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Who Bears the Cost of an Emergency: Balancing Billing's Effects on Health Care Providers, and Solutions Through Alternative Dispute Resolution

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PEPPERDINE DISPUTE RESOLUTION LAW JOURNAL

WHO BEARS THE COST OF AN EMERGENCY: BALANCE BILLING'S EFFECTS ON HEALTH CARE PROVIDERS, AND SOLUTIONS THROUGH ALTERNATIVE DISPUTE RESOLUTION

HAYDEN TAVODA

I. INTRODUCTION

In the United States, insured patients have the freedom to select non-emergency medical care from out-of-network providers, allowing patients to receive this care from the physicians they want so long as they are willing to pay out-of-network costs.[1] When it is do or die and insured patients are in need of emergency medical care but are not in the position to receive care in-network, there is legislation in place to protect patients from excess charges for out-of-network emergency care.[2] Though beneficial to the

[1] *California Law Protects Consumers from Surprise Medical Bills, Sometimes Also Referred to as Balance Billing*, DEP'T OF MANAGED HEALTHCARE (June 2017), https://dmhc.ca.gov/Portals/0/HealthCareInCalifornia/FactSheets/fsab72.pdf.

[2] *See generally* Elizabeth Davis, *How to Pay In-Network Rates for Out-Of-Network Care*, VERYWELLHEALTH, (April 26, 2020), https://www.verywellhealth.com/get-in-network-rates-out-of-network-1739069.

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consumer, it is the health providers who receive unfair reimbursement from the patient's insurance carrier.[3]

For individual health insurance organizations, the insurance company enters into contracts with doctors and hospitals to provide services at agreed upon rates, those contracted providers are what is considered "in-network."[4] However, for medical services provided to patients from doctors who are not within that patient's specific healthcare plan, called out-of-network, those providers are not subjected to any contracted rates.[5] As a result, the final bill for services provided must be balanced in a way to ensure the health providers receive fair compensation for their services.[6] This process is known as balance billing.[7]

Balance billing, which is also sometimes known as surprise billing, occurs when insured patients receive emergency care from providers that are out-of-network for their healthcare plans.[8] Patients with healthcare insurance plans often wrongfully assume that their plans will fully cover the costs of emergency procedures;[9] however, the health provider will charge patients for the excess cost of care that the insurance plan did not reimburse, hence the remaining bill comes as a "surprise" to the patient.[10]

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[3] *See* Glenn Melnick et al., *Regulating Out-Of-Network Hospital Emergency Prices: Problem and Potential Benchmarks*, HEALTHAFFAIRS.ORG, (March 23, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200320.866552/full/.
[4] Steven Allison et al., *Searching For A Solution To Surprise Medical Billing In California,* LAW360 (Aug. 26, 2019) https://www.law360.com/articles/1192125.
[5] Allison, *supra* note 4.
[6] Allison, *supra* note 4.
[7] Davis, *supra* note 2.
[8] Allison, *supra* note 4.
[9] Joshua Cohen, *Surprise Billing: Another Healthcare Market Failure,* FORBES (June 10, 2019), https://www.forbes.com/sites/joshuacohen/2019/06/10/surprise-billing-another-healthcare-market-failure/#11921919399e.
[10] Cohen, *supra* note 9.

The United States spends the highest amount on healthcare per person of any wealthy, developed country.[11] As a way to combat the already high cost of care and to protect patients, many states have passed legislation that restricts doctors and hospitals from billing patients for the amount of emergency care that is not covered by that patient's insurance carrier.[12] Although beneficial to patients, this legislation has a widely negative impact on hospitals and health care providers.[13]

The California Assembly Bill 72 (A.B. 72) protects patients who have used in-network hospitals or services, but have received certain aspects of the care out-of-network, like lab tests or specialist providers, which the patient has no control over.[14] In these circumstances the patient does "everything right," but still receives a surprise bill for the aspects of care that are not covered by their insurance plan.[15] California is one of twenty-two states to enact a law or some form of regulation that provides consumer protections against surprise billing, all of which restrict insurance carriers from holding patients accountable for the excess medical bills that the carriers will not cover.[16] California is

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[11] *How Does the U.S. Healthcare System Compare to Other Countries,* PETER G. PETERSON FOUNDATION BLOG (July 22, 2019), https://www.pgpf.org/blog/2019/07/how-does-the-us-healthcare-system-compare-to-other-countries?.

[12] Sarah Kliff & Margot Sanger-Katz, *In California, a 'Surprise' Billing Law is Protecting Patients and Angering Doctors*, THE UPSHOT (Sept. 6, 2019), https://www.nytimes.com/2019/09/26/upshot/california-surprise-medical-billing-law-effects.html.

[13] Kliff & Sanger-Katz, *supra* note 12.

[14] *California Law Protects Consumers from Surprise Medical Bills, Sometimes Also Referred to as Balance Billing*, *supra* note 1, at 1–2.

[15] *California Law Protects Consumers from Surprise Medical Bills, Sometimes Also Referred to as Balance Billing*, *supra* note 1, at 1–2.

[16] Korey Clark, *How States Are Attending to Medical Balance Billing*, LAW360 (Aug. 9, 2019) https://www.law360.com/articles/1182410/how-states-are-attending-to-medical-balance-billing.

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also among some states that protect consumers from surprise billing in both emergency and non-emergency settings.[17]

Currently, the main solutions to these disputes include either establishing a method for calculating reimbursement or providing settlement through arbitration.[18] Arbitration, as well as other forms of alternative dispute resolution, provide many benefits for all parties when a dispute arises, such as faster results and less expense and time than litigation, and the potential for more qualified finders of fact on a specific topic rather than a jury of peers.[19]

In the following case note, Part II will focus on the background of different types of health insurance carriers in the United States, the Knox-Keene Act, and the California Assembly Bill 1611.[20] Part III will discuss more specifically the issues that stem from balance billing through explicit cases.[21] Part IV will explore current and proposed solutions to balance billing issues, comparing current legislation that includes arbitration to those offered in the federal arena.[22] Finally, this note will conclude by reviewing the problem and acknowledging proposed solutions' probabilities of being enacted and their impact on balance billing disputes.[23]

II. HEALTH CARE IN THE UNITED STATES

The United States has notoriously complicated health insurance systems: the regulations, the outrageous costs of care per capita with little positive return, and the limited access to care in comparison with other

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[17] Clark, *supra* note 16.
[18] Michael Levinson, *Why Eliminating Surprise Medical Bills Is A Challenge,* LAW360 (July 22, 2019) https://www.law360.com/articles/1179513/why-eliminating-surprise-medical-bills-is-a-challenge.
[19] JUDGE H. WARREN KNIGHT (RET.) ET AL., *Advantages vs. Disadvantages of Contractual Arbitration*, *in* CAL. PRAC. GUIDE ALT. DISP. RES. 5:2 (2020).
[20] *See infra* pp. 4-9.
[21] *See infra* pp. 10-18.
[22] *See infra* pp. 18-28.
[23] *See infra* pp. 28-30.

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Organization for Economic Cooperation and Development (OECD) countries.[24] Understanding the United States health insurance systems will clarify why and how the issue of surprise billing persists.

The United States is infamous for its exorbitant medical care costs.[25] Americans are covered by public and private health insurance carriers; public care is health care provided by the government such as Medicare, Medicaid, and Children's Health Insurance Program, while private care includes either employer-sponsored insurance or individual-bought health insurance.[26] The various types of private care are: Exclusive Provider Organization (EPO), Health Maintenance Organization (HMO), Point of Service (POS), and Preferred Provider Organization (PPO).[27] Given the numerous types of care, both private and public, this section will focus primarily on HMOs.

HMOs are a type of insurance network that limits patients to receive care only from doctors who either work for or are contracted with the HMO; those doctors are considered in-network.[28] The Health Management

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[24] *U.S. Health Care Spending Highest Among Developed Countries,* JOHNS HOPKINS BLOOMBERG SCH. OF PUBLIC HEALTH (Jan. 7, 2019), https://www.jhsph.edu/news/news-releases/2019/us-health-care-spending-highest-among-developed-countries.html.

[25] Anthony Chan, *Differences Between Private and Public Insurance in the United States* (Jan. 15, 2019) https://www.pacificprime.com/blog/differences-between-private-and-public-insurance-in-the-united-states.html; *see How Does the U.S. Healthcare System Compare to Other Countries*, *supra* note 8 (explaining that "[i]n 2018, the U.S. spent about $10,600 per person on healthcare — the highest healthcare costs per capita across the OECD. For comparison, Switzerland was the second highest-spending country with about $7,300 in healthcare costs per capita, while the average for wealthy OECD countries, excluding the United States, was only $5,300 per person.").

[26] Chan, *supra* note 25.

[27] *Health Insurance Plan and Network Types: HMOs, PPOs, and More*, HEALTHCARE.GOV (last visited Feb. 10, 2020), https://www.healthcare.gov/choose-a-plan/plan-types/.

[28] *Health Insurance Plan and Network Types: HMOs, PPOs, and More*, *supra* note 24.

Organization Act of 1973 allowed for greater expansion of managed health care;[29] it requires the Federal Government to give financial support to developing HMOs for a limited trial-period.[30] The legislation's purpose was to increase competition within healthcare markets as a way to create outpatient alternatives to expensive hospital-based treatment.[31]

Though most Americans are covered by private insurance carriers, "patient dumping" by hospitals became a problem that received increased attention in the early 1980s.[32] During this time, people would be turned away from hospitals and unable to receive care due to their type of insurance or lack thereof.[33] Many hospitals preferred to turn away people in need rather than risk any economic loss for a patient that could not afford the cost of whatever care they needed.[34] In response to this problem, Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986.[35] With EMTALA, hospitals could no longer turn away patients or stall care in order to determine if a patient could afford treatment.[36] EMTALA is "a

[29] *A Brief History of Managed Care,* NAT'L COUNCIL ON DISABILITY, https://www.ncd.gov/policy/appendix-b-brief-history-managed-care (last visited Feb. 10, 2020).
[30] Marjorie Smith Mueller, *Health Maintenance Organization Act of 1973,* SOC. SEC. BULL., NOTES AND BRIEF REPS. 35 (March 1974), https://www.ssa.gov/policy/docs/ssb/v37n3/v37n3p35.pdf.
[31] *A Brief History of Managed Care*, *supra* note 29.
[32] Beverly Cohen, *Disentangling EMTALA from Medical Malpractice: Revising EMTALA's Screening Standard to Differentiate Between Ordinary Negligence and Discriminatory Denials of Care*, 82 TUL. L. REV. 645, 650 (2007).
[33] Thomas A. Gionis, *The Intentional Tort of Patient Dumping: A New State Cause of Action to Address the Shortcomings of the Federal Emergency Medical Treatment and Active Labor Act (EMTALA)*, 52 AM. U. L. REV. 173, 175 (2002).
[34] Gionis, *supra* note 33, at 186.
[35] Cohen, *supra* note 32, at 656.
[36] Robert Bitterman, *EMTALA: The Law That Forever Changed the Practice of EM*, ACEP NOW (Sept. 25, 2018), https://www.acepnow.com/article/emtala-the-law-that-forever-changed-the-practice-of-em/.

reflection of a public belief that in the wealthiest nation in the world, people should not be turned away from, or thrown out of, hospitals to die on the streets."[37]

A. THE KNOX-KEENE ACT

Although the individuals that receive care through an HMO do have insurance, issues arise regarding out-of-network care.[38] In emergency situations, a patient may be closer to an out-of-network hospital and may not want to risk traveling further away to an in-network facility to receive care.[39] EMTALA made it possible for all patients to receive emergency care at any hospital regardless of insurance plan.[40] However, patients were then being charged exorbitant amounts for emergency care at non-contracted facilities.[41] The California Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) presented a solution.[42] The Act requires HMOs to cover the costs of their consumers' out-of-network emergency services.[43] Despite this protection, the Act still left many individuals uncovered either because the services rendered were considered non-emergency medical services, or because the patient was not a member of an HMO insurance plan.[44]

After the creation of the Knox-Keene Act, insurance carriers and health care providers began disagreeing about how to balance patients' bills for out-of-network emergency

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[37] Cohen, *supra* note 32, at 655.
[38] Steven Allison, *Searching For A Solution To Surprise Medical Billing In California,* LAW360 (Aug. 26, 2019), https://www.law360.com/articles/1192125.
[39] Gionis, *supra* note 33, at 186.
[40] Bitterman, *supra* note 36.
[41] George A. Nation III, *Saving Surprise Medical Billing Legislation,* THE HILL (Sept. 16, 2019), https://thehill.com/opinion/healthcare/461163-saving-surprise-medical-billing-legislation.
[42] *Laws & Regulations*, DEP'T OF MANAGED HEALTH CARE, https://www.dmhc.ca.gov/AbouttheDMHC/LawsRegulations.aspx#knoxkeene (last visited Feb. 10, 2020).
[43] Allison, *supra* note 4.
[44] Allison, *supra* note 4.

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services because the Act restricted emergency room doctors from billing a patient for any amount of service left unpaid by the HMO.[45] Any dispute about payment could only be handled between the emergency room doctors and the HMO; a patient could not be injected into the dispute whatsoever, which typically left the physician with an unsubsidized bill.[46]

In twenty-one states, patients are not responsible for any amount of the bill left unpaid by the insurance company for emergency medical procedures.[47] This includes situations where a patient unknowingly received care from an out-of-network provider within an in-network facility, "such as a non-network anesthesiologist or radiologist contracted by the emergency department of an in-network hospital."[48]

B. CALIFORNIA ASSEMBLY BILL 1611

The California Assembly Bill 1611 (A.B. 1611) was recently introduced on February 22, 2019.[49] A.B. 1611 is currently inactive, but if enacted would have prohibited hospitals from charging any patient, not just those enrolled in HMOs, more than the "in-network cost-sharing" prices for emergency services and post stabilization care.[50] A.B. 1611 would require all health plans to either renew or amend policies after January 1, 2020 to ensure enrollees receive coverage for emergency services from out-of-network hospitals and doctors, and would prohibit hospitals from billing patients anything beyond their insurance deductibles and copayments.[51] Non-contracting hospitals and providers would be paid for emergency care through a specified

[45] Allison, *supra* note 4.
[46] Allison, *supra* note 4.
[47] Clark, *supra* note 16.
[48] Clark, *supra* note 16.
[49] Assemb. B. 1611, 2019–20 Reg. Sess. (Cal. 2019).
[50] Allison, *supra* note 4.
[51] Allison, *supra* note 4.

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formula, and non-contracting hospitals would be required to bill and collect through a stipulated method.[52]

A.B. 1611 would also provide a dispute resolution procedure in the event that either party is dissatisfied with the payment.[53] A.B. 1611 § 5(b)(1) provides "[a] noncontracting health facility providing emergency services . . . may use the independent dispute resolution procedure established under Section 1371.30. If the noncontracting health facility participates in the dispute resolution process, the health care service plan shall also participate," and that decision will be binding upon the emergency service providers and the insurance carriers.[54] Although A.B. 1611 § 5(b) applies to the health facilities that provide emergency services, it does not apply to the actual physicians, nurses, or other health providers who may be burdened by unfair compensation by insurance plans.[55]

While the California Assembly initially passed A.B. 1611, the Bill faced debate and opposition in the Senate.[56] It is likely the Bill would have gone through further editions before it was passed and enrolled;[57] however, even if A.B. 1611 had passed, balance billing issues will persist.[58] There will still be gaps in the protection of insureds, as well as in the protection of individual physicians and health providers.

III. THE REAL EFFECTS OF BALANCE BILLING DISPUTES

Common problems that lead to, and extend from, balance billing disputes can be understood through various cases. These issues range in complexity as well as subject matter and offer insight as to how intricate and pervasive

[52] Allison, *supra* note 4.
[53] Allison, *supra* note 4.
[54] Assemb. B. 1611, 2019–20 Reg. Sess. (Cal. 2019).
[55] Assemb. B. 1611, 2019–20 Reg. Sess. (Cal. 2019).
[56] Allison, *supra* note 4,
[57] Allison, *supra* note 4.
[58] Assemb. B. 1611, 2019–20 Reg. Sess. (Cal. 2019).

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surprise billing is in the American healthcare system. As provided by the following cases, it becomes clear that balance billing disputes do not just affect cost shifting between patients, providers, and insurance carriers; their subsequent litigation creates further problems than simply settling the medical bill.

A. CUTS IN PROVIDER REIMBURSEMENTS

As previously noted, out-of-network providers have little-to-no restrictions on what they can charge patients, and as a result, physicians will charge more for services provided to out-of-network patients in an attempt to subsidize for the lower rates of reimbursement they receive from insurance carriers.[59] Out-of-network physicians are called on by the hospital to provide treatment for a patient and therefore do not have contracts with patients directly.[60] Doctors instead receive reimbursement for their medical procedures by way of a quasi-contract but are only entitled to the "reasonable" value of their services, which is generally less than the actual cost for care. [61]

Emergency doctors are fearful that they carry a financial risk from cuts in reimbursements for services and will not receive fair compensation from the patient's insurance providers.[62] The following case will provide insight on how outrageous the difference in reimbursement can be and gives example to why physicians set higher rates for care than the services actually cost as a way to prevent economic loss.

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[59] Nation III, *supra* note 41.
[60] Frank Griffin, *Fighting Overcharged Bills From Predatory Hospitals*, 51 ARIZ. STATE L.J. 1003, 1014–25 (2019); Levinson, *supra* note 18.
[61] Ass'n of Am. Physicians & Surgeons v. Brown, No. 2:16-CV-02441-MCE-EFB, 2018 U.S. Dist. LEXIS 53767, at 3–12, 22–24, 27–28 (E.D. Cal. Mar. 28, 2018); Griffin, *supra* note 47, at 1015–16.
[62] Levinson, *supra* note 18.

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i. NEW YORK CITY HEALTH AND HOSPITALS CORPORATION V. WELLCARE OF NEW YORK, INC.

The discrepancy in payment that a health provider or facility may receive from an insurance carrier can be outrageous.[63]

In *New York City Health & Hospitals Corp. v. WellCare of New York, Inc.*, the Health and Hospitals Corporation (HHC), established by the New York City Health and Hospitals Corporation Act, provided the general public with medical services and facilities.[64] WellCare, a private health plan, participated within the Medicare Advantage program, providing enrollees with the same benefits that would be covered under the original Medicare.[65] HHC was a non-contracted provider facility that provided emergency services for WellCare enrollees when needed.[66] HHC hospitals would then bill WellCare for those services directly using a standard billing form, which included related revenue codes and Posted Charges.[67] WellCare would pay HHC the lower of the two amounts between the Posted Charges and the Original Medicare charge, which in most instances was the posted charges

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[63] Griffin, *supra* note 60, at 1004-06 (showing excessive medical bills of $46,000.00 for one rabies shot).

[64] N.Y.C. Health & Hosps. Corp. v. WellCare of N.Y., Inc., 801 F. Supp. 2d 126, 131 (S.D.N.Y. 2011) (citing New York City Health and Hospitals Corporation Act, N.Y. PUBLIC HEALTH, ch. 214-A, §§ 2, 5(1–7) (LexisNexis 2020)).

[65] N.Y.C. Health & Hosps. Corp., 801 F. Supp. 2d at 132. Through the Medicare Advantage program, consumers obtain the same benefits through private Managed Health Care Organizations (MA organizations) like WellCare. *Id.* at 131. MA organizations then enter into contracts with the Center for Medicare & Medicaid Services (CMS), where they pay each MA organization a set amount for each Medicare beneficiary that the MA organization enrolls, and in return, MA organizations agree to provide those enrolls with the same benefits they would be entitled to under the Original Medicare program. *Id.*

[66] N.Y.C. Health & Hosps. Corp., 801 F. Supp. 2d at 132.

[67] N.Y.C. Health & Hosps. Corp., 801 F. Supp. 2d at 132.

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amount.[68] In 2008, HHC demanded that WellCare pay the original Medicare costs, and pay the difference on all previous claims that WellCare had previously underpaid.[69] The amount in dispute was over $2.8 million.[70]

Though the Court acknowledged that the CMS offered a dispute resolution program that allowed for non-contracted providers to resolve any payment dispute with MA organizations, it was unclear if that program was in place at the time this dispute arose.[71] Absent the clear establishment of a dispute resolution program, WellCare sought to dismiss HHC's claim for failure to state a claim.[72] HHC, however, "argu[ed] that its lack of alternative remedies suggest[ed] that its suit [was] appropriate."[73] Despite the procedural uncertainty, the case was ultimately dismissed due to an absence of evidence that Congress had intended to confer non-contracted providers and facilities with third-party beneficiary rights of Original Medicare.[74]

The uncertainty over whether the appropriate procedure was to go forth with a lawsuit or use an alternative dispute remedy creates further problems, ultimately causing both parties to spend more time and money just to establish that bringing a suit was correct. In the end, because HHC was provided no way to recover any of the $2.8 million they claim was underpaid by WellCare, the healthcare facility was left to bear the burden of loss in reimbursement for providing emergency services to patients in need. The amount of risk in reimbursement that health providers and facilities undertake when providing emergency services for

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[68] N.Y.C. Health & Hosps. Corp., 801 F. Supp. 2d at 132. Posted Charges were typically less than what HHC would receive as payment under Original Medicare. N.Y.C. Health & Hosps. Corp., 801 F. Supp. 2d at 132.
[69] N.Y.C. Health & Hosps. Corp., 801 F. Supp. 2d at 133.
[70] N.Y.C. Health & Hosps. Corp., 801 F. Supp. 2d at 133.
[71] N.Y.C. Health & Hosps. Corp., 801 F. Supp. 2d at 139.
[72] N.Y.C. Health & Hosps. Corp., 801 F. Supp. 2d at 133.
[73] N.Y.C. Health & Hosps. Corp., 801 F. Supp. 2d at 139.
[74] N.Y.C. Health & Hosps. Corp., 801 F. Supp. 2d at 140.

members while being out-of-network only adds to surprise billing issues and the U.S.'s enormous health care spending by compelling providers to raise their cost of care to subsidize their losses.[75]

A. EXCESSIVE CHARGES ON PART OF THE PROVIDER

In order to combat the loss in payment as discussed in the previous case, physicians and healthcare facilities will overcharge patients and their subsequent insurance carriers for services.

ii. UNITED HEALTH SERVICES V. PARACHA

In *Unitedhealthcare Services v. Paracha*, Unitedhealthcare Services ("United") brought action against Dr. Paracha seeking to enjoin Paracha from engaging in egregious billing practices.[76] United argued that the patient, though insured, either never agreed to excessive charges by Paracha or was not advised by Paracha of those charges.[77] However, at the time Paracha provided the emergency medical care, the patient was incapacitated and unable to consider whether *any* doctor was within his healthcare network plan.[78] Essentially, United claimed that Paracha "routinely conspired to inflate the rates they charged for medical services in order to maximize the amount actually received as reimbursement from United," showing that the charges were excessive compared to Fair Health Standards.[79] Although shown to be "excessive," the Court held that

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[75] Nation III, *supra* note 59.
[76] Unitedhealthcare Servs. v. Paracha, 070033/2014, 2015 NYLJ LEXIS 1974, 2 (N.Y. Sup. Ct. September 14, 2015) (*hereinafter* "Paracha").
[77] Paracha, 2015 NYLJ LEXIS 1974 at 6.
[78] Paracha, 2015 NYLJ LEXIS 1974 at 4.
[79] Paracha, 2015 NYLJ LEXIS 1974 at 5, 7.

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Paracha was not bound to set rates for services rendered based on the Fair Health Standards.[80]

New York enacted the "Surprise Bills Law," which came into effect in March of 2015—after the *Paracha* patient was billed and the dispute arose.[81] The new law set forth guidelines for the patient, the physician, and the insurance carrier to follow when an out-of-network doctor renders emergency care.[82] Unfortunately, the law did not address retroactive adjustment of fees and was therefore unusable.[83]

In the absence of a contractually or statutorily mandated fee-cap, physicians are at liberty to set their own fees, and do so as a way to compensate for the systemic loss in compensation they have received for years.[84] This tug-of-war between physicians and insurers creates unnecessary disputes, and the lack of guidelines and legislation induces—as well as prolongs—balance billing disputes.

B. Complications in Defining Emergency Services

The issue of defining what constitutes "emergency services" presents itself as it pertains to determining how to reimburse for those services—including what types of facilities and health providers are included within balance billing regulations.

iii. YDM Management Co., Inc., v. Sharp Community Medical Group

Sharp Urgent Center—an Independent Practice Association ("IPA")—provided enrollees with an HMO plan, but allowed their patients to seek services at

[80] Paracha, 2015 NYLJ LEXIS 1974 at 7.
[81] Paracha, 2015 NYLJ LEXIS 1974 at 5.
[82] Paracha, 2015 NYLJ LEXIS 1974 at 6.
[83] Paracha, 2015 NYLJ LEXIS 1974 at 6.
[84] Paracha, 2015 NYLJ LEXIS 1974 at 6 (quoting Conn v. Gabbert, 526 U.S. 286, 291 (1999)).

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physicians' individual practices.[85] Sharp claimed that requests for reimbursement submitted by the out-of-network provider—Doctors Express—failed to include the Current Procedural Technology Codes (CPT codes) that would have informed Sharp of whether those services were for emergency medical care.[86] Sharp claimed that without those CPT codes, there was no way to prove that the services provided to Sharp members by Doctors Express were truly "emergency" medical services.[87]

Although it was an undisputed fact that Doctors Express provided emergency medical services to Sharp members, there was uncertainty as to whether an Urgent Care center could ever be entitled to reimbursement from insurance carriers because these centers are not licensed hospital based emergency departments.[88] The court maintained that there was no need to "determine whether the only providers who may be reimbursed for 'emergency services' are those who provided services within a licensed emergency department in a licensed health facility," and instead held the bigger issue was whether the services provided were in fact for "emergency services and care."[89]

The number of issues surrounding balance billing disputes that can be brought before a court are infinite, and

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[85] YDM Mgmt. Co. v. Sharp Cmty. Med. Grp., Inc., 16 Cal. App. 5th 613, 616 (Ct. App. 2017). YDM Management Company Inc. purchased accounts receivable from urgent care center Doctors Express, for services rendered to Sharp managed care members. *Id.*
[86] YDM Mgmt. Co., 16 Cal. App. 5th at 617.
[87] YDM Mgmt. Co., 16 Cal. App. 5th at 617.
[88] YDM Mgmt. Co., 16 Cal. App. 5th at 618, 621. Just as Sharp was required to reimburse non-contracted providers for emergency services, Sharp was required to reimburse YDM for those emergency services at "the usual customary and reasonable rates." YDM Mgmt. Co., 16 Cal. App. 5th at 618, 621. YDM also alleged that Sharp reimbursed Doctors Express at a rate lower than what was customary and reasonable. YDM Mgmt. Co., 16 Cal. App. 5th at 618, 621.
[89] YDM Mgmt. Co., 16 Cal. App. 5th at 627.

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the need to define emergency care only adds to the copious amount of litigation already in the American court system.

C. Complexities Due to Multiple Parties with Multiple Claims

Balance billing disputes with multiple plaintiffs and/or defendants with multiple claims can further complicate an issue when a court must decide when to compel arbitration between the parties.

iv. *In re Managed Care Litigation*

Whether courts compel arbitration depends on whether the health care providers are *non-par* (non-participating providers that have not entered into contract with the insurance carrier)[90] or are simply out-of-network.[91] In *In Re Managed Care Litigation*, a group of doctors sued various HMOs on multiple grounds, including breach of contract and unjust enrichment.[92] The multiple HMO defendants sought to compel the plaintiff health care providers to arbitrate all of their claims.[93] This dispute was complicated due to the nature of the various contracts between doctors and the HMOs: Some parties did not have contracts while others did, and of those with contracts, some held arbitration clauses while others placed limitations of the types of damages that the arbitrator could award.[94]

Despite the trial court's holding that the claims could be resolved through litigation and this decision being affirmed in the U.S. Court of Appeals for the Eleventh

[90] Joy Hicks, *Differences Between Par and Non-Par Medical Providers,* VERYWELL HEALTH (Jan. 9, 2020), https://www.verywellhealth.com/par-vs-non-par-providers-2317177.
[91] *In re* Managed Care Litig., 2003 U.S. Dist. LEXIS 23035, at 10, 32–33 (S.D. Fla. Sep. 15, 2003).
[92] *In re* Managed Care Litig., 2003 U.S. Dist. LEXIS 23035 at 14.
[93] *In re* Managed Care Litig., 2003 U.S. Dist. LEXIS 23035 at 10.
[94] *In re* Managed Care Litig., 2003 U.S. Dist. LEXIS 23035 at 14.

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Circuit, the U.S. Supreme Court held that the health providers could be compelled to arbitrate their claims under the Racketeer Influenced and Corrupt Organization Act (RICO), even though certain agreements could be seen as limits on the arbitrator's authority to award damages.[95] Legislation enforcing ADR solutions for balance billing disputes would eliminate the need for litigation to determine when arbitration can be compelled.

Arbitration would provide a clear process for all aspects of billing disputes, whether the doctor is participating or if those that are contracted with an HMO have arbitration clauses or not. Claims that do not fall under a provider-insurance contract or have an arbitration clause place a continued burden on all parties and the court rather than being resolved through arbitration.[96] Through these cases, it is clear that the issue of balance billing expands far beyond the detriments and debt it causes to patient consumers or unfair compensation for physicians. With the introduction of mandated ADR based solutions, more specifically arbitration, claims and issues surrounding balance billing could be greatly diminished.

IV. ADR AND BALANCE BILLING: IS ARBITRATION THE ANSWER?

An issue as complex as surprise billing in the United States is not easy to disentangle, however, various states have enacted legislature aimed at eliminating balance billing

[95] *In re* Managed Care Litig., 2003 U.S. Dist. LEXIS 23035 at 11, 49. The Supreme Court held that all arbitrated claims would be stayed pending adjudication in arbitration or dismissal by providers, but that not all claims that were subject to arbitration would remain active before the Court. *In re* Managed Care Litig., 2003 U.S. Dist. LEXIS 23035 at 11, 49.

[96] Richard C. Reuben, *Penn State Law Review Symposium: Building the Civilizatino of Arbitration: Personal Autonomy and Vacatur After Hall Street*, 113 PENN ST. L. REV. K 1103, 1129-30 (2009). Arbitration is faster and less costly for the parties than the judicial process, and arbitration frees up the court's docket. Reuben, supra note 96, at 1129–30.

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entirely.[97] Although it is a step in the right direction, current legislation still leaves gaps in coverage and protection.

Balance billing has received ample attention from United States legislators aiming to find a solution, and "there is strong bipartisan momentum behind the absurd practice of surprise medical bills."[98] Officials in multiple states and even Congress have proposed legislation that involves arbitration as a solution to prevent surprise medical billing.[99] This section will seek to analyze the validity of the several proposed solutions and legislation, as well as the likelihood that these solutions will be enacted.

A. TRANSPARENT MEDICAL PRICING

One proposed solution for reducing balance billing disputes is to require the price of medical care to be transparent.[100] While medical care providers develop contracts with insurance carriers for the price of care and provide the insured with information about the pricing for such care, out-of-network providers have no written contracts with the patient payor, nor do they have restrictions on how much they can charge for their services.[101]

The cost of medical procedures are confidential and privately negotiated between the hospital and insurance company, and the American Hospital Association (AHA) would like it to remain that way.[102] The AHA opposes making those negotiated prices public, fearing that this will

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[97] Clark, *supra* note 16.

[98] Mary Ellen McIntire, *Bipartisan Group of Senators Offers Plan to Curb Surprise Medical Bills*, 2019 WL 2135176 (May 16, 2019).

[99] Levinson, *supra* note 18.

[100] Cohen, *supra* note 9.

[101] Levinson, *supra* note 18.

[102] Emily Felder, *HHS Rule Could Disrupt How Hospitals and Insurers Set Rates*, LAW360 (April 29, 2019), https://www.law360.com/articles/1153737/hhs-rule-could-disrupt-how-hospitals-and-insurers-set-rates.

cut market competition.[103] The AHA argues that consumers want more expansive information on the amount of out-of-pocket costs, rather than the explicit price itself.[104] Though transparency in costs for out-of-network procedures would appear to provide a clear cut solution by reducing balance billing disputes,[105] methods of alternative dispute resolution could instead be a viable option for reducing costs while keeping the major players involved happy.

B. STATE AND FEDERAL LEGISLATION, CURRENT AND PROPOSED SOLUTIONS

The issue of balanced billing has permeated throughout the country, with many states attempting to solve the problem through proposed legislation.[106] In 2019, thirty-two states considered legislation to solve balance billing problems, with only seven bills enacted out of the total ninety-four bills proposed.[107]

Although a push by states for legislation aimed at resolving balance billing is a positive move forward, some argue that these proposed bills can only go so far due to the Employment Retirement Income Security Act (ERISA) of 1974, a federal law that exempts employer provided insurance plans from state regulation.[108] In these "self-insured" plans, employers provide health insurance to their employees who then pay claims directly through company funding, rather than contracting with an insurance carrier to

[103] Felder, *supra* note 102.
[104] Felder, *supra* note 102.
[105] Levinson, *supra* note 18.
[106] Clark, *supra* note 16; the states that have provided some form of protection against balance billing includes California, Connecticut, Florida, Illinois, Maryland and New York that have provided comprehensive protections such as for emergency and non-emergency situations and applied to both HMOs and PPOs; Arizona, Maine, Minnesota and Oregon passed legislations providing consumers with balance billing protection; and New Hampshire and New Jersey expanded their pre-existing protections. Clark, *supra* note 16.
[107] Clark, *supra* note 16.
[108] Clark, supra note 16.

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cover claims as in "fully insured" plans.[109] Self-insured plans cover about 61% of insured workers across the United States.[110]

Though beneficial in many respects, current state legislation still leaves a large number of Americans unprotected. Looking to alternative dispute resolution techniques in resolving other medical care disputes can provide insight into how successful these methods would be for issues surrounding balance billing. The problems that persist with balance billing regulations could be greatly diminished with the enaction of an ADR-based solution.

i. ADR AND HEALTH CARE DISPUTES

Past matters resolved through alternative dispute resolution processes provide templates for quick, efficient, and fair resolution in lieu of litigation.[111] For example, when there are claims for reimbursement by a hospital from an HMO for dozens of patients, each patient can potentially fit into multiple categories of coverage, with varying types of claims, degrees of timeliness, and amounts for awards in damages.[112]

Instead of costly and time-consuming litigation, a mediator was able to take less than thirty minutes to sort out the varying information for each patient from a spreadsheet, from there the HMO and provider were able to resolve all claims of the dispute in less than two hours.[113] Through means of alternative dispute resolution, parties are able to concentrate on collaborative mediation.[114] Although the

[109] Clark, *supra* note 16.
[110] Clark, *supra* note 16.
[111] Viggo Boserup, *Regulatory Oversight in Health Care*, LAW360 (Feb 27, 2009), https://www.law360.com/articles/89429/regulatory-oversight-in-health-care.
[112] Boserup, *supra* note 111.
[113] Boserup, *supra* note 111.
[114] Boserup, *supra* note 111.

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parties still have the option to take reimbursement disputes to trial, it is unlikely that a court would utilize such spreadsheets in the same way that proved to be advantageous in mediation, and a resolution would be significantly delayed.[115]

Similarly, in a situation where there were fewer claims, but still ranged in complex issues, the mediator was able to again lay out a spreadsheet, call each party and resolve the issues over the phone, all of which happened in less than thirty minutes.[116] All parties were relieved of the time and energy from having to be physically present at a mediation.[117]

When it comes to arbitration-specific solutions for medical disputes, Utah has required pre-dispute arbitration agreements for medical malpractice claims.[118] Utah's legislators found that the cost of malpractice insurance increased due to a growing number of claims and high demands of awards, which then increased the cost of health care by forcing physicians to practice defensive medicine and to subsidize the costs of their increased premiums through their patients.[119]

While litigation expends time, energy, and money, alternative dispute resolution procedures "redirects those efforts toward resolution in a more controlled and effective process."[120] By such, alternative dispute resolutions can allow what already restricted resources currently available could go towards addressing other challenges facing the healthcare industry as a whole.[121] Arbitration would be a

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[115] Boserup, *supra* note 111.
[116] Boserup, *supra* note 111.
[117] Boserup, *supra* note 111.
[118] James C. Dunkelberger, *Between a Rock and a Hard Place: The Plight of Health Care Arbitration Agreements Under Federal law*, 2010 B.Y.U.L. REV. 1869, 1873–75.
[119] Dunkelberger, *supra* note 118.
[120] Boserup, *supra* note 111.
[121] Boserup, *supra* note 111.

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benefit to the healthcare industry across the United States as it would reduce the amount of money being thrust into the already exorbitant costs of healthcare for Americans.[122] Although the high price of healthcare will not be solved or reduced to the amount of other OECD countries, reducing costs from any facet would be advantageous. The use of mediation in other medical disputes was fast, succinct, and efficient, which bodes well for the use of ADR to handle balance billing issues as well.

i. INDEPENDENT ARBITRATION AGREEMENTS BETWEEN PROVIDERS AND INSURANCE CARRIERS

As previously discussed, medical procedure prices are privately negotiated between the hospitals and insurance providers, and making those prices public would arguably cut market competition.[123] The AHA stresses that health providers are concerned that rate-setting legislation will create "a plan-determined, nontransparent process that will upend private payment negotiation."[124] Both insurance carriers and out-of-network providers are advocating for autonomy in handling surprise billing.[125]

Legislators are pushed and pulled along industry and political lines in drafting federal legislation, but what is of the utmost importance is that legislators continue to protect patients from exorbitant medical costs and ensure they remain covered by their insurance plans.[126] Arbitration can be a beneficial tool for providers who do not deserve to

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[122] *But see* Loren Adler et. al, *Rep. Ruiz's Arbitration Proposal for Surprise Billing (H.R. 3502) Would Result In Much Higher Costs And Deficits*, HEALTH AFFAIRS (July 16, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190716.355260/full/ (arguing that it would increase costs through higher premiums).
[123] Felder, *supra* note 102.
[124] Levinson, *supra* note 18.
[125] Levinson, *supra* note 18.
[126] Levinson, *supra* note 18.

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carry the burden of diminished reimbursement.[127] Arbitration as a resolution is also pushed for by providers' groups, who advocate for individualized arbitration as a means to settle these specific disputes.[128] Insurance carriers may also stand to benefit from arbitration as they can be forced to litigate and defend multiple claims arising out of the same occurrence in a variety of venues.[129] Using arbitration would essentially eliminate this impediment.

States may have difficulty working proposed legislation requiring arbitration around ERISA.[130] Within ERISA is a broad provision preempting state laws "as they may now or hereafter relate to any employee benefit plan," which includes employee-sponsored health insurance plans.[131] Although states can still enact legislation that applies directly to insurances plans or health providers, the proposed bills cannot affect employee benefit plans.[132] Therefore, states are preempted from requiring employee based insurers to pay for out-of-network surprise billing.[133]

However, overall, the introduction of arbitration to handle balance billing disputes nation-wide would be beneficial to all parties involved; it can act as a great advantage for courts burdened by a backlog of cases, as well as for the insurance providers and physicians burdened by excessive litigation.

[127] Levinson, *supra* note 18.
[128] Levinson, *supra* note 18.
[129] Vince Colella, *Michigan No-Fault Insurance Reform: A Tragedy Of The Commons*, LAW360 (Aug. 5, 2019), https://www.law360.com/articles/1180874/mich-no-fault-insurance-reform-a-tragedy-of-the-commons.
[130] Levinson, *supra* note 18.
[131] Levinson, *supra* note 18; 29 U.S.C.A. § 1144.
[132] Levinson, *supra* note 18.
[133] Levinson, *supra* note 18.

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ii. NEW YORK'S SOLUTIONS TO BALANCE BILLING

Under New York's Workers' Compensation Board Rules and Regulations § 327.10, arbitration committees settle disputes that arise from medical billing.[134] These committees consist of three appointed physicians, one of which must be nominated by the president of the Healthcare Association of New York State and one that may be nominated by the insurance carrier.[135] Though the rule was unclear on how the third arbitrator would be selected in this process, once nominated, the entire medical bill is arbitrated by the hospital's arbitration committee.[136] Whatever items of care provided would then be subject to the medical fee schedule.[137]

Aside from medical billing disputes arising from Worker's Compensation claims, in 2015, New York passed a surprise billing law that uses arbitration to settle balance billing disputes between health care providers and insurance companies; each party submits a proposed amount to the arbitrator who then decides the final award.[138] Consequentially, financial analysis from New York's Department of Financial Services found that arbitrators decide based on dollar amounts that are above the 80th percentile of normal costs, leading to an overall increase in cost of medical care in the State.[139] Arbitrators apparently receive guidance from New York law which suggests they consider the 80th percentile of the billed charges, which are the charges set by the providers, instead of considering "commercially reasonable rates" based on in-network rates

[134] N.Y. Workers' Comp. Law § 327.10 (McKinney).
[135] N.Y. Workers' Comp. Law § 327.10 (McKinney).
[136] N.Y. Workers' Comp. Law § 327.10 (McKinney).
[137] N.Y. Workers' Comp. Law § 327.10 (McKinney).
[138] Rachel Bluth*, To End Surprise Medical Bills, New York Tried Arbitration. Health Care Costs Went U,* NPR (Nov. 5, 2019), https://www.npr.org/sections/health-shots/2019/11/05/776185873/to-end-surprise-medical-bills-new-york-tried-arbitration-health-care-costs-went-.
[139] Bluth, *supra* note 138.

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charged in that geographic region.[140] In response, New York senators have sought to develop an alternative bill that would still rely on arbitration as a solution, but would instead suggest arbiters to consider the commercially reasonable rates.[141]

Although this bill is not perfect, it has saved New Yorker's more than $400 million in emergency medical services since its implementation in early 2015 through 2018 and has proved successful in ameliorating balance billing issues for patient consumers in the state.[142] Critics are concerned that Washington D.C. does not have the same "leadership, compassion, and courage" that was necessary for tackling such a complex issue.[143] As medical costs continue to rise and consumers are being crushed by the debt resulting from surprise medical billing,[144] Washington would stand to benefit by following New York's example.

i. SENATORS CASSIDY AND HASSAN'S PROPOSED LEGISLATION

Senators Bill Cassidy and Maggie Hassan aim to introduce legislation that would prevent insured patients from receiving surprise medical bills for emergency situations.[145] Although patients receive insurance through government aid, and the Knox–Keene Act provides protections for HMO member patients,[146] not all who are covered by other insurance systems are protected from

[140] Bluth, *supra* note 138.
[141] Bluth, *supra* note 138.
[142] Linda A. Lacewell, *Winning the Fight Against Surprise Medical Bills,* NEW YORK DAILY NEWS (Oct. 1, 2019), https://www.nydailynews.com/opinion/ny-oped-winning-the-fight-against-surprise-medical-bills-20191001-aoyalydhmncmjhn23tpyujmrxm-story.html.
[143] Lacewell, *supra* note 142.
[144] Lacewell, *supra* note 142.
[145] McIntire, *supra* note 98.
[146] DEPARTMENT OF MANAGED HEALTH CARE, *supra* note 35.

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receiving bills after emergency medical services.[147] This bill would protect non-HMO insured patients from receiving surprise billing for "emergency services, non-emergency services following emergency care at an out-of-network [facility] when the patient cannot be transported to an in-network facility and care provided by an out-of-network provider at an in-network facility."[148]

The bipartisan senators' legislation would require insurance providers to automatically pay the difference between a patient's in-network cost sharing and the median in-network rate for smaller claims, allowing providers or carriers the option to appeal the payment through arbitration for certain larger claims.[149] In that arbitration, both parties would be able to propose their best offers, the arbitrator would then make a decision, choosing one of the two offers based on their analysis of the "commercially reasonable rates in that geographic area."[150]

This proposed legislation has been compared to California A.B. 72, which despite leaving gaps in patient protection for out-of-network emergency services, has still successfully reduced the number of surprise billings for patient consumers.[151] However, while beneficial for consumers, California physicians claim A.B. 72 has lowered their pay.[152] Sen. Hassan and Cassidy's bill pushes for a lower dollar threshold required to enter into arbitrations, a solution beneficial to healthcare providers, most likely because it will allow them to negotiate for higher compensation for a greater number of claims.[153]

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[147] McIntire, *supra* note 98.
[148] McIntire, *supra* note 98.
[149] Margot Sanger-Katz, *Bans on Surprise Medical Bills May Pass After All*, THE UPSHOT (Dec. 8, 2019), https://www.nytimes.com/2019/12/08/upshot/deal-surprise-medical-bills.html.
[150] McIntire, *supra* note 98.
[151] Sanger-Katz, *supra* note 149.
[152] Sanger-Katz, *supra* note 149.
[153] Sanger-Katz, *supra* note 149.

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This proposed bill is also similar to New York's current surprise billing law in that an arbitrator will decide between each parties' proposed offer, but differs by considering the reasonable geographic rates, rather than the average amount of billed charges, which has led New York arbitrators to consistently decide on amounts above the normal costs of care.[154] While this legislation would use an alternative method for arbitrators to determine what constitutes reasonable rates, it still may be unappealing to insurance carriers.[155] Due to physicians regularly charging higher out-of-network rates to compensate for their overall loss in reimbursement, the "reasonable" rates within geographic regions would be increased as well.[156]

While bipartisan support for the bill substantially increases its likelihood of being enacted,[157] White House administration officials have stated they were not in favor of arbitration as a means of settling balance billing disputes.[158] Although this comes as a concern, Senator Cassidy, who too was skeptical about using arbitration over other ADR methods, feels that his proposal is the "sweet spot," only using arbitration as a second step when insurance and health providers could not reach an agreement.[159]

While this legislation has its fair share of critiques by both physicians, insurance carriers, and the White House, both California and New York's balance billing laws have shown to be successful in reducing out-of-network care debt for patients, and there is a potential for legislation *like* Sen. Cassidy and Hassan's bill to improve balance billing nationwide.

[154] Bluth, *supra* note 138.
[155] Levinson, *supra* note 18.
[156] Ass'n of Am. Physicians & Surgeons v. Brown, *supra* note 57.
[157] Sanger-Katz, *supra* note 149.
[158] McIntire, *supra* note 98.
[159] McIntire, *supra* note 98.

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V. THE ALEXANDER–MURRAY OPTION

Another solution called the "Alexander–Murray" option is a bill targeting various areas of concern in the health care sector, including public health, health education, prescription drugs, transparency, and surprise billing.[160] Similar to Senators Cassidy and Hassan's proposed legislation, advocates of this bill suggest paying out-of-network providers through a "median in-network rate,"[161] that would require setting a rate based on what other doctors in the same area are paid for the same procedure, or using a database of local charges to calculate what the median in-network price would be.[162]

The Alexander–Murray option has been entered before the Senate and is widely debated, but currently there is no sign that the bill will be brought to an agreement or resolution.[163] This proposal provides three options to protect patients against balance billing,[164] essentially combining aspects of California's A.B. 72, Senators Cassidy and Hassan's Proposal, and New York's surprise billing law.[165] The first would require any in-network facility to guarantee that all individual providers are considered in-network for health plans and their patients (A.B. 72).[166] The second option would allow any surprise bill over $750 to be

[160] Rachel Bluth, *Sen. Alexander Releases Bipartisan Plan to Lower Health Costs, End Surprise Bills*, KHN (May 23, 2019), https://khn.org/news/sen-alexander-releases-bipartisan-plan-to-lower-health-costs-end-surprise-bills/.
[161] Nation III, *supra* note 41.
[162] Levinson, *supra* note 18.
[163] Levinson, *supra* note 18.
[164] Mary Ellen McIntire & Andrew Siddons, *Alexander, Murray Outline Plan to Lower Health Costs*, ROLL CALL (May 23, 2019), https://www.rollcall.com/2019/05/23/alexander-murray-outline-plan-to-lower-health-costs/; *see also* Exhibit B, *TITLE I: Ending Surprise Medical Bills*, LHCC Act Section By Section, https://www.help.senate.gov/imo/media/doc/LHCC%20Act%20section%20by%20section%205_23_2019.pdf.
[165] *See* CA A.B. 72, Sens. Cassidy & Hassan's proposal, and the NY billing law.
[166] McIntire & Siddons, *supra* note 164.

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arbitrated between the payer and the provider by each giving their best offer and allowing an independent judge to decide (Senators Cassidy and Hassan's bill).[167] And finally, the third option would require the insurance provider to pay the physician or facility at the median rate in the specified geographic region (NY surprise billing law).[168]

There is concern that the Alexander–Murray option will upset health provider groups because physicians still run the risk of receiving reduced compensation from insurance carriers.[169] But, supporters of the proposal guarantee they will step in if insurance carriers decline hospitals' and physicians' adequate payment.[170]

In order to continue both health providers and insurance carriers' desire to keep the costs ambiguous while maintaining an arbitration provision, the Alexander–Murray option has the potential to solve a myriad of issues caused by balance billing. By having a lower minimum dollar amount to enter into arbitration, more disputes can be resolved without the unnecessary costs and disadvantages of litigation. Using median rates of care in balance billing arbitrations provides parties with room to negotiate costs, while satisfying the AHA's desire to restrict standardized and transparent rates for medical services.[171] The Alexander–Murray option provides more expansive options for handling balance billing disputes, while retaining arbitration as a fundamental solution.[172]

VI. CONCLUSION

Surprise medical billing disputes present a grave problem that only adds to the already exorbitant prices of

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[167] McIntire & Siddons, *supra* note 164.
[168] McIntire & Siddons, *supra* note 164.
[169] Bluth, *supra* note 160.
[170] Bluth, *supra* note 160.
[171] Felder, *supra* note 102.
[172] Bluth, *supra* note 160.

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medical care in the United States.[173] It places a burden on all sectors of the industry, from consumers, to physicians, and the insurance providers involved. With so many affected by surprise emergency billing, there is a wide range of complex litigation that follows.[174] Ultimately, an arbitration-inclusive solution is imperative to protecting health providers against balance billing, while maintaining protections for health consumers.

The proposed legislation discussed in Part IV offers some aspect of arbitration to solve balance billing disputes between insurance carriers and hospitals or physicians, even if only as a "second" option.[175] The inclusion of arbitration clauses is essential in combating balance billing issues by eliminating many of the disadvantages that come with litigation. Excessive time, costs, and obstacles that arise in litigation because of the intricacies of the American healthcare system — as illustrated in Part III—can be avoided through arbitration.[176] Though some members of Congress may be wary of using arbitration in balance billing disputes, there is a great possibility that between the various options being brought before the House, arbitration clauses will be incorporated into legislation that will hopefully pass in the near future.[177]

While Sens. Cassidy and Hassan's proposed legislation may currently have the greatest likelihood to be enacted because of its bi-partisan support, the Alexander–Murray option would be the most promising bill to protect the interest of all parties.[178] The bill combines aspects of current successful balance billing laws in California and New York, and contains features proposed by Sens. Cassidy

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[173] Chan, *supra* note 25.
[174] *See* N.Y.C. Health & Hosps. Corp. v. WellCare of N.Y., Inc., 801 F. Supp. 2d 126, 126 (S.D.N.Y. 2011); *Paracha*, 2015 NYLJ LEXIS 1974 at 2.
[175] *See supra* note 165.
[176] Boserup, *supra* note 111.
[177] McIntire, *supra* note 97.
[178] Bluth, *supra* note 160.

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and Hassan's legislation, providing the most expansive options for settling by requiring that all independent physicians be considered in-network while at in-network facilities, mandating that insurance carriers pay physicians the standard geographic rate, and using a low-threshold arbitration option in which deliberation is based on the median in-network rates.[179] If enacted, this option has the potential to make a big impact on the United States' balance billing issue. The bill would allow for a nation-wide industry standard in handling these disputes, taking the guess work out for states searching for comprehensive regulations.

[179] Bluth, *supra* note 160.

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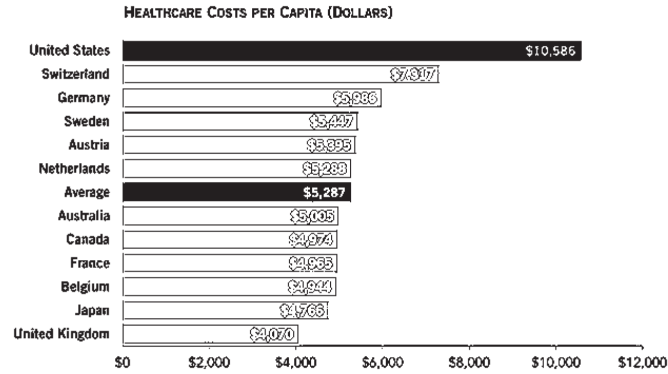
EXHIBIT A

Per capita healthcare spending in the U.S. is almost twice the average of other wealthy, developed countries



SOURCE: Organisation for Economic Cooperation and Development, *OECD Health Statistics 2019*, July 2019.
NOTES: Data are for 2018. Chart uses purchasing power parities to convert data into U.S. dollars. Average is for other wealthy OECD countries with above median GDP and above median GDP per capita.
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EXHIBIT B

TITLE I: Ending Surprise Medical Bills	
Sec. 101. Protecting patients against out-of-network deductibles in emergencies.	• Requires that emergency health care charges to a patient are counted toward the patient's in-network deductible. • Ensures that patient protections for emergency services apply in all relevant settings of care.
Sec. 102. Protection against surprise bills.	• Patients are held harmless from surprise medical bills. Patients are only required to pay the in-network cost-sharing amount for out-of-network emergency care and for care provided by ancillary out-of-network practitioners, and for out-of-network diagnostic services at in-network facilities. Facilities and practitioners are barred from sending patients "balance" bills for more than the in-network cost-sharing amount. • If a patient is stabilized after entering a facility through the emergency room, the patient must be given advance notice of any out-of-network care, an estimate of the patient's costs for out-of-network care, and referrals for alternative options for in-network care. If a patient is not given adequate notice, the patient would be protected from surprise bills or out-of-network cost-sharing.
Sec. 103. Resolution —Three Options (Below)	• For all three options outlined below, the resolution of a surprise bill would apply to all self-insured employer health plans. A state may choose to enact or continue in effect state laws or regulations relating to surprise bills, such as arbitration or benchmarking, for markets regulated by the state, including fully-insured plans in the group and individual market and state government plans.
Subtitle A—Option 1: In-Network Guarantee	• Requires that an in-network facility guarantee to patients and health plans that every practitioner at that facility will also be considered in-network • Practitioners and facilities have two options to be considered in-network: 1) Practitioners can choose to join the networks for health plans that have a network agreement with the facility; OR 2) Practitioners who choose not to go in-network can choose to bill the health plan through the facility, rather than sending separate bills to the patient or the health plan. • For emergency care delivered out of network, practitioners and facilities have 30 days to privately determine reimbursement with the health plan. If no agreement can be reached after 30 days, the plan will pay the facility and practitioner based on the median contracted rate for services in that geographic area.
Subtitle B—Option 2: Independent Dispute Resolution	• For surprise bills that are $750 or less, the health plan will pay the practitioner or facility based on the median contracted rate for services in that geographic area. • For surprise bills that are greater than $750, either the health plan or the facility or practitioner can elect to initiate an independent dispute resolution process, using a third-party arbiter certified by the Secretary of Health and Human Services, in consultation with the Secretary of Labor. The plan and provider will submit a best final offer, and the arbiter will be supplied with information to review the offer, including the median in-network rate for services in that geographic area. The arbiter will make a final, binding decision on the best offer, and the loser will pay for the cost of arbitration.
Subtitle C—Option 3: Benchmark for payment	• For surprise bills, the health plan will pay the practitioner or facility based on the median contracted rate for services in that geographic area.
Sec. 106. Simplifying emergency air ambulance billing.	• Requires that bills for air ambulance trips be broken out by air and medical charges, so that patients and health plans can better understand the cost of emergency air transport.