



CAHC Preliminary Estimates of Options for Surprise Billing and Out-of-Network Rate Caps
May 28, 2019

This memo illustrates possible budgetary impacts of a range of proposals to cap or set healthcare providers’ billing rates for out-of-network and emergency services. Some proposals would cap or set rates only for a limited set of “surprise” bills from hospital-related providers – such as anesthesiologists, radiologists, pathologists, or emergency physicians – who do not participate in patients’ networks despite the hospital’s in-network status. Other proposals would cap out-of-network and emergency rates for all providers and facilities, addressing the surprise billing issue but also indirectly creating more sweeping limitations on pricing relative to Medicare’s rates, particularly for hospitals. Most of these proposals would lower health spending for both taxpayers and patients. Table 1 illustrates these approaches.

Table 1. Proposals Addressing Rates for Out-of-Network and Emergency Services.

Impact on Federal Deficit, Cost (+) or Savings (-) in billions	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2020-2029
Surprise Billing Contexts Only											
AEI -- Ban Balance Billing/Require Hospitals to Contract w/ Docs	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-9
ERIC/Brookings Option 1 -- Cap Rates at 125% of Medicare \1	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-20
Manhattan -- Cap Rates at 150% of Medicare	-1	-1	-1	-1	-2	-2	-2	-2	-2	-2	-16
Cassidy Original Discussion Draft -- Set Rate 125% of Average	1	1	1	1	1	1	1	1	1	1	10
E&C Disc. Draft (Pallone-Walden) Set Rate at Median In-Network	Approximately Budget Neutral on Premiums; \$50 million APDC funding										
Senate Group Bill (Cassidy-Bennet) Set at Median In-Net. w/ IDR	Increase in Premiums Due to Administrative Cost of IDR, Other Disclosure and Admin. Reqs										
Senate HELP Discussion Draft (Option 1 Network Matching)	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-7
All Out-of-Network and Emergency Billing\2											
PPI -- 175% of Medicare in 2022 Phasing Down to 120% by 2035	0	0	-14	-18	-22	-27	-31	-37	-43	-50	-241
CAHC 200% of Medicare 2020 Phasing Down to 150% Over 5 Yrs	-6	-8	-19	-31	-45	-60	-63	-66	-69	-72	-440

Source: Council for Affordable Health Coverage (CAHC).

Notes: Estimates include both revenue and spending impacts. IDR = Independent Dispute Resolution (binding arbitration). PPI = Progressive Policy Institute. ERIC = ERISA Industry Committee. ERIC proposal is also supported by other employer groups. Estimates do not include billings for ambulance services. APDC = All Payer Claims Database.

\1 Brookings Option 2 would be a hybrid, requiring hospital contracts with (and no balance billing from) anesthesiologists, pathologists, and radiologists, but capping rates for ambulance services and emergency physicians. We have not estimated that proposal yet. Employer groups include ERIC, ABC, Retailers etc.

\2 Caps would apply to all out-of-network hospital and physician care, including non-emergency services.

\3 PPI's proposal is part of a larger package that also eliminates the payroll tax, so the revenue impact of the savings is about half as much as under current law.

Table 1 illustrates two important concepts. First, there is an important distinction between proposals that would **cap** out-of-network rates vs. those that would **set** rates. Rate caps would limit rates above the cap, but would not necessarily raise rates below the cap. On the other hand, rate setting proposals would lower rates for some providers, but would also raise rates for providers whose prior rates were below the set rate. Legislative wording as simple as “shall pay” vs. “shall not pay more than” could make a substantial difference on the impact on health costs. Second, proposals that are limited to surprise billing contexts would have a much smaller system-wide impact than proposals that could cap rates for all out-of-network care, including non-emergency care.

Preliminary results:

- **American Enterprise Institute (AEI):** AEI’s proposal that in-hospital providers not be allowed to bill patients separately, but instead must bundle their services within the facility fees hospitals negotiate with health plans, would save about \$9 billion over the ten-year budget window (2020-2029) for the federal budget.¹

¹ Benedic N. Ippolito & David A. Hyman, “Solving Surprise Medical Billing,” *AEI* (March 2019). Available at: <https://www.aei.org/wp-content/uploads/2019/03/Solving-Surprise-Medical-Billing.pdf>.

Under this proposal, we assume in-house provider rates are reduced toward average billing rates hospitals themselves negotiate with health plans, which we estimate are about 190 percent of Medicare rates.

- **ERISA Industry Committee (ERIC):** ERIC and other employer groups have suggested a cap on out-of-network surprise billings of 125 percent of Medicare rates.² The Brookings Institution has suggested a similar option.³ The Manhattan Institute’s proposal is similar to the ERIC proposal, except using 150 percent of Medicare rates as the cap.⁴ CAHC estimates the ERIC proposal would save \$20 billion over ten years; the Manhattan Institute proposal would reduce the deficit by \$16 billion over that period.
- **Senator Cassidy Original Draft:** The original discussion draft legislation proposed by Senator Cassidy⁵ would set rates (as opposed to capping them) at 125 percent of current average rates (not Medicare rates). By setting rates rather than capping them, and using current rates rather than Medicare, we estimate this proposal would raise physician fees for many in-hospital providers. Budgetary costs would be about \$10 billion between 2020 and 2029.
- **House Energy and Commerce (E&C) Committee (Pallone-Walden):** The discussion draft would set rates at 100 percent of current median in-network rates. We estimate this would be approximately budget neutral, with premiums roughly unchanged. By using median rates rather than average, the proposal would reduce premiums a little, since median rates are believed to be below average rates due to a few high outliers impacting the mean. However, setting rates (rather than capping them) implies a rate increase for providers whose current rates are below the median. Our preliminary assumption is that these impacts would roughly offset. The House E&C bill would also spend a small amount of money to subsidize state all-payer claims databases (APCDs).
- **Senate Bipartisan Working Group:** A recent follow-up Senate proposal spearheaded by Senators Cassidy and Bennet would set rates at current median in-network rates, but then would allow both providers and payers to submit claims to an independent dispute resolution (IDR) program, sometimes referred to as binding arbitration. We have not completed an analysis of this approach, but believe that this proposal would have similar costs as the E&C proposal if the IDR was rarely used. However, if providers used IDR frequently, the administrative costs could be substantial. We do not yet have estimates of whether the IDR criteria would tend to raise or lower rates on the merits. This follow-up Senate proposal also contains several other disclosure and data submission requirements that could be administratively burdensome and could raise premiums.
- **Senate HELP Committee (Alexander-Murray):** The HELP Committee discussion draft outlines three options: (1) a proposal to require providers to bundle their services with hospital fees (as suggested by AEI) OR

² See [comment letter](#) to Senate HELP Committee from American Benefits Council, National Retail Federation and The ERISA Industry Committee (April 2, 2019).

³ Brookings Option 2 would be a hybrid, requiring hospital contracts with (and no balance billing from) anesthesiologists, pathologists, and radiologists, but capping rates for ambulance services and emergency physicians. We have not estimated that proposal yet. See <https://www.brookings.edu/research/state-approaches-to-mitigating-surprise-out-of-network-billing/> and <https://www.healthaffairs.org/doi/10.1377/hblog20190523.737937/full/>.

⁴ Chris Pope, “The Cost of Hospital Protectionism,” *Manhattan Institute* (January 2019). Available at: <https://www.manhattan-institute.org/html/costs-of-hospital-protectionism>.

⁵ Protecting Patients from Surprise Medical Bills Act [DRAFT], 115th Congress (2018). Available at: <https://www.cassidy.senate.gov/imo/media/doc/Discussion%20Draft-%20Protecting%20Patients%20from%20Surprise%20Medical%20Bills%20Act.pdf>.

contract with all health plans with which the hospital has contracts; (2) a proposal similar to the follow-up Cassidy/Bennet group proposal, with rates set at the median in-network rate and IDR; and (3) a proposal similar to the House E&C proposal. We believe the first option, referred to as “network matching,” would save nearly as much as the AEI proposal, with most providers choosing to bundle their services with hospital’ facility fees, while some others would be able to negotiate new in-network rates closer to their current out-of-network rates.

- **Council for Affordable Health Coverage and Progressive Policy Institute:** Proposals to cap all out-of-network rates, as suggested by CAHC and the Progressive Policy Institute (PPI), would likely lead to much larger reductions in health costs and much higher budgetary savings than proposals that would only impact rates in surprise billing contexts. This is because broader out-of-network caps have the potential to restrain hospital rates in addition to those of hospital-based independent providers. A more general cap on out-of-network fees would give insurers considerable added leverage in negotiating in-network rates, because health plans could switch to fee-for-service reimbursement at the capped rates if health systems or provider groups refused to lower their rates toward the new cap.⁶ We estimate that the draft CAHC proposal, which would cap rates for all out-of-network and emergency services at 200 percent of Medicare in 2020, declining to 150 percent over 5 years, could reduce the federal deficit by more than \$400 billion over the ten-year budget window. PPI’s proposal to cap out-of-network rates at 175 percent of Medicare in 2022, falling to 125 percent over a dozen years, could save nearly \$250 billion over ten years, despite the fact that for technical reasons PPI’s other budget and tax proposals would limit the revenue savings.

Estimating Details and Assumptions

The following section provides additional details on CAHC’s preliminary estimates. Importantly, these estimates should be taken as rough illustrations or caricatures, intended more to show how the various proposals would compare rather than attempting to predict final budgetary estimates from the Congressional Budget Office (CBO). Likewise, any of these proposals could have more complex secondary impacts, which we do not attempt to trace.

The underlying theory of the estimates is that out-of-network billing possibilities essentially determine a provider’s asking price for in-network rates. That is, a provider’s market ability to collect revenues for out-of-network services will be equal to the in-network rates they would accept from networks.⁷ For example, if a hospital could stay outside networks, and earn, say, 150% of Medicare rates at sufficient or desired volume, then that hospital has no incentive to join a network that pays less than 150% of Medicare. Likewise, if a physician group could earn 300% of Medicare outside networks with sufficient or desired volume, it would be unwilling to join a network at less than 300%.

Of course, this is a relatively simple theoretical basis, and networks often try to entice providers to join at lower

⁶ In theory, hospitals could refuse to serve out-of-network patients on a fee-for-service basis at the capped rates. However, we are assuming that health systems would generally choose to treat non-emergency out-of-network patients at the capped rates, since the revenue margins from those patients would still be higher than margins for Medicare and Medicaid patients, and would be substantially higher than marginal costs. Note that these illustrative estimates do not contain lag times or phase-in periods to account for the time needed to renegotiate insurance contracts or re-file alternative models of health insurance plans with regulators. In reality, these adjustments could take several years.

⁷ In provider/plan negotiation, a provider’s ability to bill out-of-network is essentially equal to their “best alternative to negotiated rate” or “BATNA.” See: <https://www.pon.harvard.edu/daily/batna/translate-your-batna-to-the-current-deal/>. On a provider to provider basis, in-network rate agreements are essentially equivalent to providers’ out-of-network rates, because out-of-network billing possibilities defines the provider’s BATNA for negotiating in-network rates.

rates by promising higher volume in exchange. In this case, the “sufficient or desired” volume assumption is operating at the level of whole specialties; it may not apply in individual cases.

Other assumptions are more routine: we use a 30% marginal income/payroll tax rate to convert employer benefit savings to revenues (15% for PPI, which embeds rate caps in a broader proposal that also eliminates the payroll tax). We are assuming a subsidy rate of 75% for ACA coverage, and that most of the subsidy is scored as spending (as opposed to revenues). For these preliminary estimates, we are assuming surprise billing contexts are 20% of in-hospital physician billings, and that 50% of states (based on claims/premiums) already have addressed surprise billing contexts in baseline.

Table 2 shows our estimates for baseline payment rates relative to Medicare. Information guiding the assumptions on average provider rates includes MedPAC’s March 2019 report⁸ (overall physician = 133% of Medicare; Radiology twice Primary Care), CBO’s working paper on hospital prices⁹ (190% of Medicare), Stead and Merrick 2018¹⁰ (Anesthesiology 300+% of Medicare), CBO’s report on variation in physician prices¹¹ and Trish et al JAMA¹² (Pathology, Emergency, and various physician). Physician salary and distribution by specialty data are from MedScape (see Table 3, below).¹³

A recent report by Chapin White and Christopher Whaley of the RAND corporation, using more recent data on hospital rates than the CBO working paper, suggests that average hospital rates were about 240% of Medicare rates in 25 states.¹⁴ We have not yet included this newer data in our estimates.

Table 2. Assumed Baseline Payment Rates Relative to Medicare.

Assumed Average Billing Rates Relative to Medicare

Anesthesiologists	300%
Emergency	250%
Radiology	200%
Pathology	175%
Category Average	244%
Primary Care Physicians	100%
Non-Primary Specialists	150%
All Physicians	133%
Other Professionals	100%
Hospitals	190%

Source: CAHC

⁸ Medicare Payment Advisory Council. *Report to the Congress: Medicare Payment Policy* (March 2019), available at: http://medpac.gov/docs/default-source/reports/mar19_medpac_entirereport_sec.pdf?sfvrsn=0.

⁹ Jared L. Maeda & Lyle Nelson, “An Analysis of Private-Sector Prices for Hospital Admissions,” *Congressional Budget Office* (April 2017). Available at: <https://www.cbo.gov/system/files/115th-congress-2017-2018/workingpaper/52567-hospitalprices.pdf>.

¹⁰ Stanley W. Stead & Sharon K. Merrick, “ASA Survey Results for Commercial Fees Paid for Anesthesia Services – 2018,” *ASA Monitor* 2018;82(10):72-79. Available at: <http://monitor.pubs.asahq.org/article.aspx?articleid=2705479>.

¹¹ Daria Pelech, “An Analysis of Private-Sector Prices for Physicians’ Services,” *Congressional Budget Office* (January 2018). Available at: <https://www.cbo.gov/system/files/115th-congress-2017-2018/workingpaper/53441-workingpaper.pdf>.

¹² Erin Trish, Paul Ginsburg, Laura Gascue & Geoffrey Joyce, “Physician Reimbursement in Medicare Advantage Compared With Traditional Medicare and Commercial Health Insurance,” *JAMA Intern Med.* 2017;177(9):1287–1295. Available at: <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2643349>.

¹³ Medscape, Physician Compensation Report 2018. Available at: <https://www.medscape.com/slideshow/2018-compensation-overview-6009667#1>.

¹⁴ Chapin White & Christopher Whaley, “Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely: Findings from an Employer-Led Transparency Initiative,” *RAND Corporation* (2019). Available at: https://www.rand.org/pubs/research_reports/RR3033.html.

Importantly, our estimates do not yet include distributions of physician or hospital rates; that is, we are working only from category averages. For example, if we assume that average rates for anesthesiologists were 300% of Medicare and average rates for Pathologists were 175% of Medicare, a *rate cap proposal* of 200% of Medicare (such as year 1 of the CAHC proposal) is estimated to lower anesthesiology rates to 200%, but there would be no estimated impact on Pathologists’ spending. Likewise, a *rate setting proposal* at 250% of Medicare, would be estimated to lower anesthesiology rates from 300% to 250% of Medicare, but raise pathology rates from 175% to 250%.

In reality, the distribution of rates behind the assumed averages implies that the CAHC proposal would actually lower rates for some pathologists whose rates were above the 175% average *and* the 200% cap. So, by the nature of using overall category averages, we have estimated less savings from rate cap proposals than would actually take place.

CAHC’s estimates assume no dynamic volume adjustments or upcoding “gaming” in reaction to rate caps. Assuming providers would react to forced rate reductions or caps with volume adjustments and billing upcoding was very fashionable in the 1990s, but evidence for those sorts of dynamic adjustments has been very weak or non-existent over the last two decades, in a variety of contexts. CAHC’s preliminary estimates assume providers are essentially profit maximizers in baseline, and that no dynamic or long-term indirect adjustments are made to rate caps. A better question is whether rate caps would reduce supply. We are assuming that rate caps at the thresholds in the proposals estimated (120% of Medicare rates or higher) would not impact the supply of services to the extent that it would need to be modeled. Some hospital-based physicians hit hard by the caps could retire or withdraw labor, but we assume hospitals could re-supply in relatively short order without noticeable quality reductions, possibly by using lower-degreed providers in some cases.

Table 3. Estimates of Physician Compensation and Distribution.

Physician Annual Compensation, By Specialty	Average Annual Compensation (000s)	Percent of Physicians
Plastic Surgery	501	2%
Ortopedics	497	3%
Cardiology	423	3%
Gastroenterology	408	2%
Radiology	401	4%
Dermatology	392	1%
Anesthesiology	386	5%
Otolaryngology	383	1%
Urology	373	1%
Oncology	363	2%
Ophthalmology	357	2%
Critical Care	354	1%
Emergency Medicine	350	6%
Surgery, General	322	3%
Pulmonary Medicine	321	1%
Ob/Gyn	300	5%
Average	299	100%
Nephrology	294	2%
Pathology	286	2%
Psychiatry	273	6%
Allergy & Immunology	272	1%
Physical Medicine & Rehabilitation	269	1%
Rheumatology	257	1%
Neurology	244	3%
Infectious Diseases	231	2%
Internal Medicine	230	13%
Family Medicine	219	18%
Diabetes & Endocrinology	212	1%
Pediatrics	212	8%
Public Health & Preventive Medicine	199	1%

Source: Medscape Physician Compensation Report 2018

<https://www.medscape.com/slideshow/2018-compensation-overview-6009667#1>