Partnerships at Families USA; we have Molly Smith, Vice President Coverage and State Issues Forum, the American Hospital Association, and Jeanette Thornton, the Senior Vice President for Product, Employer and Commercial Policy, America's Health Insurance Plans.

We will just begin with each of them making remarks and we will start with Jeanette and move down that way.

MS. THORNTON: All right, good morning, thanks for hanging with us. As was men mentioned, my name is Jeanette Thornton. I am coming here today representing America's Health Insurance plans, and our members provide health insurance from

individual markets, small group market, large group market, both the fully insured products and self-insured products as was mentioned on the earlier panels.

From our perspective, we really do view the issue of surprise billing as one of those huge pain points for people in the healthcare system. I think when people share their stories about the bills that they are seeing that are a surprise to them, it really reduces their value and their trust in the viability of a commercial health insurance market, and that is why we think it's so important that we are here talking about today, and talking about policy solutions to address it.

Today I want to talk about, sort of, two buckets of things, one I will share a little bit of our lessons learned from the state perspective and I will also talk about sort of where we are in terms of some of the Federal policy discussions that are ongoing today.

For a number of years we have worked with states across the country that have been enacting legislation to address the issue of surprise medical billing and we have heard from the earlier panelists a little bit about some of the various state approaches. You know, we do have already 17 states that have prohibitions on balance billing and a number of other states, well over half, that have some sort of protections for out-of-network billing, and that sort of self-insured employer opt-in that was mentioned earlier.

But it's so interesting, this issue, it's certainly a hot issue. I think our state folks let us know that over 40 states have some sort of pending legislation that they are discussing in this area, so it is certainly something that is hitting state policy makers in their discussions. But I think for a number of reasons that were mentioned earlier, we have sort of pivoted to working at the states to also seeing a need for Federal legislation in this area to fill some of the gaps.

One of the things that was mentioned was those individuals, about 100 million people who are covered in the large group market through a self-funded employer, and in most cases, these individuals are not protected by the different state laws that are in place across the country, and it would also be very difficult for an employer who has, you

know, a few people in every state across the country to have to follow each one of those state bills for those two people; it would just be really burdensome to have to do that.

We've also seen a number of states that just haven't acted or have protections that really only address, sort of, a piece of the problem and this is, again, something that Federal legislation could, sort of, fill those gaps.

And finally, I'll say the issue of ground ambulance and air ambulance is really important to us in terms of addressing and in terms of the stories we have seen around people particularly hit by surprise medical bills; I know that it was mentioned some additional complexities with addressing that, but we definitely think it is important, that it's part of the discussion. If we have solved it for hospital or physician's services, but not for ambulances, I don't think we have really solved the problem. So that is definitely something that I think is really important to stress in any of these discussions.

The last thing I'll mention, and I think Loren mentioned this in his opening remarks, that it's important that consumers are taken out of the middle of the issue, but also, it's important that any solution does not increase healthcare costs. So we have to look at how this impacts consumers' pocketbooks, both in their out-of-pocket expenses but also in how it drives health insurance premiums across the country, so, it's important to keep that premium component in mind.

So, let me shift a little bit to some of our policy recommendations and we welcome some more discussion throughout the panel. I think all of us here on the panel would agree that we support legislation that would sort of take people out of the middle of this discussion. Sort of the ban balance billing, get consumers out of the middle; have consumers be responsible for a cost sharing amount that is more aligned with what they would be expected to pay if the care was in-network. I think we can all agree on that but one of the challenges I see, if we only do that, if we only balance bill, ban balance billing, if we only look at the cost sharing amount, we are not really solving the problem.

I think Loren showed this in some of his data, that in some particular

provider types, the market is really, I'll use a complicated economic term, it's out of whack, right (laughter)? We see these extremely high payments on one side and if we are just basically saying, okay health plan, you work this out, we are not solving the problem. I think it's going to lead to hire health insurance premiums and that is why we are a really interested in looking at these different, sort of, benchmark-like approaches.

We have seen a number of states take a look at those and enact legislation, and I definitely think that it has to be part of the solution. So it has to be something that doesn't raise healthcare costs but is also fair and transparent for the providers. Obviously, this is something that, you know, it takes two to tango here. We want to make sure they are addressed.

I want to also respond to, sort of, the comment that, oh, if you set a benchmark for these narrow surprise billing situations, this is a slippery slope to government control of healthcare. You know, I really disagree with that previse. Just yesterday the AEI, I think your neighbors just right up the street, put out a paper that looked at the issue of surprise billing and also, sort of, recommended similar type of solutions for some of these narrow situations; also, highlighting some of the high costs, so this certainly is a bipartisan issue if you have Brookings and AEI on different sides of the political spectrum, all sort of raising these issues and potential policy solutions; so, super fascinating there.

I'll talk briefly about arbitration. You know, we have certainly seen the use of arbitration to sort of resolve these disputes between providers and health plans in a number of states. The one thing I'll say about that is that it can be rather clunky and it can be rather expensive. We pulled some data from some arbitration firms that are out there and used in Texas and some other places, you know, just the filing fee of $1,500, so if you are talking about some of these small things, that can really add up when you are talking about number of claims and different areas and how that could potentially add administrative costs to a system that -- you know, that I don't think we all need right now.

I also want to hit on the issue of consumer notice. A lot of individuals are

focusing on, well, if we just had transparency, if we just had a notice around what providers and what networks are in, that would, sort of, solve the problem. You know, if you are going into labor and you get that stack of paper, you're going to sign anything because you're about, you know, you are going through a very challenging time at the moment (laughter), right? You'll sign anything, and so just allowing consumers to get notice, oh by the way, you may have seen an out-of-network provider, you may be balance-billed, you're going to sign it, right? And that is not really solving the problem. It's is certainly giving people notice, but again, it can't just be part of the solution. Now, whether or not notices play a part of that is something we can certainly discuss.

So, just sort of in sum, it's really important as we are looking at surprise billing, we think about the pricing and the high prices that are out there, and we think about solutions that both address consumer protections, which I think we all agree on, but also look at ways to, sort of, correct some of these market distortions that we are seeing in the market, and also, making sure that we don't increase healthcare costs. You know, I don't think this is an issue of narrow networks and high deductibles. We see this across the spectrum. I think this is an issue that we are really excited that folks are talking about and we are hopeful to see some actions and discussions this year on this issue. So, with that I will turn it over to our next speaker.

MR. GINSBERG: Thank you very much, and actually, before Molly Smith speaks, if I was putting this panel together two years ago I would have had an insurer, a physician, a consumer, but it's really what I have been learning since, shows the very important that hospitals play, so I am delighted that we have you and look forward to your remarks.

MS. SMITH: Thank you so much and good morning everyone. Thank you for having me here. So, this is a really important issue for hospitals, absolutely. We care a lot about the patients that we serve and it is not a good scenario -- I think that, again, we all agree, if they receive bills that they were unprepared for, that they weren't expecting -- our

work on this issue actually goes back several years. The focus of Brookings paper is on state level solutions and, in fact, that is where we really began our work. We worked very closely in the development of the NAIC's Model Network Adequacy Act and the surprise billing provisions therein. And when that Act was completed, we adopted it, or endorsed it and we worked with our state hospital association colleagues as they were working with state policy makers to identify solutions to surprise billing.

Unfortunately, though, for many of the reasons that have been mentioned here already, it's become clear what some of the limitations are on state level solutions. So the ERISA preemption is one, obviously oft cited, but one that Jeanette just mentioned, which is very important to us, is the fact that we don't have all of the states moving towards adoption of resolution. We obviously have a ton of activity, but we are not optimistic at this point that all patients across the nation would be protected if we rely on the state process. So, we have now really shifted out focus to Federal solutions and we do support Federal legislation to address this issue.

I will say with respect to hospitals, I think what we have heard a lot about today is that it's a pretty rare instance where it's the facility, or the hospital, sending a balance bill, not to say that it doesn't occur, but it is a more, sort of, rare instance. What often happens, it's not rare though, that of course there is out-of-network hospital care, particularly in emergency situations, but it's that health plans and hospitals have, sort of, forever dealt with that problem and they have a long-standing history of, sort of, negotiating out-of-network emergency reimbursement. Obviously, as we mentioned, disputes do occur; balance billing can occur and as we are looking towards a solution, our first principle is that patients should not receive balance bills in scenarios like emergency care, or when they go to an in-network facility with every expectation that their providers are in-network and receive from an out-of-network ancillary provider.

We do want them to be taken out of the middle. We do want prohibition on balance billing. But once that happens we do get to this question about what is the role of

the government, whether it's the state, if we are still talking state solutions, or the Federal government, in getting involved in setting the reimbursement between a provider and the plan. And as I mentioned today, on the facility side, this process is largely working and it's not clear to us that the government has a need to, sort of, intervene in that process, whether it's by setting a rate or some sort of arbitration process. We think that, at least for the facility portion, that can largely be handled the way it is today.

Speaking a little bit to the issue of setting rates, I think there has been a sort of general assumption in some of the comments that we have heard this morning, that hospitals can either absorb the additional costs of, kind of, subsidies to physicians, in order to prevent balance billing from certain specialties from happening, or that they can simply pass those costs onto the insurer. If we are talking about the latter situation, I'm not really sure what we have gained, if we are simply then having the insurers paying the hospitals more. It seems that we have just sort of disrupted a process to the same outcome, and if you are talking about the former I think there is a gross misunderstanding of a hospital's ability to absorb these additional costs without some sort of ramifications for other investments that they might make, whether it's in the services that they provide to their community or other activities. So, I think we should be cautious about assuming that hospitals can just automatically, sort of, take on those additional costs.

Jeanette raised the issue of notice and I think that this sort of fits into a broader discussion around patient education and patient navigation. I couldn't agree with you more that I don't think notice is -- first of all, it's definitely not a comprehensive solution. It's not clear to me how much value it adds at all, anyway. Not to say that patients shouldn't have a good sense of, you know, who is delivering their care and whether they are in-network or not; but again, from our perspective, if you protect that patient from a balance bill, it somewhat becomes irrelevant and we have just heard a lot of challenges with explaining to the patients and adding to their confusion at a very vulnerable point in time.

But that is not to say that we don't all play a role in helping patients navigate

the healthcare system. Our members, of course, every day are working very closely with the patients who they serve to help them coordinate their care, to navigate the healthcare system. We work with their insurers to help address issues or questions around costs and cost-sharing, and I think that there is definitely more that can be done there. Employers, when they are selecting products on behalf of their employees, helping them better understand their coverage, same with making sure that provider directories are accurate, and then this work actually extends beyond just our members, and doing their part.

We actually, as associations, have worked together on consumer education tools. And just this last fall actually, AHIP, the HANIC, HFMA here in the audience as well worked together to develop a consumer guide to help educate patients about what surprise bills are, why they occur and how to avoid them. So that is work that we are deeply committed to; to work with our stakeholder partners as well as our members.

The last thing I want to note is the issue of network adequacy and I thought the paper had some interesting data that suggested that this isn't an issue of network adequacy and that the incidents of the potential for surprise bills can occur in narrow network plans or broader network plans, but we are hearing about an issue that is related to network, so they think is worthy of further exploration, and that has to do with a misalignment between the providers that are in-network and the facilities that are in-network.

So you may have a network that is narrow or broader, but you have the issue of the anesthesiologists, for instance, that are in that network, don't participate or don't practice at the facilities that are in-network. And it's something that we are increasingly hearing about. We ourselves don't have data at this point but I just encourage you to think about that as this sort of broader issue of network adequacy.

The final thing I just want to mention, and this was raised, I think, Mary mentioned it in her comments earlier about some of the other, sort of, tangential issues that arise; I think this one is worthy of note. So, our members do get a lot of calls from patients who are confused, or concerned, or surprised about their bills but in the vast majority of

instances, the bills that they are calling about aren't what we are talking about in terms of a surprise bill. They are surprised by their bill, but it's simply because they are unfamiliar with their insurance design, and particularly with their deductible, and so they call very surprised that they maybe have a $2,000 bill but they thought they were covered.

I know that is not what we are talking about today, and this is a very different issue, but I think it's worthwhile in noting that, that is again, the vast majority of calls that our members receive about surprise with bills, and that is not going to be addressed through the work that we are doing here. It is, though, why the AHA has consistently supported and advocates for enrollment in comprehensive coverage with comprehensive networks so that issues like that are minimized. So, I just wanted to raise that and thank you again this morning, I'm really looking forward to the discussion.

MR. GINSBERG: Thank you very much, Dr. Cirillo.

DR. CIRILLO: Well good morning everyone. I was going to say thank you for inviting me but I'm not really sure I want to do that (laughter). And, you know, in policy and advocacy you know, the adage is that you either have a seat at the table or you are on the menu (laughter). Somehow I feel both all of a sudden (laughter).

So, I'm a practicing emergency physician. I will be working a shift tomorrow morning at 7 o'clock, and I want to share with you that of all the Stakeholders here, and I appreciate the role that each of us play, but I'm going to be at the bedside tomorrow with another person who is entrusting me to take care of them. And I would just have you all stop for a minute and think about some of the portrayal of physicians. And I am here on behalf of the emergency physicians but I'm the only physician here, so I just want you to remember that none of us went in this to gouge people, to ransom patients. Look, I went into medicine to take care of people and I truly believe that.

There is an issue that affects your constituents, the people I take care, and they tell me the stories. If they get a bill from somebody that is out-of-network, I understand that that is a problem. They tell us -- you'd be surprised at what people who come to the

emergency room will tell you, even though I just met them. They tell you a lot of stuff and they share the stories how an out-of-network bill might financially hurt them, they talk about high deductibles, they talk about the system is so complicated that they can't possibly figure out what they are going to owe, even when they ask all the right questions. So, I think honestly, for all of us who care about this, there is an opportunity for all of us to work together to make this better for you, for your family member who goes and gets a procedure, and I will share with you are personal story, and I couldn't have made this up.

My 24-year-old son who, thanks ACA, is still on my healthcare insurance, had a colonoscopy yesterday. When he was having problems, and he lives in Boston, we live in Rhode Island, but he went to his PCP, had some initial testing and the recommendation was you need a colonoscopy, and now I'm a parent, now I'm just concerned. And so, he goes to the colonoscopy yesterday, he describes how wonderful the prep is, if any of you have ever had that (laughter), and then he calls me to say everything was okay, and all you feel is a sense of relief.

It was about two hours later I said, hey, by the way, was the gastroenterologist in-network or out-of-network? And his answer was, I don't know. And, I'm like, so here I am getting ready for the panel and I'm like, I'm the know it all guy here, right? And then my son didn't ask the right question. So, look, if that level of complexity didn't get to him, we have work to do.

I want to speak to the issue of this, the market being broken. And I just want to share with you some of the reality of emergency physicians and what we do. Every day, 15% of the people who I take care of, are still uninsured. 30% of the people I take care of have Medicare, 25% have Medicaid and 30% have commercial insurance.

For the folks who have no money, who are uninsured, we collect essentially zero. For folks who have Medicaid we collect about half of Medicare, maybe 75 to 80 dollars, on average, regardless of how sick they are. And when people start referencing numbers of, the markets broken, you have to -- and you want to compare it to other

providers -- look, an office-based provider, they choose the patients they want to see.

Loren's right, there is an elastic demand. Every day, the patients who feel they need to come, they should come. When those patients come, I take care of them. I don't ask them about their insurance, I don't challenge them about whether they can pay. Not only is it illegal, it's immoral and I would never do that. But we take care of who comes, and at night time, you know, particularly in a rural hospital, if no patients come to a rural ED overnight, but the physician is there and ready, who covers that cost? So there is a cost to having an emergency care system that's the safety net where somebody is there 24/7/365 and we take care of people regardless of their ability to pay.

That may not be a fair system the way it was set up, but it's the way the system is. I will offer to you that when people start talking about that there is gouging, or there is bad behavior, look, the system that we create legislatively, first of all, should fix it for everybody; both at the state level and at the Federal level. It should fix all of the problems, not just the certain group of providers, not just the in-network facilities and out-of-network providers, but it should really fix this for everyone. And, I will offer to you the only solution that does that right now is arbitration.

Rather than conjecture about what could happen, I think we should be scientific about this and look at the history of what has happened. New York State has the model that has now four years of a track record, and I will offer to you that the solutions there have been successful and you know why? Because, when was the last time you heard a story in the media about an out-of-network bill in New York State? I challenge you to find one.

The system of arbitration with reference points has worked. Charges have not gone up and for the five levels of emergency medicine some of the charges have actually started to come down over four years. The number of cases of arbitration eligible in New York State, in 2018, was 552; That is out of 3.2 million commercial ED visits, not the 8 million total visits but of 3.2 million visits with patients with commercial insurance, which is

about 40% of the New York State market, 552 cases of arbitration and the decisions were split about 50/50, which to me means that the system is working to do what we really want, which is to get plans and providers to be able to come back to the table and negotiate an in-network that they can live with.

We think that New York State has worked to do that. It has taken patients out of the middle, it's created -- for an analogy, if you are a bad bowler you pull up the bumper guards so that you can kind of bowl in those bumper guards, and as long as you charge and play within the bumper guards, you're going to be okay, and the patient's is out of the middle. And, for my company, I will tell you, I work for a company that is a larger national company, but in New York State, before that law went into place, we were only able to negotiate in network of five of the eight larger insurers. Once that system went in place, we are not in network with seven of eight. So we were able to make progress and get back to the table with an insurer and come to something that we really believe works.

So, from the provider community, I will tell you, we do care about patients, we are not really trying to take their money for no reason, and that there is a system, I think, of all the problems in healthcare, that are really, really, really complicated, this one is fixable. And, I think if we all work together as Stakeholders we can do that, so thank you.

MR. GINSBERG: Thank you, Claire.

MS. MCANDREW: Well, hi everyone, thanks so much, I'm Claire McAndrew with Families USA. Families USA is a consumer advocacy organization and we are focused on making sure that everyone has access to the best health and the best healthcare, regardless of who they are, where they live, so obviously surprise out-of-network bills are really an affront to our mission. And, while we focus our work primarily through policy advocacy, both at the national and the state level, by nature of the information we put out there, what we are talking about in the media, on our website, we get a lot of calls from the consumers who are facing surprise medical bills and so we hear a lot about just how big of a problem this is and we have been hearing about it since the '90s, when with the rise of

managed care, more and more consumers were confronting this issue.

Since that time we have been focused, state by state, year by year, on putting protections in place with policy makers and Stakeholders, and so I really agree with what we have been hearing all day, which is that those protections at the state level have been really meaningful, really important, but they are patchwork. They obviously leave out self-insured folks. Some states are trying to bring in the self-insured market through an opt-in but it's not really addressing that problem. The solutions at the state level are obviously slow, they are building momentum but to really get everyone covered across the country, we really believe a Federal solution is needed.

So, it's a really exciting time. We see a lot of opportunity. And we have two principles that I think echo a lot of what we have heard about all day for that Federal solution. The first, of course, is protecting the consumer from the balance bill itself, and the second is holding down underlying costs.

And so regarding our recommendations for how to achieve those principles, the first thing I want to talk about is the scope of the protection. I really agree with what we heard from Commissioner Altman in Pennsylvania about making sure that the scope is broad enough to include all situations where consumers are getting surprise bills. We worry that if we try to list off which providers are included in surprise bill protections, we are inevitably going to leave out situations where consumers are getting surprise bills because consumers don't just get surprise bills in facilities, they don't just get surprise bills in in-network facilities, and I think that Commissioner Altman's example about the mammograms where consumers were going to in-network OBGYNs that they have been going to for years and then all of a sudden, those OBGYNs were sending out mammograms to be read by out-of-network labs, that is a surprise bill that consumers deserve protection from, so we are urging policy makers to really think about full scope and legislation.

We also want to be sure that the bills are just never reaching the consumer. We heard earlier from Loren with an A, I'm going to change that up and call her Lauren B

because Loren Adler told me he's confused since his last name starts with an A (laughter), so Lauren B talked about the fact that when consumers have to take action to get protection, it doesn't happen. They don't know how to get that protection so we really want to ensure that to the greatest extent possible consumers don't actually have to do anything to get protection; they just don't get the surprise out-of-network bill. And along with that, that has to mean that consumers in a surprise bill situation are only charged the in-network rate for care, and that legislation is explicitly clear that the cost also accrued to the in-network deductible and the in-network out of pocket cap. I think the legislation has to be crystal clear about that so there is not debate.

Notices have come up a lot in this discussion and I think that actually relates to the scope discussion. There are some situations where clearly we just wouldn't need a notice and I think that relates to emergency care or in-network facilities, but going back to that dialogue about the scope of providers, there are some situations that maybe you wouldn't typically think of receiving a surprise bill where consumers are getting them. I think that relates to those typical doctor's offices.

I recently got what I consider a surprise bill. I've been going to the same dentist forever and then one day I got there and they were no longer in my network. My plan didn't tell me, my dentist didn't tell me. I really would have liked notice and without that notice, I don't think that the provider should have been able to balance bill me, so maybe we are not considering that a surprise bill in this dialogue but I think it should be considered one.

So, to discuss on the situation about underlying costs, this is a really interesting issue. It's been interesting from the consumer perspective. I have actually been told by a Stakeholder that I shouldn't care about the billing rate between the insurer and the provider because as long as the consumer is protected from actually getting that bill, like, that the consumer issue is solved. And that is frankly not true. If the rate between the insurer and the provider is not reasonable and not holding costs down, that is a consumer problem.

MR. GINSBERG: Mmm.

MS. MCANDREW: Consumers will see that in their premiums and they will see an impact on the network structure. And so Families USA does have some perspectives on addressing this problem. I will say that we think it can be addressed in different ways as long as the guardrails in the framework are set up correctly. And so the discussion earlier today from Loren Adler started with a discussion of different ways to address this including a benchmark rate. We think a benchmark rate could be a great way to go if that rate is set up appropriately.

We have been supportive of state bills that were set with 125% of Medicare as the rate. We also think that arbitration is worth exploring, again, if it has appropriate guardrails. Additionally, I think the ideas of trying to make sure that a facility has the same network status as all of the providers who practice there is a great idea. I do have questions about politically, if we can get that through in a timely manner. And another thing I would throw out there is does it have to be either or. I have heard all of these concerns about each method, arbitration, administratively burdensome, is it costly, could be get to the appropriate benchmark rate, could there be a combination where, sort of, low level bills are set with a benchmark rate and then, you know, the more high cost bills are sent at arbitration and they are compiled together so there is no administrative cost for each and every time you go through arbitration.

I guess my message overall is that I think this is a solvable problem and my biggest concern is that Stakeholders are going to fight over these details to a point where we miss the opportunity to pass legislation and that would be the biggest disservice, and frankly a harm to consumers. And so my plea to Stakeholders is make a good-faith effort, come to the table, and get this done because this window for consumers to make change is critical and consumers cannot wait any longer for protection.

The last thing I will say is that although I think a Federal solution is what's most needed now, I don't want to discount the activity at the states. I think it needs to keep

going while we move forward on Federal legislation and even potentially after, if states can continue to innovate above and beyond what we see at the Federal level. We are open to the idea that a state that has already solved this problem in a way that works for its market, with rigorous standards, could potentially keep that protection in a way that allows them to not be preempted by a Federal standard.

But I think you are hearing my message loud and clear, it's that Stakeholders need to come to the table at a good-faith effort now to work this out, not let payment rates be something that keeps legislation from passing this year. It needs to get done and Families USA is really eager to work with everyone to make that happen. Thank you.

MR. GINSBERG: Well, I would like to thank all of you for very thoughtful comments and one issue that kept coming up today, from Claire and the earlier panel, is the situation about balance surprise bills and beyond the situations that we are all focused on, ambulances, hospital based physicians, etc., and the question is on the one hand I don't think we want to apply these approaches to all physicians services, or all provider services, because that would a be radical change I don't think could get done. So the question is, is there anything that can be done in these little pockets, or is it something we just have to say, you know, well, we solved 95% of the problem, and if anyone has anything thoughts on that.

MS. THORNTON: Well, I can start; obviously I think our most pressing issues are sort of emergency care, what we call sort of unintentional care, so, if you are at an in-network provider, and then the ambulance issue that I mentioned. Some of these other scenarios, I think we need to think about consumer simplicity. We work together on this consumer guide for surprise billing, as Molly mentioned, and it think it was like 70 pages (laughter), so if you need a 70-page document to help people avoid surprise bills, you have a problem, right (laughter)?

So, I think where we can focus on, on those other scenarios, are some of these transparency tools so that you know, there is an education with providers that they are

educating their patients before that mammogram is delivered, or before -- this is the radiologist I'm going to use, let's work together to make sure that that is an in-network, there are other sort of tools that could be available.

So, I think I'm more of, sort of, let's start small, and look at where we can really have some meaningful action but think about other solutions that could address some of the other scenarios that have been mentioned.

DR. CIRILLO: I think, Paul, in critical situations, if you have one person who is responsible for a critical activity, and that person doesn't do that right, then there is a failure. So, I think there are multiple -- you know, there is a responsibility of the plans, of the facilities, of the providers and the patient, and I think if we all align on that, and we have a system of checks and balances where each of us is asking that question, hey is this going to be an in-network or out-of-network service, if we all take responsibility for that, I think we have a much greater chance of eliminating those situations where care is anticipated, it's scheduled -- all of those we really can fix. I think that's the easy one here, because that is one that has nothing to do with payment, it has to do with just the consumer, the patient, being able to make a really informed decision.

MS. MCANDREW: I guess I'll just say that to me transparency doesn't address consumers issues unless it's transparency with a stick, where is if consumers weren't given appropriate information in advance, they don't have to pay for care, for example, out-of-network, I gave my example of my own situation, I wasn't given advance notice, there was no transparency so I don't think I should have had to pay for an out of network service and there are some state laws that I think are doing a better job of getting at some of the issues I mentioned, for example, in New Jersey, it's very clear that if an in-network provider uses the services of an out-of-network provider or facility such as an out-of-network lab to read results, that surprise billing protection is applicable.

And so, I will say that, you can probably tell by my remarks, my perspective on this as someone sort of working it from an advocacy angle, is to get something done

without falling on the sword over issues as long as we get to maybe 95%. At the same time, I think it is short sighted to try to assert that surprise bills happen mostly or only in these certain facilities when really, we are hearing from Commissioners that they are getting massive complaints about things like in-network providers in a doctor's office setting, not a facility, sending labs out-of-network. And so, I don't think we should see this as, sort of, a construct that applies in a certain setting and policy must address it that way. I think we should be moving towards trying to address it in, frankly, all care settings.

MR. GINSBERG: Another question and then we will go to the audience; you know, the growth of staffing companies, particularly in some of these specialties in recent years, has that been a positive or a negative for the issues of surprise billing.

MS. SMITH: Let me just start, maybe I'm going to start not by answering specifically about surprise billing but I will say that there are some places in the United States, particularly in rural areas where hospitals have a very hard time recruiting for key critical staff and in those instances, it has been very positive -- and it's not just rural areas, but I think that is the prime example, where it has been very positive to have partners who are able to bring that expertise into an area that otherwise can't recruit for it. So, your question is very specific but I would encourage us to think more broadly about the pros and cons about these kinds of constructs beyond just that.

MR. GINSBERG: Yes.

MS. THORNTON: If I may, I think we have seen some data, I think the Zack Cooper analysis that was cited in the Brookings report, does sort of show the impact when you have consolidation and certain staffing companies coming into a particular region and what that does for healthcare prices, and also how it does potentially drive up the rate of certain billed services. So, I certainly think, sort of the question earlier about there is a loop hole out there, sort of, money is sort of following the loop hole and a lot of times this is happening in states that have very specific surprise billing type laws. Texas, for example, where there is reference to billed charges, and so the companies are sort of following

protections and I think that is why our member plans in Texas are really actively advocating for some changes to the Texas law. And we are sort of seeing some of the ramifications of that in that state.

MR. CIRILLO: I would just say that there has been consolidation in many aspects of the healthcare market on the facility hospital side, on the insurance side, and to some degree on the provider side. I don't know that that is a good or bad thing. I think that really is dependent upon how those individual companies and entities operate.

In Zack Cooper's work, Zack looked at one insurance company and he looked at two provider companies. I don't know that that is a valid sampling of the entire market, and I would say if we are really going to make judgments about either side, we should really look at the whole market.

The company I work for, 95% of the patients we see are in-network. So, not every company takes the same approach, not every insurer takes the same approach, and I think it's about how does that local market, and again, I would say the rural hospital in Montana, you know, might use a contract group like ours, or they might contract with a small group of providers who want to stay in rural Montana. The contracting dynamics in that situation are so different that doing a one size fits all approach really is not fair to either side. And I think that is the unintended consequence, is you do have markets where the systems works, the providers work with the plans, and really this is okay. It's not perfect in every place, but I think we have to be careful about generalizing about whether consolidation is good or bad because it really depends upon that market.

MR. GINSBERG: Thank you. Let's have questions from the audience.

QUESTIONER: Just real quick, on the scope of providers, one thing that strikes me is an issue that sort of relates to the notice question because there is a sense that if, for good reason, the principal provider or the patient want to go out-of-network, they should be allowed to and so to the extent you cover all situations of out-of-network billing, you've got to provide a way to opt into that, but if you do that then you've got to decide, do

we hand this piece of paper to everybody who goes out-of-network or only to select groups. And so, I'm just wondering if there are any solutions to that problem or if for one reason, to stay more restricted, is to not have to deal with the opt-in problem.

MS. SMITH: I mean, I would say this; I think a lot of states have sort of grappled with this, sort of, in what type of scenarios do the state laws sort of apply. And so I think we can learn a lot from the states. I think that the challenge here, these are often providers and I think Loren mentioned this, where you don't say, oh I want a great anesthesiologist today, right? You're not necessarily making a choice, you are not searching a provider directory for these providers and I think that is why we are seeing some of these distortions but I think there would be some operational challenges in terms of how do you make sure that the provider and all of the parties involved, sort of, understand, is this protected by the surprise bill legislation or is this outside of the scope and I think this gets into some really technical operational issues that we really have to think very carefully about as we are implementing and designing it.

MS. MCANDREW: And I agree that there are certainly challenges to making this a streamline effort that is not an extreme paperwork burden. There are laws, I think even in the District of Columbia and beyond where there are requirements that practices have to provide good faith notice, if you are going to be leaving a network or issuers have to provide notice that there is contract termination within 30 days or 60 days.

And so there is also sort of that element that if you are terminating contracts, how do you notify patients of the change and if that notice doesn't get out there, is there a period under which there is some responsibility for in-network payment, to the question of more broadly, is do you need to have some sort of understanding transparently to the patient to sort of sign on the dotted line, that you know, this does not accept my insurance.

I think that's an open question and I don't know that I would rule it out at this point, but I think that this is an area for future policy making to make sure that there is

transparency there.

MR. GINSBERG: Yes, the gentleman in the dark sweater.

QUESTIONER: Hi, thank you so much for your statements today.

MR. GINSBERG: Can you please identify yourself please.

QUESTIONER: Yes, my name is Steve Chaz.

MR. GINSBERG: Okay.

QUESTIONER: Okay, hi, two scenarios. The first one is at a recent hospital stay, I did my due diligence, I identified that the surgeon was in-network and even spoke to their office and asked them to make sure the anesthesiologist was in-network and that the facility was in-network. But during the arc of that hospital stay, I had a parade of white coats come to see me at the bedside who were on the teams of let's say the surgeon hospital list or other anesthesiologists coming in to see me and would eventually charge me.

Their visits with me would sometimes be at the doorway, hey, how are you and they'd walk on and that's a $475 charge. Someone else would come and say, I'm just checking to see you're all right, I'd say I am, and they'd walk on, another charge for that. So, there is an intersection between surprise billing and unethical billing that hasn't really come up and this is something that I have observed on two or three recent, sadly, experiences at hospitals. That is scenario one.

Scenario two is even doing the due diligence of investigating doctors in directories, or practitioners in directors, whatever they may be, just because they are in the directory doesn't mean you will be covered for them. And even after multiple phone calls to the doctor's office or practitioner's office, as well as to the insurance company I later found out that unless they are insured at a particular address, that if you see them in their other office where they say, he's not free at that office but at this office, you know 10 blocks away he can see you, that all of sudden he or she is out-of-network.

Please address these overwhelming burdens to consumers and how to navigate that successfully.

MS. THORNTON:

MR. GINSBERG: Thank you.

MS. THORNTON: I could start with the finer directory one as that makes the most sense for me as from a health plan, so yes, I think that the importance of accurate, reliable information in a health plan provider directory is really important. I would say that our plans are working hard to try to get the best most accurate up to date data possible, but I do know sometimes there are gaps and challenges with that. We also rely on the practitioners responding and letting us know when they move and when they change, so it certainly is a two-way street in terms of insuring that the provider directories are accurate, but I definitely agree that that is certainly welcome discussion on how do we improve the accuracy of those directories, and Molly, do you want to talk about the other one, I thought you would.

MS. SMITH: Yeah, absolutely, so I think what you are really referring to are consulting physicians who come by and -- you know, again, I think that in our definition of when a surprise medical bill could occur, that fits the bill so when we say that we do not believe that a patient should be balance billed beyond their network offering, it would include the scenario that you've just described.

Now, I can't really speak to that sort of physician, and you are in an emergency visit, these aren't emergency physicians who are stopping by, so I don't know to what extent you may want to comment. We don't have those physicians specialties represented here to sort of explain that process, or what's happening, but just from our perspective, from the facility perspective, we would like to protect patients in those situations.

MR. GINSBERG: Thanks, gentleman with the white hair (laughter). It could be worse.

QUESTIONER: Hey, I've got some right (laughter)?

MR. GINSBERG: It could be worse. There you go (laughter).

QUESTIONER: My name is John Hennessey. I work with a firm, we help health plans and patients with these high balance bills and I think you are correct, it's a rare incidence but when it's your bill, it's a really big deal. Sometimes in healthcare we get very caught up in, we're special, we're different, but in our view a lot of what we see is basically open price term contracts, which are dealt with in the uniform commercial code that the purchaser in the case where there is not a pre-agreed price, is do a reasonable price. And so one of the things we do is work on that. The challenge is, how do you get to a prompt resolution, rapid dispute resolution, and we appreciate that there is some support for arbitration and we get that it's difficult, but if we are not doing arbitration how do we get to prompt dispute resolutions so people aren't sitting with these house bills, because some of them are that big, for 6, 8, 12, 19 months and worried about their credit.

So, we like arbitration but we are interested in what other models get us to an answer quickly because I think that is probably the most important thing, it's so people can move on. I think it's incredibly difficult to be a decent healthcare consumer. It's tough to figure out what TV you're going to buy when you see a wall of TVs, in healthcare it's even tougher. So, any thoughts on if arbitration isn't the right answer, what is something that gets us to yes or no as fast as we can.

MR. CIRILLO: I would just point out that in New York State, it has a 30 day -- it's a 30 day process and it's done by document submission, so it is not your traditional arbitration process where people go through a long process and go and person, so basically what happens is a claim is filed, the New York State Department of Finance issues an IDR Number to that. If the claim is deemed to be eligible, and many of them are not eligible because they are not really an out-of-network situation, documents are submitted by both sides and the arbiters review those and a decision is made within 30 days.

So, it's not the traditional arbitration process and so we think, again, that there is a lot about what New York State has done that I'm not sure how forward thinking they were and how many questions they were answering, but we think they have set up a

good process that has worked to really take the patient out of the middle, it's not cumbersome, it's not overbearing; we got verbal, and I know verbal doesn't count to anything in the world but, from New York State, one of the deputy commissioners, that they -- there was no additional administrative cost; that they assign this to people within their division. The cases get assigned to the arbiters and the cases get ruled.

And so, we think there is a lot to look at there. No answer is perfect but we think there's a lot about that system because it covers all of the providers, it covers all of those scenarios. We think that they may have really found a sweet spot there.

MS. THORNTON: One of the good lessons we can look at is under the Affordable Care Act, there is something called the Greatest of Three Rule. So for emergency room care it does provide some sort of payment benchmark in which plans have to follow when there is an out-of-network emergency that a consumer faces. And what this does is it does allow us to pay the claim to the consumer very quickly and have a good understanding from, you know, rate setting and actuarial perspective, what those costs are going to be and be able to automate that in the claims process so we are not, sort of, just kicking it out of the automated process to look as some of this more manual process about arbitration. That's something that has been in the market since 2014, it's a good sort of something to look at as we are thinking about this.

MS. MCANDREW: So I think to, sort of, maybe summarize these two comments, with arbitration, and we mentioned that we are open to multiple models, arbitration from our perspective could work with the right guardrails and one of those guardrails would be timelines, and do your point on arbitration, it actually takes longer than some of the other options on the table because you have to go through a process, and that is what I think Jeanette is referring to.

So, from our perspective at Families is if you are going to have an arbitration process, we'd want to make sure it was time-limited and that it is binding. So there is no going back and revisiting it. But, to Jeanette's point, if you had a benchmark rate

saying, this is the rate we use in these situations, that rate is what is used to pay the insurer to the provider, and we have mentioned 125% of Medicare as an example. You don't even have to go through a negotiation, it's just, this is the rate, it's paid, and that could happen even faster. And so we are open to both if done right but I think, you know, that is to address that question about timeliness.

MS. SMITH: Could I just though, I'll be very quick, just about some of the comments about the New York model. So, as I mentioned before very rarely do facilities and health plans get into these, sort of, protracted disputes, so they have not had to really rely on the New York arbitration model, it's really rather been the physicians, however, we have heard very positive things from our members in New York State in particular. Again, they are not necessarily going through the process but the doctors who may be working in their facilities who do go through the process, or even more so, what is more frequent, it just sort of avoids the need. It really creates an incentive for the physicians and the plans to work it out before it even gets there.

So I will just say to underscore the comments that he made, that has also been the experience of hospitals in New York.

MR. CIRILLO: And the New York State Health Foundation issued a report at the end of February about, hey, where are we, is the process working? And they reviewed their system and they gave themselves a fairly favorable report on the process. The two areas that they said that they wanted to work more were network adequacy and transparency. So, I would tell you I think that is a good report if you want to get a sense of where New York State feels they are and how the process has worked for patients.

MR. GINSBERG: Okay and we have time for one more question. Yes, Sir.

QUESTIONER: Just quickly on the dispute, we heard a lot of talk about these dispute resolution processes like arbitration but I think you have to take a step back a second, and you'll probably know this having dealt with your dentist, for a consumer to call the billing office of a hospital or to call their insurance company or to call their doctor's billing

facility, it is an incredible difficult experience.

There is typically a lot of finger pointing, the doctor says you have to talk to this one, the hospital says you have to talk to that one, nobody seems to be saying, if you are unhappy about this, other than you can write a letter, here is what you can do. So consumers are left not having any idea how to navigate this. Their insurance company will tell them, well this is the contract rate, or under your plan, this is how it works, you have to pay the balance bill, period.

And then, of course, call centers are set up so that you can't get to a business person or a higher-level person so you've got these barriers to utilizing things like arbitration that are not -- arbitration is not going to be affective if people are not able to navigate the system easily.

MS. SMITH: So, I could not agree with you more and we definitely different approaches to dispute resolution, one that has to be patient initiated and other where if you ban balance billing it's really the provider who initiates the process. The patient may be completely unaware at that point that there is even kind of a behind the scenes negotiation happening, because they have been protected. We think it's really important that you look at the latter rather than the former, you know, because, I think we've seen in Texas, for instance, and I think there's a lot more awareness among consumers now, that that process exists, but when they have to initiate there is a long lead time where you may patients who are paying bills that they actually don't need to pay that could go under the process, so I think that I completely hear your concern but this is a design feature that has been solved for -- and can be solved for if we implement something like that at the Federal level.

MS. MCANDREW: The point is those bills don't come to you anymore.

MR. CIRILLO: Right.

MS. MCANDREW: The bills are banned, so you're only now getting, in these situations, you the consumer, only gets the bill for the in-network cost and it's happening behind the scenes that the insurer and the provider work it out.

QUESTIONER: It does apply to what this gentleman was talking about fly-by --

MS. MCANDREW: No, in the future, if we pass this legislation he no longer gets those bills.

QUESTIONER: (Inaudible) issue.

MS. MCANDREW: He no longer gets those bills, that's --

MR. GINSBERG: I can't fix the -- okay, I think w

MS. SMITH: I think those --

MR. GINSBERG: Okay, you know let's --

MS. SMITH: Oh, sorry.

MR. GINSBERG: I think we've run out of time and I want to thank the panel for a marvelous job and thank the Brookings staff for making this conference possible and the Laura and John Arnold Foundation for their support of our surprise billing project. Thank you very much.

MS. MCANDREW: Thank you.

MS. SMITH: Thank you (applause).

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