

**Out-of-network involuntary medical care:
An analysis of emergency care provisions of the Patient
Protection and Affordable Care Act**

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I. Introduction

The Patient Protection and Affordable Care Act (PACA) was enacted in March, 2010.² Included among the many provisions of this sweeping healthcare reform bill are new requirements that health plans offering benefits for emergency services must meet.³ As described in more detail herein, the new requirements prohibit the use of preauthorization requirements, regulate cost-sharing provisions for out-of-network emergency care, and establish minimum health plan reimbursement levels to providers for out-of-network emergency care. While PACA specifies the new requirements, the Act does not specify how plans must meet those conditions. On June 28, 2010, the Secretary of Health and Human Services (HHS) published Interim Final Rules (IFR) that describe how HHS will implement the out-of-network emergency service provisions.⁴

I was asked by America's Health Insurance Plans (AHIP) to examine the provisions related to out-of-network emergency services and the corresponding sections of the IFR, and to provide an economic analysis of the likely consequences of the new provisions and rules. In my review and analysis, I explore the following areas: (1) important respects in which the new provisions are likely to fall short of the goal of protecting patients who receive out-of-network emergency service from unreasonably high costs; (2) various practical complications apparently not contemplated in the IFR; (3) modifications or additions to the IFR that would result in fewer complications or unintended negative consequences; and (4) likely consequences of the rules in the market for emergency medical services, with a particular emphasis on factors that may, to the detriment of health plan enrollees, reduce emergency providers' incentives to join health plans' provider networks. I also offer a set of general principles for reforming patient protections, both in the context of out-of-network emergency services and with respect to other types of "involuntary" out-of-network use of medical services (e.g., treatment, without prior patient knowledge, by out-of-network anesthesiologists at in-network hospitals).⁵

The central conclusions of this analysis are as follows:⁶

² Public Law 111-148.

³ The requirements are in a new Section of the Public Health Service (PHS) Act—Section 2719A.

⁴ See *Federal Register*, June 28, 2010, pp. 37188-37241.

⁵ Involuntary situations include care received from other out-of-network physicians at in-network hospitals, non-emergency out-of-network care to address an immediate medical situation received during travel to areas without network coverage (other than travel for the purpose of obtaining such care), and care to cover a specialized service when that service is not available from the plan's in-network providers.

⁶ This paper does not purport to offer a comprehensive analysis of all aspects of PACA that might impact emergency

1. Neither PACA nor the corresponding IFR offer meaningful patient protections against balance billing by out-of-network emergency service providers.

- The relevant section of PACA does not mention rate regulation. Nevertheless, the IFR propose that HHS regulate, via price floors, the amounts health plans pay for out-of-network emergency services.⁷ Insofar as the goal of the proposed rate regulation is to protect patients from the substantial risks they face from balance billing for these and other “involuntary” medical services, the IFR are likely to fall well short of the mark. Setting a floor on the amount that health plans pay providers does not prevent providers from balance billing patients.
- If the goal is to protect patients, alternative approaches, including regulation of balanced billing itself, would likely do so more directly and effectively—to the extent that any kind of price regulation is deemed necessary.

2. The rate regulations in the IFR arbitrarily define “reasonable” reimbursement.

- The IFR define a payment for out-of-network emergency service as reasonable if it is at least as large as the greater of (i) the plan’s “usual, customary, and reasonable” rate as normally determined, (ii) the median amount the plan pays to in-network providers for the same service, and (iii) the amount Medicare would pay for the same service.
- The IFR offer no justification for concluding that lower rates are unreasonable. And no justification is given for concluding that only the *greatest* of these three rates is reasonable. Puzzlingly, the proposed definition would label Medicare rates—which are set administratively by the Centers for Medicare and Medicaid Services, a division of HHS—as not reasonable under many circumstances, and may also treat full payment of billed charges as unreasonable.

3. The rate regulations require calculation of a median in-network rate for each plan; this proposal suffers from numerous conceptual and practical flaws. Use of this formula may have unintended effects.

services or other involuntary care. Rather the analysis is confined to Section 2719A and the corresponding sections of the IFR. The conclusions should therefore be interpreted as describing incremental effects of this Section and corresponding IFR against the backdrop of broader changes likely to occur due to healthcare reform.

⁷ As a general matter, rate regulation can introduce substantial distortions and inefficiencies into markets. For this reason, economists typically endorse such regulations only as a measure of last resort.

- For example, the formula, which does not specify any geographic adjustments, may create a windfall for providers in low cost areas.
 - Additionally, because the formula is only applicable to out-of-network providers, it may induce some providers to leave networks, to the detriment of consumers.
 - This provision may reveal competitively sensitive information; in particular, individual out-of-network providers may learn how their own rates compare to the median rates paid to their rivals.⁸
4. **By increasing the profitability of out-of-network emergency service provision relative to in-network provision, the IFR provisions undermine some emergency service providers' incentives to participate in health plan networks.** If emergency service providers leave health plan networks, consumers will be exposed to more, not less, financial risk (in the form of potentially very large balance bills) when they require out-of-network emergency care.⁹

I.A. Background

Because providers make health plan network participation decisions based on comparing benefits from serving a plan's members on an out-of-network basis relative to an in-network basis, any regulation of out-of-network rates or compensation may also lead to unintended consequences for network participation and for in-network rates. As an example of this principle, the proposed IFR determination of "reasonable" plan reimbursement rates for out-of-network emergency services is likely to reduce the relative attractiveness of network participation for some emergency service providers, possibly leading to reduced provider participation, or higher in-network rates. Either way, consumers are likely to lose.

The linkage between out-of-network compensation, plan participation decisions, and in-network rates arise from market forces at work when plans negotiate contracts with providers. Health insurance plans and managed care organizations (MCOs) assemble networks of providers who agree to treat their enrollees on pre-specified terms. When a patient uses an in-network provider to obtain covered services, the amount of provider compensation and cost sharing between the patient and the health

⁸ Disclosure of competitively sensitive information to competitors has the potential to facilitate collusion, as recognized by the U.S. Department of Justice and the Federal Trade Commission. See *Antitrust Guidelines for Collaborations Among Competitors*, Issued by the Federal Trade Commission and the U.S. Department of Justice, April 2000, p 6. Available at <http://www.ftc.gov/os/2000/04/ftcdojguidelines.pdf>.

⁹ Another possibility is that health plans increase in-network rates to such providers in order to keep them in-network. In this case, consumers still pay more, but they will do so in the form of higher premiums or greater cost sharing.

plan are determined in advance through mutually-agreed contractual terms. Pre-negotiation of the relevant prices and payments by the health insurance plan on behalf of the patient gives all parties greater certainty about costs and benefits, minimizes risks associated with providing or obtaining services, and provides a framework for controlling costs and improving quality (e.g., through plan review of provider credentialing and plan programs aligning payment with quality improvement processes).¹⁰ Thus, use of in-network services greatly enhances the efficiency and value of health care delivery and is common practice, as recognized in PACA.¹¹

However, in certain “involuntary” situations, a patient may—out of necessity or without the patient’s knowledge—use out-of-network providers.¹² Typically, in these situations there is less certainty because there is no pre-negotiation of the relevant prices and payments. Plans provide enrollees with information on their cost-sharing obligations in out-of-network circumstances, and may disclose their methodology for reimbursing out-of-network providers. But in the absence of some prior understanding of the amount of the provider’s bill, there is tremendous uncertainty as to what the patient ultimately will owe, because the patient often is responsible for the provider’s charges to the extent that these exceed the plan’s reimbursement. The practice of providers billing patients for charges that exceed the plan’s reimbursement is known as “balance billing.” Some states have prohibited “balance billing” by out-of-network providers, including in some “involuntary” situations.¹³ In the remainder of states and situations, however, patients’ obligations, typically based on the provider’s charges, are made known to the patient only after service is rendered.

Providers’ charges are not negotiated and often greatly exceed the plan’s allowed reimbursement, leaving the patient subject to an uncertain and possibly large “balance bill” for services when—as in an emergency—the patient lacks the time or the knowledge to investigate in advance the network status or rates charged by particular providers. Patients, who likely are unaware of the size of their potential financial obligation when they obtain services, may suffer sticker shock and have difficulty paying undiscounted charges, which are sometimes many multiples of Medicare rates. In addition to the uncertainty and high costs for consumers, providers and plans face costs and uncertainties related to involuntary out-of-network care. Providers may incur costs to collect bills and face possible write-

¹⁰ Benefits from competition between providers due to contracting between health plans and providers are well recognized. See, G. Vistnes, “Hospitals, Mergers, and Two-Stage Competition,” *Antitrust Law Journal*, 671-692, vol 67, 2000.

¹¹ For example, selective contracting and network formation by MCOs has produced meaningful reductions in private healthcare costs. See, D. Dranove, R. Lindrooth, W. D. White, and J. Zwanziger, “Is the impact of managed care on hospital prices decreasing?,” *Journal of Health Economics* 27 (2008) 362–376.

¹² The IFR report that approximately 8% of emergency room visits by members of plans associated with the Blue Cross Blue Shield Association were out-of-network. See *Federal Register*, June 28, 2010, p. 37213.

¹³ See J. Hoadley, K. Lucia, and S. Schwartz, *Unexpected Charges: What States Are Doing About Balanced Billing*, California Healthcare Foundation, April 2009. Available at <http://www.chcf.org/~media/Files/PDF/U/UnexpectedChargesStatesAndBalanceBilling.pdf>.

offs of charges, leading to substantial uncertainty about how much and whether they will be paid. Plans face potential provider challenges over the amounts plans pay, as well as potential member concerns about large financial exposure to out-of-network provider bills. Simply put, out-of-network use for emergency and other involuntary care raises risks for all parties and contributes to higher costs and inefficiencies in the healthcare system.

I.B. Some principles for reform of patient protections

Since federal rules related to out-of-network use of emergency services fall against a backdrop of ongoing concern about the cost of out-of-network services in various “involuntary” situations, the IFR provide an important opportunity to consider what the appropriate rules should be to govern such situations or, at least, what principles should guide such rules.

This paper considers various principles that new regulations should respect, where possible. These include:

- Patient Protection. Patients should be assured access to emergency services as they are needed. However, to the greatest extent possible, patients should also be protected from large and uncertain costs arising from their need for emergency care and other involuntary use of services, including large costs arising from balance billing.
- Support for healthcare networks. Provider participation in health plan networks provides an effective mechanism for plans and providers to work cooperatively, both to improve efficiency and to improve quality of care (e.g., through plan review of provider credentialing and programs that align payment with the quality and efficiency of care). Patients benefit when providers join health plan networks because this leads to negotiation of mutually acceptable reimbursement rates in advance of the need for services and because it eliminates the possibility of balance billing. Therefore, any changes in reimbursement for out-of-network coverage should preserve the incentives for providers to participate in health plan networks.
- Feasibility. Any new rule should be workable, with private parties having access to sufficient information at reasonable cost to ensure compliance.
- Appropriate provider compensation. Providers must be assured adequate compensation for their services, but should not be permitted to collect unreasonably large charges from health

plans or patients when a patient facing a health emergency appropriately uses an out-of-network provider.

- Appropriate respect for private decisions. To the greatest extent possible, while taking account of other policy goals, rules should be designed to interfere as little as possible in the relationship between patients, health plans, and providers. In particular, regulatory solutions should be used only to solve substantial problems, and only when market solutions are proven to be inadequate. If a policy decision is enacted that replaces market interactions with regulation, the displacement should be narrowly targeted to achieve the policy goals in a manner that causes the fewest unintended consequences and creates the greatest benefit for consumers.

As discussed below, while the IFR follow some of these principles, they do not follow others as fully as they could; the IFR may also result in a number of unintended consequences at odds with these principles.

II. “Coverage of emergency services” in PACA

PACA (Public Law 111-148) adds a new Section 2719A to the Public Health Service (PHS) Act that imposes certain requirements on health plans offering any benefits for emergency services.

- Plans must cover emergency services without prior authorization.
- Plans cannot impose additional limitations or conditions on benefits provided for out-of-network emergency services, beyond those applying to in-network emergency services.
- A beneficiary’s cost sharing obligation, when specified as a copayment or coinsurance rate, must be the same for in-network and out-of-network emergency services.
- Other forms of cost sharing (e.g., deductibles) can be different for out-of-network and in-network emergency services, but only to the extent that the out-of-network provisions apply to all out-of-network services, and not to emergency services alone.

Section 2719A does not (1) address the method by which health plans should establish the allowed amount subject to cost-sharing when emergency services are provided out of network, (2) impose any

restrictions on the charges billed by providers, or (3) restrict balance billing by out-of-network providers.¹⁴

III. HHS's Interim Final Rules implementing Section 2719A

III.A. Requirement for “reasonable” reimbursement

Although Section 2719A does not mention any regulation of provider reimbursement, the IFR specify “reasonable” provider reimbursement requirements for out-of-network emergency services and deem reimbursement “reasonable” if it meets certain conditions.¹⁵ The stated justification for this extension in scope is that lower reimbursement would “defeat the purposes of the protections in the statute.” As the subsequent discussion in the IFR makes clear, protecting patients against unreasonable balance billing is one of these purposes.

The IFR deem reimbursement reasonable if it is the greatest of three alternative measures:

1. The median amount negotiated by the health plan with in-network providers for the emergency service provided¹⁶;
2. The amount for the emergency services calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary and reasonable) but substituting the in-network cost-sharing provisions for the out-of-network cost-sharing provisions;¹⁷ or
3. The amount that would be paid under Medicare for the emergency service.

These provisions, in effect, impose a price floor on the amount that health plans can pay providers of out-of-network emergency service. They do not, however, restrict the amount that providers can charge or balance bill patients.

¹⁴ As noted before, particular state laws might, however, restrict such balance billing.

¹⁵ *Federal Register*, June 28, 2010, pp 37194-95.

¹⁶ The median is the middle reimbursement when contracts are ordered by their reimbursement levels. Therefore half of the contracts specify a greater amount, and half specify a lesser amount. The IFR specify that it is the median of the prices negotiated with different in-network providers (and thus, not the median of actual in-network reimbursement payments made) that should be used to implement this provision.

¹⁷ Under Section 2719A these cost sharing provisions should be the same.

III.B. Assessment of the “reasonable reimbursement” rule

The proposed rules do not indicate the standard used for defining reasonable reimbursement, or why lower reimbursements would be unreasonable.¹⁸ The remainder of this section identifies a number of conceptual and practical problems with the proposed regulation and standard. Of particular importance, the greatest financial risk to patients in out-of-network care settings almost certainly comes from balance billing obligations arising from unexpected and unreasonable charges. As the discussion in this section explains, the proposed regulations of plan reimbursement to providers do not address this issue and so may provide little protection to patients.

III.B.1. The IFR do not demonstrate why regulation of reimbursements is necessary

The proposed rules do not offer a compelling explanation for why regulation of “reasonable reimbursement” is necessary for implementing the patient protections of Section 2719A. The IFR contemplate a hypothetical situation in which a health plan pays an “unreasonably low amount” to a provider “even while limiting the coinsurance or copayment associated with that amount to in-network amounts.”¹⁹ In fact, this would have no impact on fixed copayments. For patients with coinsurance that is specified as a percentage of the allowed amount, cost-sharing would be lower, not higher. The only mechanism by which unreasonably low payments by a health plan could expose the patient to additional out-of-pocket costs is through increased balance billing by the provider.²⁰

Therefore this hypothetical possibility would circumvent the patient protections of Section 2719A (as claimed in the IFR) only because the IFR do not include direct protection from unreasonable balance billing. Regulation of the health plan’s reimbursement is at best an indirect method for protecting the patient from unreasonable balance billing, as discussed further in Section III.C. Clearly, the most direct way to protect patients from unreasonable balance billing is to regulate balance billing, as some states have already done.

¹⁸ The rules specify that a reimbursement is reasonable if it meets a certain minimum, but does not explicitly state that lower reimbursements are unreasonable. This paper assumes that the latter is implied.

¹⁹ *Federal Register*, June 28, 2010, p. 37194.

²⁰ For example, if the provider charges \$100 and the plan pays \$60, the patient will be exposed to a potential balance bill of \$40. If the plan reduced its payment to \$45, the patient could face a balance bill of \$55.

III.B.2. Possible complications and unintended consequences of regulating out-of-network reimbursement

Economists generally favor market solutions over the type of price regulation proposed by the IFR. This is because establishing appropriate prices is a difficult regulatory problem and because price controls—even when initially implemented using efficient, objective standards—tend to become inefficient and ineffective at achieving the intended goals of regulation as market conditions change.²¹ Therefore, economists typically view price regulation as, at best, a last-resort solution to failures of the marketplace. Rarely is price regulation the best solution to a consumer protection issue.

To the extent that unexpectedly low plan reimbursement of providers is a potential problem, it may be most appropriate to address that problem through other means. Health plans are generally obligated to provide out-of-network reimbursement to providers in accordance with the terms of their contracts with groups or individual members. Often these contracts specify the method to be used for determining reimbursement. Promoting greater clarity, specificity, and transparency of contractual terms between plans and groups or members relating to the plan's reimbursement obligations, enhancing education of plan members about these terms, and improving mechanisms for addressing member grievances in this area should largely eliminate any unexpectedly low reimbursement. As explained further below, direct regulation of reimbursement is a comparatively blunt instrument for solving potential underpayment issues, is likely to have unintended consequences, and interferes in the contractual relationship between plans and their members.

The IFR appear to determine that regulating reimbursement to out-of-network providers is necessary to limit the financial burden on patients in emergency situations. However, because the greatest financial risk to patients in out-of-network care settings almost certainly comes from balance billing obligations arising from unexpected and unreasonable charges, regulating plan reimbursement to providers is unlikely to offer meaningful protection to patients. Furthermore, as explained below, regulation of prices in out-of-network settings may lead to unintended consequences by making it more difficult for plans and providers to reach acceptable terms for in-network reimbursement, thus undermining the substantial benefits to all parties that flow from network participation.

These risks could be lessened, while still protecting consumers against some unexpected out-of-network charges, through suitable disclosure requirements when care is offered on an out-of-network basis. However, in emergencies and other situations involving truly involuntary care, disclosure will

²¹ Notably, while the IFR provide a rule to define “reasonable” reimbursement, they do not offer any objective standard for determining whether the rule is itself appropriate, and thus offer no basis for deciding whether the rule fulfills any broader policy objectives, such as economic efficiency or fairness.

not mitigate the financial risk to patients.²² Therefore, the Secretary of HHS may deem price regulation appropriate in these settings, despite the risk of substantial unintended effects on network participation and network pricing. But to the extent that out-of-network price regulation is deemed appropriate, despite these risks, regulating balance billing would be both a more direct and more effective approach to protecting consumers from unanticipated or unreasonable costs. Indeed, should the Secretary determine that price regulation is required, prohibiting providers from collecting unreasonable charges would be an appropriate complement to the prohibition on unreasonable plan reimbursement proposed in the IFR.

Assuming the Secretary does decide to regulate prices, certain principles should guide the effort in order to maximize potential benefits and minimize the possible harm from unintended consequences. Such regulation should provide market participants with increased clarity by setting forth principles, if not completely objective standards, for determining reasonable prices. Further, the definition of reasonable should be sufficiently flexible and specify mechanisms for making adjustments in response to market changes or other variations in market conditions. For example, a standard that fails to adjust to significant market changes or regional differences in the supply, cost, or quality of healthcare services is likely to create serious distortions and to hinder efficient delivery of those services.

III.B.3. Lower reimbursement may also be reasonable

The proposed standard does not offer any reasons why lower levels of reimbursement are unreasonable. The requirement that reimbursement equal the greatest of the three measures appears to be arbitrary, and a case could be made that the lowest of the three measures would be a superior standard. For example, the proposed rule would label HHS' own Medicare reimbursement rates as unreasonable in any situation where Medicare rates are below either of the other two measures. Using the lowest of the three measures would avoid this contradictory outcome.

The IFR's definition of "reasonable" makes no reference to actual charges and thus leaves open the possibility that reimbursement could be found unreasonable, even if it covers actual charges. This could open the door to litigation producing no benefit to consumers, or otherwise, if providers retroactively determined that their own charges were below the IFR's "reasonable" reimbursement standard.

²² Furthermore, requiring disclosure in an emergency setting might be impractical, particularly when the need for treatment is immediate.

III.B.4. Potential problems with the median in-network rate calculation

The median calculation proposed in the IFR raises potential problems in several important respects:

- The proposed median treats all in-network providers equally regardless of the providers' locations. Therefore, the median could be greater than the usual, customary, and reasonable (UCR) amount in locations with low costs and less than the UCR amount in locations with higher costs. Requiring reimbursement at least as high as the median, and with no geographic adjustment, would have the effect of increasing guaranteed out-of-network reimbursement in locations where the UCR amount is below the in-network median, potentially creating a windfall to providers, and an increase in medical costs to plans in locations where actual costs of providing the service are low. Furthermore, because these windfalls would be available only to out-of-network providers, their creation would provide incentives for in-network providers to leave plan networks or to negotiate increases in their in-network rates.
- The use of the median fails to account for variation in rates related to differences in costs or quality of care between providers. Nor does it account for creative risk-sharing arrangements between plans and in-network providers that aim to control costs and increase quality. Such programs are increasingly in use, including by federal programs, and form a key part of the reforms set forth in PACA. Indeed, PACA establishes the Center for Medicare and Medicaid Innovation, which is designed to test models that promote care coordination and feature risk-based comprehensive payments that transition away from fee-for-service based reimbursement.²³ Due to the IFR's use of a one-size-fits-all measure of in-network rates, out-of-network providers offering poor quality of care and poor cost control could gain an entitlement to in-network rates offered to providers who offer exceptional quality of care.
- The median calculation described in the IFR does not account for differences in patient volume from one provider to another. For example, if the in-network provider with the lowest reimbursement rate also accounts for 98% of a plan's in-network emergency services utilization, with two other providers each seeing only 1% of patients at a much higher rate, the higher rates paid for 2% of the patients would determine the median, and the rate actually paid for 98% of patients would not be considered reasonable.
- Calculation and monitoring of the median in-network rate may well be expensive, generating costs that outweigh potential benefits. Because plans sometimes contract with thousands of providers over a broad geographic area, and because network participation and negotiated rates can change frequently, collecting all of the required in-network rates may be a difficult

²³ See Section 3021 of PACA. PACA also specifically includes provisions on these types of arrangements, including bundled payments and accountable care organizations (ACOs).

and costly process. To the extent that plans extend the geographic scope of their in-network benefits by subcontracting with a rental network, calculation of the median may require additional monitoring of rental networks' provider contracts, further increasing the compliance burden.²⁴ Consideration should be given to alternative approaches that are less administratively burdensome. Furthermore, the median itself may be subject to frequent changes, as contracts are renegotiated and providers join or leave networks, causing uncertainty about the “reasonableness” of reimbursement rates over time.

- Independent verification of the median calculation would require intrusive disclosure of the terms of contracts between health plans and providers.²⁵ Health plans and providers typically keep the terms of their contracts confidential, which facilitates reaching mutually beneficial agreements and discourages coordinated pricing by providers.²⁶ Therefore, absent unusual disclosures, only the health plan, or its network subcontractor, will have the information required to implement the median calculation. Verification that a health plan's reimbursement is “reasonable” under the IFR will require some disclosure of the competitively sensitive terms of the contracts, possibly exposing payment terms from in-network provider contracts to out-of-network providers.

III.B.5. Problems with relying on the “generally used” method

The second measure used by the IFR to establish “reasonable” reimbursement is an amount “calculated using the method the plan generally uses to determine payments for out-of-network services (such as the usual, customary and reasonable charges).” Many plans use UCR reimbursement to establish out-of-network payments, where the allowed amount (before cost sharing is applied) is some percentile—often the 80th percentile—of historical charges submitted by providers within the same geographic area and for the same service. However, plans have been free to vary this definition as part of plan design.

²⁴ The IFR definition is not clear about whether rates negotiated by subcontractors, such as rental networks, are to be included when calculating the median. A rental network is an entity that assembles a network of provider contracts over a broad geographic area. Plans subcontract with these networks so that their members can access the providers on an in-network basis at pre-negotiated rates. Reimbursement to the provider is typically determined by the contract negotiated between the rental network and the provider.

²⁵ The IFR do not specify any monitoring or verification requirements, but clearly some means of verification will be required, at least occasionally, to ensure compliance.

²⁶ Disclosure of competitively sensitive information to competitors has the potential to facilitate collusion, as recognized by the U.S. Department of Justice and the Federal Trade Commission. See *Antitrust Guidelines for Collaborations Among Competitors*, Issued by the Federal Trade Commission and the U.S. Department of Justice, April 2000, p 6. Available at <http://www.ftc.gov/os/2000/04/ftcdojguidelines.pdf>.

The IFR are unclear about whether a plan could alter the method “usually” used to determine payments after the new rules go into effect. To the extent the IFR will be interpreted to lock in current methods for determining payments, it may produce an unreasonable standard for reimbursement when applied to future, changed market conditions. Locking in reliance on existing methodologies for determining out-of-network compensation could be especially problematic given the evolving nature of resources, data, and approaches used in this area. Indeed, other provisions in PACA may accelerate this evolution.

III.C. The IFR reflect a missed opportunity to curb balance billing and control costs

While PACA features many provisions intended to “bend the cost curve” downward, the IFR do not address unreasonable provider charges or prohibit balance billing of patients and so reflect a missed opportunity to reduce costs for emergency services.²⁷ As noted in Section III.B.1, the justification offered for regulating plan reimbursement to providers implies that the intent of Section 2719A is—implicitly, if not explicitly—to protect patients from unreasonable balance billing by providers. However the IFR do not meaningfully address balance billing. As discussed in Section III.B.2, regulating balance billing by providers would be a more direct and more effective approach to protecting consumers from unanticipated costs than regulating health plan reimbursement to providers. Should the Secretary of HHS ultimately implement price regulation, prohibiting providers from collecting unreasonable charges would be an appropriate complement to the price regulation specified in the IFR.

Balance billing of unreasonable charges for out-of-network services can be a significant problem for patients. A 2009 survey sponsored by America’s Health Insurance Plans (AHIP) documents numerous examples of providers billing amounts more than 100 times as large as the amount allowed under Medicare for the same service.²⁸ These balance bills can amount to tens of thousands of dollars. For example, a recent edition of Crain’s Health Pulse Extra reports examples of charges for emergency services in New York that exceeded Medicare by almost \$30,000 in some cases.²⁹ In a

²⁷ In fact, the IFR appear to reflect an expectation that patients will be subject to balance billing, noting that, “[b]ecause the statute does not require plans or issuers to cover balance billing amounts, and does not prohibit balance billing, even where the protections of the statute apply, patients may be subject to balance billing.” See *Federal Register*, June 28, 2010, p. 37194.

²⁸ See America’s Health Insurance Plans, *The value of provider networks and the role of out-of-network charges in rising health care costs: a survey of charges billed by out-of-network physicians*. August 2009. Available at <http://www.ahipresearch.org/PDFs/ValueSurvey/AllStatesReport.pdf>.

²⁹ See *Crain’s Health Pulse Extra*, January 21, 2009, Crain’s New York Business. Available at <http://hcfany.files.wordpress.com/2009/01/crains-extra-1-21-09.pdf>.

recent article, the *New York Times* reports on the sticker shock many consumers face when they realize the charges that they may be liable for when receiving emergency care.³⁰ The *Times* story also highlights the large gaps between providers' charges and the discounted, actual transaction prices providers typically receive.

Balance billing of unreasonable charges may present a larger financial risk to patients than anything related to copayments, coinsurance, or other forms of cost sharing with the health plan. Because the IFR do not address problems created by unreasonably high charges and subsequent balance billing, the financial health of the patient will continue to be at substantial risk when visiting an out-of-network provider for emergency care.

IV. Likely effects of the new rules

IV.A. Effects of equal cost sharing for in-network and out-of-network services

The Section 2719A provisions will lower copayments or coinsurance payments associated with out-of-network emergency services for some patients. While these provisions do reduce the financial pressure for a patient to seek in-network care when facing a possible emergency, the provisions also “may require some health plans to make higher payments to out-of-network providers than are made under their current contractual arrangements.”³¹ Apart from the effect of raising costs for some plans, this change is likely to lead to several less obvious consequences:

- By reducing incentives to use in-network providers, patients may be more inclined to use higher-cost, out-of-network providers in situations where patients have some discretion.³² This may, however, expose patients to greater balance billing for unexpected charges.
- Some patients may be more likely to use out-of-network emergency services for some care that does not actually require emergency services, particularly if the best alternative is to go to an out-of-network provider on a non-emergency basis, and if copayments and coinsurance rates remain higher for that care.³³

³⁰ Lesley Alderman, “Demystifying, and Maybe Decreasing, the Emergency Room Bill,” *New York Times*, August 6, 2010.

³¹ *Federal Register*, June 28, 2010, p. 37213.

³² Some of the other emergency care provisions of Section 2719A, such as the elimination of requirements for pre-authorization, may contribute to this effect.

³³ Section 2719A specifies a “prudent layperson” standard to define emergencies.

- Some patients may be more willing and able to pay full charges when faced with balanced billing for out-of-network charges because their total out-of-pocket cost is reduced by the cost-sharing provisions. Insofar as patients are more willing to pay these bills, providers may step up efforts to collect these, further raising total costs of care.
- For plans that currently require greater patient cost-sharing for out-of-network emergency services, the changes will increase the portion of reimbursement that out-of-network providers receive from health plans relative to patients.³⁴ This could have the dual impact of increasing medical costs, by increasing the amount collected by providers, while reducing disputes between providers, patients, and plans.

The previous points assume that plans respond to the new rules by reducing cost-sharing requirements for out-of-network services to bring them into parity with in-network cost-sharing. But as noted above, this will increase costs for those plans. In order to mitigate those cost increases, plans may respond by also raising cost-sharing requirements for in-network services somewhat, so that a smaller cost-sharing adjustment for out-of-network services is needed to achieve parity.

IV.B. IFR regulation of reasonable reimbursement will reduce provider incentives to participate in health plan networks

The proposed IFR's definition of "reasonable" reimbursement guarantees that an out-of-network emergency service provider can obtain reimbursement at least as great as the median rate offered to in-network providers. This may create incentives for some emergency service providers to leave plan networks, harming consumers by depriving them of the quality-enhancing and cost-reducing features of plan networks and by exposing them to more balance billing. In particular, any in-network provider currently receiving a rate from a health plan that is below that plan's median rate could obtain increased reimbursement by leaving the network.³⁵ The next section describes in more detail the economics that drive in-network reimbursement rates and provider network participation decisions.

IV.B.1. Provider decisions to participate in plan networks

Physicians (or other providers) who contract to be network providers generally give up the option to balance bill patients for charges beyond the contractually allowed amounts. In exchange, they

³⁴ That is, if the patient's copayment falls from \$40 to \$20, the plan's payment will increase by \$20. Insofar as it is easier for providers to collect this amount from a health plan than from an individual patient, fewer disputes may result.

³⁵ Whether it would be sensible for a provider in this situation to leave the network will depend also on other considerations, including the effect of leaving the network on the provider's volume of patients; this effect is likely comparatively small for providers of emergency services.

generally require some offsetting consideration. The amount of compensation needed to induce physician participation depends on the value of the balance billing option. The value of the balance billing option in turn depends on the magnitude of charges over and above what a provider would receive as out-of-network reimbursement from the plan (typically UCR reimbursement), and the difficulty of collecting full charges.³⁶

Plan participation can reward doctors by making available larger volumes of patients, which accrues because health plan members have financial and other incentives to seek care from in-network providers. The incentive from increased patient volume is likely to be especially great for primary care services, where patients usually are able to exercise choice over which provider to use. With services such as primary care, visits are more predictable and regular, which make it easier for patients to select in-network care. Where this pattern applies, providers will be more willing to participate in networks and negotiate discounts in exchange for increased patient volume. In such cases, the provider also foregoes the balance billing option in exchange for the likelihood of a greater flow of patients.

The balance between the incentives of health plans and providers may be very different for emergency service providers. Often patients will access emergency providers based on location (e.g. when traveling), distance, available transportation, waiting times, or other quality of care features, without any awareness of or regard for cost or network participation. Consequently, patients may be fairly unresponsive to plan incentives to use network providers. In this case, emergency service providers may have a lower expectation of increased patient volume from network participation. On the other hand, the same forces that cause patients to disregard the network participation status of an emergency services provider also cause patients to highly value broad networks, since use of a network provider eliminates the risk that the patient will be subject to balance billing for high emergency care charges. Therefore, all else equal, patients will attach more value to plans with networks that include more emergency service providers.

As a consequence, plans may be especially eager to sign up emergency service providers for their networks, even in the absence of discounts. At the same time, given their limited prospects for increased patient volume through network participation, emergency service providers may require premium rates as a condition of network participation to compensate them for the loss of the balance

³⁶ For example, suppose that a provider treats 200 out-of-network patients. The provider's charges for each patient are \$150 and all patients are covered by a single insurer. The health plan reimburses out-of-network providers a rate of \$100 (based on UCR), a portion of which is paid by the patient in the form of a copayment. In this case, the provider, if it remains out of network, can balance bill each patient an additional \$50. If 20% of patients pay the balance bill, the value of this option is \$2,000 (20% of 200 patients is 40 patients, each paying a balance of \$50), or \$10 per out-of-network patient.

billing option. Putting these facts together, plans and emergency service providers may even negotiate contracts for network participation with rates that reflect a premium over out-of-network rates.

IV.B.2. How the IFR will distort emergency providers' plan participation decisions

As noted in the introduction, health insurance networks provide substantial benefits to consumers and help to reduce health care costs. For example, plan participation by a provider protects patients from balance billing by that provider. These benefits are undermined if the reimbursement methodology for out-of-network providers leads in-network providers to abandon networks. As explained below, the IFR's reimbursement rule is likely to have this effect with respect to emergency service providers.

The IFR's reimbursement rule necessarily guarantees an emergency service provider out-of-network reimbursement at least as great as the out-of-network reimbursement already available to that provider, and offers an even larger guaranteed rate to the extent that the median in-network rate for the same service is greater still.³⁷ When this occurs, *the provider's incentive to participate in the network necessarily falls*, because the value of the out-of-network alternative is greater than before. This is a fundamental means by which the IFR may undermine plan networks.

Generally, there are two possibilities. The first is that the median in-network rate for emergency services will rarely exceed the corresponding out-of-network payment as determined by the method that the plan usually uses. In this case, the median in-network rate will rarely determine the "reasonable" reimbursement amount. Consequently, the primary effects of the rule would be to add administrative burden and to risk disclosure of competitively sensitive information, with little or no effect on payments for out-of-network emergency services, and consequently little additional protection for patients. In this case, the provision introduces costs, risks, and distortions without offsetting benefits.

The second possibility is that the median in-network rate for emergency services often exceeds the corresponding out-of-network payment that the plan would make using its usual method. In this case, the median in-network rate will often be the greatest of the three amounts in the "reasonable" reimbursement rule, and so the IFR will often guarantee an out-of-network emergency provider an amount equal to the median in-network rate. In this scenario, any in-network emergency service provider paid rates below the median would have a strong incentive to leave the network and thereby

³⁷ One of the three "greater of" metrics specified in the IFR is the payment calculated using the same method the plan generally uses to determine payments for out-of-network services. Therefore, under the IFR, payment can be no lower than what providers currently receive.

increase its rates to at least the median in-network level.³⁸ Additionally, such a provider would gain the option to balance bill. If this option is sufficiently valuable, even network providers with rates above the median may abandon the network. If emergency service providers leave health plan networks, increased balance billing is likely to result. The effect of the IFR in this case runs directly contrary to the goal of protecting patients.

Moreover, in this second case, the effects may snowball over time. In-network providers with low rates may have especially strong incentives to leave the network under the new rule. When they leave the network, the median will be recalculated from the remaining, more expensive provider contracts, causing the median to increase. The increase in the median will, in turn, increase the incentive for the remaining providers to leave the network, possibly exposing plan members to further balance billing risks for out-of-network emergency services.

IV.B.3. The distortion of physician incentives may increase medical costs

The discussion in the preceding section assumed no change in the in-network rates offered to individual providers. In response to the increased incentive to leave the network that the IFR create, some providers may demand higher rates to remain in a health plan's network. To the extent that plans pay these larger premiums, medical costs for in-network services will rise. Increases in some in-network rates may also cause the median to rise, which in turn could raise the “reasonable” reimbursement guaranteed for out-of-network services. This could create additional incentives for other providers to leave the network, creating further pressure on health plans to increase in-network rates.

³⁸ The same considerations also reduce incentives of providers to join networks in the first place, especially at rates below the median.