Journal of Dispute Resolution

Volume 2022 | Issue 2 Article 12

2022

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HOME RUN OR STRIKE OUT: CAN BASEBALL ARBITRATION SOLVE AMERICA'S MEDICAL DEBT CRISIS?

Sarah Jolley[1]

I. INTRODUCTION

In 2012, a New York woman named Claudia Knafo found herself in need of a complicated spinal surgery.[2] She immediately began the long and arduous process of selecting a physician in her insurance network, even going so far as to interview prospective surgeons to confirm their in-network status.[3] Claudia finally selected a well-regarded local surgeon, whose website verified his in-network status with her health insurance plan, after calling his office to confirm.[4] Weeks after her successful spinal surgery, Claudia received notice that the doctor's receptionist and website were incorrect—the surgeon was not actually in-network.[5] Claudia's health insurance plan provided $66,0000 of the $101,000 value of the operation, but she still found herself saddled with a surprise medical bill of $35,000.[6] To add insult to injury, her health insurance company later determined it had overpaid, and instructed Claudia to recover the $66,000 from her surgeon.[7] Faced with what she describes as a "nuclear attack" from both her surgeon and insurer, Claudia began searching for help.[8] Her story found its way to insurance regulators, consumer advocacy groups, the state attorney general's office, and finally New York State lawmakers.[9]

What Claudia experienced is an all-too-common practice called "surprise medical billing," which occurs when a patient unknowingly receives medical care from a provider outside of their insurance network.[10] In recent years, surprise medical billing has emerged as a major consumer protection issue, with as many as 1 in 5 patients receiving a surprise bill after surgery.[11] A 2020 study conducted by Yale University researchers examined the healthcare data of 350,000 patients covered by a large commercial insurer, and revealed twenty percent

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[2] Sarah Kliff, *A spinal surgery, a $101,000 bill, and a new law to prevent more surprises*, VOX (Mar. 19, 2019), https://www.vox.com/health-care/2019/3/19/18233051/surprise-medical-bills-arbitration-new-york.

[3] *Id.*

[4] *Id.*

[5] *Id.*

[6] *Id.*

[7] Kliff, *supra* note 2.

[8] *Id.*

[9] *Id.*

[10] Kaitlyn Finley, *The Growing Problem of Surprise Medical Bills*, STATE NETWORK POLICY (Sept. 9, 2020).

[11] Elena Renken, *Study: 1 In 5 Patients Gets A Surprise Medical Bill After Surgery*, NPR (Feb. 11, 2020), https://www.npr.org/sections/health-shots/2020/02/11/804906330/study-1-in-5-patients-gets-a-surprise-medical-bill-after-surgery#:~:text=Surprise%20Billing%20Is%20As%20Common%20After%20Elective%20Surgery%20As%20In,bill%20post%2Dsurgery%20exceeds%20%242%2C000.

received a surprise medical bill after surgery.[12] The lack of transparency between patients, providers, and insurers that leads to surprise medical billing presents a major problem not only for patients, but also the American healthcare system at large.[13]

When Claudia and patients with similar experiences started advocating for change, their state legislatures listened.[14] Beginning with New York, states began passing healthcare reform laws to prevent patients from receiving surprise medical bills.[15] Using a unique form of arbitration originally designed to settle salary disputes among Major League Baseball teams and players, these states require providers and insurance groups to agree on a fair price for the medical services in question or plead their case before an arbitrator.[16] This style of arbitration, often referred to as "final-offer" or "baseball" arbitration, has since been adopted into federal legislation designed to combat surprise medical billing on the national level.[17]

This article focuses on the application of baseball arbitration to surprise medical billing disputes, an issue that has gained increased attention at both the state and federal level. Part II examines the history of baseball arbitration and its contemporary applications. Part III explores the growing problem of medical debt and surprise medical billing in the United States, examining its impact on patients and the economy. Part IV discusses state level efforts to combat surprise medical billing debt and the use of baseball arbitration to settle disputes between hospitals and insurance companies. Finally, Part V analyzes the effect of similar baseball arbitration provisions in upcoming federal legislation. While surprise medical billing reforms protect consumers by reducing the amount of medical debt incurred from out-of-network treatment, final-offer provisions in legislation may provide unwanted incentives for hospitals and insurers to raise healthcare prices. Can America's favorite pastime provide the solution to our ongoing surprise medical billing crisis without causing healthcare costs to skyrocket? The answer hinges on the criteria arbitrators are allowed to consider when selecting a final offer.

II. BASEBALL ARBITRATION'S ORIGINS AND CONTEMPORARY USES

"Final-offer" arbitration, also known as "high/low" or "baseball" arbitration, is a form of alternative dispute resolution ("ADR") best known for its modern application to salary disputes in Major League Baseball ("MLB").[18] Final-offer arbitration is now so closely associated with professional baseball salary negotiations that the terms "final-offer

[12] Karan R. Chhabra et al., Out-of-Network Bills for Privately Insured Patients Undergoing Elective Surgery With In-Network Primary Surgeons and Facilities, JAMA 323(6): 538–547, https://jamanetwork.com/journals/jama/fullarticle/2760735?guestAccessKey=9774a0bf-c1e7-45a4-b2a0-32f41c6fde66&utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_content=tfl&utm_term=021120

[13] *See generally* Finley, *supra* note 10.

[14] Kliff, *supra* note 2.

[15] *Id.*

[16] *Id.*

[17] Alexandra Wilson Pecci, *Arbitration It Is. But How To Decide Who Wins in Surprise Billing Disputes?*, HEALTHLEADERS MEDIA (Jan. 22, 2021), https://www.healthleadersmedia.com/revenue-cycle/arbitration-it-how-decide-who-wins-surprising-billing-disputes.

[18] Benjamin A. Tulis, *Final Offer "Baseball" Arbitration: Contexts, Mechanics and Applications*, 20 SETON HALL J. SPORTS & ENT. L. 85, 86 (2010).

arbitration" and "baseball arbitration" are synonymous.[19] In a baseball arbitration, both parties attend a hearing where they argue their position and present a single final offer to a panel of arbitrators, who in turn select only one of the parties' offers.[20] This system contrasts with more traditional forms of arbitration, which give arbitrators broad authority to make settlement decisions that lean towards one offer or another or simply split the difference between the parties' offers.[21] The baseball arbitration hearing acts as the final step in the negotiation process, and is implemented when parties cannot reach an agreement through other means of ADR such as negotiation or mediation.[22]

Final-offer arbitration first emerged in MLB during the 1970s as a result of collective bargaining and salary negotiations between owners and player associations.[23] Prior to the introduction of baseball arbitration, players held only one-year contracts, which allowed them to frequently switch teams.[24] To combat the problem of revolving players, teams often entered into informal agreements where they promised not to poach certain valuable players.[25] These informal agreements led to the development of a "reserve system" that effectively forced certain players to remain on one team.[26] In response to disagreements over salary negotiation and team mobility, MLB players worked with the National Labor Relations Board to form a union and begin collective bargaining.[27] The 1973 Basic Agreement featured the first introduction of salary arbitration provisions to MLB's collective bargaining agreement.[28]

Baseball arbitration has many purported benefits for players and teams—incentivizing settlement, lowering costs, balancing interests, and producing fair market results.[29] Prior to an arbitration, the parties participate in a series of initial negotiations to adjust the player's salary.[30] An arbitration deadline is set for the upcoming season, and if the parties fail to successfully negotiate a salary agreement, they proceed with the arbitration hearing.[31] Players and teams are still free to reach a settlement agreement once they begin the arbitration process; it is not unheard of for parties to reach an agreement right outside the

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[19] *Id*.

[20] *Id*.

[21] *Id*.

[22] Final Offer Arbitration Supplementary Rules, INTERNATIONAL CENTER FOR DISPUTE RESOLUTION, (Jan. 1, 2015), https://www.adr.org/sites/default/files/Final%20Offer%20Supplementary%20Arbitration%20Procedures.pdf.

[23] Roger I. Abrams, *Inside Baseball's Salary Arbitration Process*, 6 Univ. Chi. L Sch. Roundtable 55, 58 (1999) (discussing the history of baseball's salary arbitration process).

[24] Bibek Das, *Salary Arbitration and the Effects on Major League Baseball and Baseball Players*, 1 DEPAUL J. SPORTS L. & CONTEMP. PROBS. 55 (2003)

[25] *Id.*

[26] *Id*.

[27] *Id*. at 58.

[28] *Id*.

[29] Jeff Monhait, *Baseball Arbitration: An ADR Success*, 4 HARV. J. SPORTS & ENT. L. 105, 131 (2013).

[30] *Id*.

[31] *Id*.

hearing room.[32] This arbitration system lowers costs and prevents delays, as it keeps players and teams out of costly court battles and resolves the salary dispute before the next season.[33]

Perhaps most importantly, baseball arbitration purportedly produces equitable results and encourages parties to submit reasonable bids that tend towards the median.[34] Unlike other forms of arbitration where arbiters can compromise by selecting a number between the parties' bids, baseball arbitration requires arbitrators to choose one of the parties' offers.[35] As the arbitrators have instructions to select the bid closest to the player's "real market value" in this winner-takes-all system, parties have incentives to submit reasonable rather than aspirational offers for fear their bid will be rejected.[36] Given that parties have a greater chance of reaching a mutually agreeable result through negotiation, they have incentives to avoid the arbitration process altogether. Because only one party's proposal is selected by the arbitration panel, participants might secure more of their interests through negotiation before turning to arbitration as a last resort.

While baseball arbitration is most closely associated with its long history as a salary dispute resolution tool in MLB, in recent years it has risen in popularity as an ADR strategy in other areas.[37] Today, parties apply baseball arbitration to disputes involving international negotiations over trade, mergers and acquisitions, real estate, tax, insurance, and other commercial issues.[38] For instance, since the early 2000s, the United States routinely inserts baseball-style arbitration provisions into international tax treaties with countries such as Canada, France, Germany, and Belgium.[39] Through these treaties, countries solve corporate tax disputes over who should collect multinational companies' transfer pricing taxes through binding baseball-style arbitration.[40] Revenue agents from both countries submit proposals to tax arbitration panels made up of three experts, one chosen by each country and the third by the other two experts.[41] The United States has experienced great success using this method of arbitration, collecting as much as $100 million in international tax disputes with Canada.[42] These promising results have created a broader interest in applying baseball-style arbitration provisions to other industries.[43]

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[32] Maury Brown, *Who's Winning The MLB Salary Arbitration Game? Here's Data From 1974 to 2015*, FORBES (Feb. 23, 2015), https://www.forbes.com/sites/maurybrown/2015/02/23/whos-winning-the-mlb-salary-arbitration-game-heres-data-from-1974-to-2015/?sh=efc5ba61558e.

[33] Monhait, *supra* note 12, at 132.

[34] *Id*.

[35] *Id*.

[36] *Id*.

[37] Erin Gleason & Edna Sussman, *Final Offer/Baseball Arbitration: The History, The Practice, and Future Design*, 37 ALTERNATIVES TO THE HIGH COSTS OF LITIGATION 8, 10 (2019), https://sussmanadr.com/wp-content/uploads/2019/04/Baseball-arbitration-alternatives-final-1-2019.pdf.

[38] *Id.* at 16.

[39] Patrick Temple-West, *International arbitration for tax disputes, "baseball" style*, REUTERS (Nov. 25, 2012), https://www.reuters.com/article/us-usa-tax-arbitration/international-arbitration-for-tax-disputes-baseball-style-idUSBRE8AO06T20121125.

[40] *Id.*

[41] *Id.*

[42] *Id.*

[43] Gleason & Sussman, *supra* note 37.

III. STATE LEVEL USES OF BASEBALL ARBITRATION IN SURPRISE BILLING REFORM

As the issue of medical debt grows in the United States, some state legislatures are looking to combat surprise medical bills, which are believed to be a contributing factor in overall medical debt.[44] Surprise medical billing occurs when patients are charged for unknowingly receiving out-of-network care.[45] A few states, such as New York, New Jersey, Georgia, Virginia and Illinois, have implemented legislation requiring hospitals and insurance companies to go through a final-offer arbitration process to settle disputes over out-of-network costs before transferring costs to their patients.[46]

A. The Growing Problem of Medical Debt

The Census Bureau's Survey of Income and Program Participation (SIPP) revealed that as of 2017, roughly nineteen percent of American households have medical debt.[47] The distribution of medical debt was associated with factors such as race, education, and familial status.[48] Black and Hispanic households were more likely to carry medical debt than white households.[49] Households with young children were also more likely to carry medical debt than those without children.[50] Households with a member who had attained some college but not graduated with a degree were more likely to carry medical debt than households with members who completed higher education or no higher education.[51] Overall, the results of the Census Bureau's study reveal that the issue of medical debt disproportionately affects families with children and people of color.

Nineteen percent of Americans experiencing medical debt may not seem like an urgent problem, but the actual monetary amount associated with medical debt is staggering. Today, the total medical debt carried by Americans is estimated to be $140 billion, almost double earlier estimates of $81 billion in the mid 2000s.[52] A group of researchers from Harvard, Stanford, and the National Bureau of Economic Research reached this number by analyzing the consumer credit reports for a nationally representative group of individuals from January 2009 and June 2020.[53] Their study's findings revealed that medical debt began

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[44] David Blumenthal & Shanoor Seervai, *The Underlying Causes of Surprise Medical Bills*, Commonwealth Fund (Apr. 26, 2019), https://www.commonwealthfund.org/blog/2019/underlying-causes-surprise-medical-bills.

[45] *Id.*

[46] Maanasa Kona, *State Balance-Billing Protections*, Commonwealth Fund (Feb. 5, 2021), https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections.

[47] Neil Bennett et al., *19% of U.S. Households Could Not Afford to Pay for Medical Care Right Away*, United States Census Bureau (Apr. 7, 2021), https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in- united-states.html. (The median amount carried by most households was $2,000).

[48] *Id*.

[49] *Id*.

[50] *Id*.

[51] *Id*.

[52] Bennett, *supra* note 47.

[53] Raymond Kluender et al., *Medical Debt in the US, 2009-2020*, 326 JAMA 250, 251 (2021).

to exceed national levels of other forms of consumer debt around 2014 and has consistently outpaced other forms of consumer debt since then.[54]

In keeping with its upward trend, medical debt has also become one of the nation's leading causes of bankruptcy.[55] As many as two-thirds of all bankruptcies in the United States are tied to medical issues, and more than 530,000 families enter bankruptcy each year because of unpaid medical bills.[56] Foreclosures, living beyond one's means, providing help to friends or relatives, student loans, and divorce or separation all trail behind medical bills as causes of bankruptcy.[57]

B. Surprise Medical Billing

Some might attribute exorbitant healthcare costs and medical debt solely to uninsured patients, but many of the patients saddled with burdensome medical debt are covered by insurance.[58] Patients risk losing their healthcare if they are suddenly fired from their job or if long-term illness causes them to lose their employment because medical insurance is often tied to employment in the United States.[59] A significant group of insured Americans struggling with unpaid medical costs can trace their debt back to one thing—surprise medical bills, also known as "balance" bills.[60]

Surprise medical billing occurs when patients unexpectedly or unknowingly receive medical care from an out-of-network provider.[61] This may occur when a patient receives emergency medical care at an in-network facility, but the patient is seen by consulting physicians (like emergency room doctors) who do not have contracts with their insurance plan.[62] Emergency room services are notorious for surprise medical billing.[63] An estimated one-in-five inpatient emergency room visits in the United States may lead to surprise medical bills.[64] Surprise billing can also result when a patient receives non-emergency medical care, but a complication arises during or after the procedure, requiring a consultation from an out-of-network specialist.[65] Many healthcare plans create insurance "narrow networks" of covered doctors and hospitals with an exclusion of higher priced healthcare providers.[66] If holders of "narrow-network" plans receive out-of-network medical care, it is very likely that their insurance plan will cover little to none of the costs, saddling patients with unexpected medical

[54] *Id*. at 252.

[55] Reed Abelson, *Study Ties Bankruptcy to Medical Bills*, N.Y. TIMES (Feb. 2, 2005), https://www.nytimes.com/2005/02/02/business/study-ties-bankruptcy-to-medical-bills.html.

[56] Lorie Konish, *This is the real reason most Americans file for bankruptcy*, CNBC (Feb. 11, 2019), https://www.cnbc.com/2019/02/11/this-is-the-real-reason-most-americans-file-for-bankruptcy.html. (Estimated 66.5% of all bankruptcies attributable to healthcare costs.).

[57] *Id*.

[58] Abelson, *supra* note 55.

[59] *Id*.

[60] Blumenthal & Seervai, *supra* note 44.

[61] *Id.*

[62] *Id*.

[63] *Id.*

[64] Christopher Garmon & Benjamin Chartock, *One In Five Inpatient Emergency Department Cases May Lead To Surprise Bills*, 36 HEALTH AFF. 177, 179 (Jan. 2017).

[65] Blumenthal & Seervai, *supra* note 44.

[66] *Id*.

bills.[67] In most of these cases, patients are unaware they are receiving out-of-network care or unable to consent to out-of-network care.[68]

C. New York Takes Action

In 2012, the New York State Department of Financial Services released a comprehensive report on surprise medical billing in the state in response to more than 2,000 complaints from residents.[69] The report found that surprise medical billing greatly contributed to overall medical debt, which was a leading cause of personal bankruptcy in the state.[70] The report revealed that patients were receiving surprise bills for emergency room services, such as an $83,000 bill for an out-of-network plastic surgeon to reattach a severed finger.[71] Emergency room visits often lead to surprise bills, because patients receiving emergency care may not be in a condition to give informed consent.[72]

However, the leading cause of surprise medical billing surprisingly turned out to be scheduled, non-emergency care.[73] This problem arose most frequently in situations where patients had consented to a procedure and cleared it with their insurer but were not informed that an out-of-network specialist would be consulting or performing part of the procedure.[74] The report cited one patient who diligently confirmed that both his surgeon and the hospital where he was undertaking heart surgery were within his insurance network, only to recover from surgery and find himself responsible for a $7,516 bill from an out-of-network surgeon who participated in the procedure without the patient's knowledge or consent.[75] The report identified common problems that led to surprise billing—namely comparison shopping difficulty, lack of disclosure for non-emergency care, excessive billing, and reduced coverage for out-of-network care.[76] Further, the report went on to propose a series of reforms, including increased transparency in patient care, prohibition of excessive charges, and the creation of minimum insurance coverage.[77]

In response to the report and consumer complaints, New York passed the "Surprise Bill" law, which was approved in October 2014 and went into effect on March 31, 2015.[78] Under New York's law, patients are not required to pay out-of-network provider charges for surprise out-of-network services, so long as the charges are higher than the patient's standard

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[67] *Id*.

[68] *Id.*

[69] BENJAMIN LAWSKY, N.Y. FIN. SERV., AN UNWELCOME SURPRISE: HOW NEW YORKERS ARE GETTING STUCK WITH UNEXPECTED MEDICAL BILLS FROM OUT-OF-NETWORK PROVIDERS (Mar. 7, 2012), http://www.statecoverage.org/node/4012.html.

[70] *Id*. at 1.

[71] *Id.* at 2.

[72] *Id.*

[73] *Id*.

[74] LAWSKY, *supra* note 69, at 2.

[75] *Id.*

[76] *Id.* at 2-4.

[77] *Id*. at 36-37.

[78] N.Y. Fin. Serv. § 601 (2014).

in-network copayment, deductible, or coinsurance rate.[79] New York's law currently protects patients in a variety of other circumstances where they might receive surprise medical bills.[80] Patients are protected from surprise bills when they receive medical care at a participating hospital or ambulatory surgical center in their insurance plan's network, but are unknowingly treated by an out-of-network physician without their written consent. This protection also applies when an in-network physician refers the patient to an out-of-network provider and the patient unknowingly uses their services.[81] New Yorkers are also protected from surprise billing for emergency services, including inpatient care following emergency treatment.[82] The New York law attempts to ameliorate the problem of insured patient costs by stipulating that insurers must develop reasonable payment rates for out-of-network care, illustrate how their out-of-network payments were calculated, and show how they compare to usual and customary rates.[83]

New York's Surprise Bill law also established an "independent dispute resolution process" for healthcare providers and insurers.[84] When providers and insurers disagree about the costs of the out-of-network care the patient received, the New York law directs them to go through a dispute resolution process rather than transfer costs directly to the patient.[85] Section 6 of the Surprise Bill law requires a dispute resolution process which closely mirrors the system of negotiation and final-offer arbitration found in MLB:

> (6) When determining a reasonable fee for the services rendered, the independent dispute resolution entity shall select either the health care plan's payment or the non-participating physician's fee. An independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in section six hundred four of this article.[86]

In addition to requiring arbitrators to select one party's offer over another, the dispute resolution process allows providers and insurers to participate in a series of negotiations designed to help the parties reach an equitable resolution.[87] If the negotiations fail, the next step for providers and insurers is to present offers to neutral arbitrators.[88] This system of ADR —a series of negotiations followed by final-offer arbitration— closely resembles that used by MLB.

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[79] NYS HEALTH, ISSUE BRIEF: NEW YORK'S EFFORTS TO REFORM SURPRISE MEDICAL BILLING 10 (Feb. 2019), https://nyshealthfoundation.org/resource/new-yorks-efforts-to-reform-surprise-medical-billing-2.

[80] *Surprise Medical Bills and Emergency Services,* N.Y. FIN. SERV. (2022), https://www.dfs.ny.gov/consumers/health_insurance/surprise_medical_bills.

[81] *Id*.

[82] *Id.*

[83] *Id.*

[84] N.Y. Fin. Serv. § 605 (2014).

[85] *Id*.

[86] N.Y. Fin. Serv. § 607 (2014).

[87] *Id.*

[88] *Id*.

After hearing the parties present their offers, the panel of arbitrators are required to consider a series of factors informing their decision on how to value the out-of-network care the patient received:

In determining the appropriate amount to pay for a health care service, an independent dispute resolution entity shall consider all relevant factors, including:

> (a) whether there is a gross disparity between the fee charged by the physician or hospital for services rendered as compared to:
>
> (1) fees paid to the involved physician or hospital for the same services rendered by the physician or hospital to other patients in health care plans in which the physician or hospital is not participating, and
>
> (2) in the case of a dispute involving a health care plan, fees paid by the health care plan to reimburse similarly qualified physicians or hospitals for the same services in the same region who are not participating with the health care plan;
>
> (b) the level of training, education and experience of the physician, and in the case of a hospital, the teaching staff, scope of services and case mix;
>
> (c) the physician's and hospital's usual charge for comparable services with regard to patients in health care plans in which the physician or hospital is not participating;
>
> (d) the circumstances and complexity of the particular case, including time and place of the service;
>
> (e) individual patient characteristics; and, with regard to physician services,
>
> (f) the usual and customary cost of the service.[89]

These factors encourage the arbitration panel to select an offer that more closely resembles the cost of in-network care. However, it balances these considerations with the time and skill of the out-of-network medical provider.[90]

The arbitration panel is created and determined by the state superintendent, who is charged with establishing a process for "certifying and selecting independent dispute resolution entities."[91] The same section also provides that "[a]n independent dispute

[89] N.Y. Fin. Serv. L. § 604 (2014).

[90] *Id.*

[91] N.Y. Fin. Serv. L. § 601 (2014).

resolution entity shall use licensed physicians in active practice in the same or similar specialty as the physician providing the service."[92]

D. Impact of the New York State Law on Surprise Medical Billing

In passing these baseball-style arbitration provisions, legislators and healthcare experts hoped that surprise billing medical costs would decrease in the state.[93] Jeffrey Gold, a senior vice president with the New York Hospital Association who worked on the law's drafting, stated, "In baseball arbitration, whoever is closer to reality wins…. I felt that was very quick and easy and would very quickly set a market rate for what was an acceptable behavior."[94] In a rare showing of solidarity, the plan was supported by both insurance companies and an association of emergency room doctors, two groups who rarely find themselves on the same side of medical billing disputes.[95] Lawmakers, insurance companies, and physician groups were hopeful the bill would solve the lingering problem of surprise medical billing in the state.

More than five years after the passage of the Surprise Bill law, enough data has been collected to provide insight into the bill's practical effects. As of 2018, New York's law had been used to settle more than 2,000 billing disputes.[96] Yale researchers found that the New York law reduced out-of-network billing by thirty-four percent and lowered in-network emergency physician payments by nine percent.[97] Their data was based on 323,936 emergency room visits at New York hospitals between 2011 and 2015, which captures approximately $1 billion in emergency health care spending.[98] To test the impact of the New York State laws, researchers compared New York hospitals' out-of-network rates, physician in-network payment rates, and facility payment rates before and after the legislation's passage.[99] Andrew Cuomo, the former governor of New York, lauded the dispute resolution program, announcing it saved New Yorkers more than $400 million in emergency medical costs alone.[100]

These positive results seemingly contrast with the results of a 2019 report released by the New York State Department of Financial Services, which found that healthcare costs had generally risen in the state since the adoption of the 2014 surprise billing law.[101] What is the reason for this discrepancy between lower patient surprise bills and overall rising

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[92] *Id.*

[93] Kliff, *supra* note 2.

[94] *Id.*

[95] *Id.*

[96] *Id*.

[97] Zack Cooper et al., *Surprise! Out-Of-Network Billing For Emergency Care in the United States*, NAT'L BUREAU OF ECON. RSCH. (2018).

[98] *Id.* at 33.

[99] *Id.*

[100] *Governor Cuomo Announces of New York's Landmark Out-Of-Network Law Protecting Consumers from Surprise Medical Bills,* N.Y. DEPT. OF FIN. SERVICES, (September 17, 2019), https://dfs.ny.gov/reports_and_publications/press_releases/pr1909173.

[101] Linda A. Lacewell, *New York's Surprise Out-of-Network Protection Law: Report on the Independent Dispute Resolution Process*, N.Y. DEPT. OF FIN. SERVICES (2019) https://www.dfs.ny.gov/system/files/documents/2019/09/dfs_oon_idr.pdf.

healthcare costs? Physicians are responding to surprise billing protection laws by increasing their in-network fees, and insurance companies are increasing premium rates, which in turn raises health care costs for all consumers. [102]

IV. SURPRISE MEDICAL BILLING REFORMS ON THE FEDERAL LEVEL

The issue of surprise medical billing has gained increased attention at the national level since the adoption of New York and other states' surprise medical billing laws.[103] The Covid-19 pandemic further heightened executive and legislative interest in a federal solution, resulting in new protections for consumers that went into effect in 2022.[104] This legislation represents a massive win for consumer protection and surprise medical billing reform at the national level.

A. Surprise Medical Billing Under the Trump and Biden Administrations

In January 2019, the Trump administration directed government officials to find a solution for surprise medical billing.[105] As the issue of medical debt and surprise medical billing gained national prominence, multiple congressional bills were proposed attempting to lessen surprise bills.[106] Senator Maggie Hassan (D-NH) partnered with Senator Bill Cassidy (R-LA) to lead a bipartisan effort to end surprise medical billing.[107] In 2019, the Senate Health, Education, Labor, and Pensions (HELP) Committee introduced the STOP Surprise Medical Bills Act as part of the Lower Health Care Costs Act, a broader package of legislation to address health care costs.[108]

In 2020, Congress passed the No Surprises Act as a part of a broader Covid-19 economic relief bill.[109] As of January 2022, the No Surprises Act protects patients from surprise bills for out-of-network medical care.[110] Consumers are protected from surprise billing when they seek emergency care, are transported via air ambulance, and receive medical care at an in-network hospital but are unknowingly treated by an out-of-network physician.[111] The No Surprises Act makes it illegal for healthcare and insurance providers to

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[102] Michael Ollove, *Laws to Curb Surprise Medical Bills Might Be Inflating Health Care Costs*, PEW (May 20, 2021), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2021/05/20/laws-to-curb-surprise-medical-bills-might-be-inflating-health-care-costs.

[103] Mihir Dekhne et al., *Federal Policy To End Surprise Billing: Building On Prior Approaches*, HEALTH AFFAIRS (Feb. 22, 2019), https://www.healthaffairs.org/do/10.1377/forefront.20190221.859328/full.

[104] Ricardo Alonso-Zaldivar, *Consumer relief: COVID bill to end 'surprise' medical bills*, AP NEWS (Dec. 21, 2020), https://apnews.com/article/covid-bill-end-surprise-medical-bills-d17da7204ade433d20ea8305c2d0538c.

[105] Dekhne et al., *supra* note 93.

[106] *See generally id*.

[107] *See* Alonso-Zaldivar, *supra* note 104.

[108] *See generally id.*

[109] Loren Adler et al., *Understanding the No Surprises Act,* USC-BROOKINGS SCHAEFFER ON HEALTH POLICY (Feb. 4, 2021), https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/02/04/understanding-the-no-surprises-act/.

[110] *Id.*

[111] Julie Appleby, *Congress Acts to Spare Consumers from Costly Surprise Medical Bills,* NPR (Dec. 22, 2020, 5:01 AM), https://www.npr.org/sections/health-shots/2020/12/22/949047358/congress-acts-to-spare-consumers-from-costly-surprise-medical-bills.

bill patients more than they would receive for in-network cost-sharing established by the patients' insurance (with the notable exception of ground ambulance services).[112] Health plans must treat out-of-network medical care as if it were in-network when calculating patient cost-sharing.[113] The new law does grant exceptions for consumers who want to be treated by an out-of-network specialist, provided that the physician gives a good-faith cost estimate and the patient consents within 72 hours of the scheduled treatment.[114]

To resolve disputes over surprise bills, the federal legislation establishes a baseball arbitration process to determine how much insurers must pay out-of-network physicians.[115] It gives insurers and healthcare providers 30 days to try to negotiate payment for out-of-network bills.[116] If a provider is dissatisfied with a health plan's payment and cannot settle an amount through negotiation, they can initiate arbitration.[117] The Secretaries of the U.S. Departments of Health and Human Services, Labor, and Treasury are tasked with establishing a process to certify a pool of neutral arbitrators with relevant expertise and no conflicts of interest.[118] The No Surprises Act calls for the insurer and provider to jointly agree upon an arbitrator from that pool.[119] If the parties are unable to reach an agreement, the federal government will select an arbitrator from the pool.[120] Both parties must pay an administrative fee for engaging an arbitrator.[121] Additionally, the losing party must pay the arbitrator's fee.[122] The burdens imposed by this process give parties additional incentives to negotiate a settlement within the proposed 30-day window.

One neutral arbitrator must select between the final offers submitted by each party, "taking into consideration several factors including the health plan's historical median in-network rate for similar services."[123] This is a significant departure from the criteria used in similar state level surprise billing reforms, which typically rely on billed charges or Medicare and Medicaid rates.[124] Lawmakers are hopeful that these arbitrator instructions strike an acceptable compromise between the wants of providers and insurers, and will secure a net win for consumers.[125] The Congressional Budget Office predicts that the law will save taxpayers $17 billion over ten years by reducing commercial insurance premiums between 0.5% and 1%.[126] While there remains uncertainty surrounding the true economic effect of these new arbitration provisions, the experience of states like New York provides insight into possible

[112] Adler et al., *supra* note 109.

[113] *Id*.

[114] *Id.*

[115] *Id.* (note that "baseball arbitration process" is the same as a "final-offer arbitration process").

[116] Appleby, *supra* note 111.

[117] Adler et al., *supra* note 109.

[118] *Id.*

[119] *Id.*

[120] *Id.*

[121] *Id.*

[122] Adler et al., *supra* note 109.

[123] *Id.*

[124] *See* Jack Hoadley & Kevin Lucia, *Are Surprise Billing Payments Likely to Lead to Inflation in Health Spending?*, THE COMMONWEALTH FUND (Apr. 26, 2021), https://www.commonwealthfund.org/blog/2021/are-surprise-billing-payments-likely-lead-inflation-health-spending.

[125] Appleby, *supra* note 111.

[126] Adler et al., *supra* note 109.

nationwide consequences and emphasizes the importance of well-crafted arbitration guidelines.

B. Impact of Arbitration Instructions on the Success of Healthcare Reform

The relative success of surprise billing laws depends on what factors the arbitrator is allowed to consider when selecting a final offer, as evidenced by the results of state-level reforms. According to a New York Department of Financial Services, when state guidance allowed arbitrators to consider the 80th percentile of billed charges (list prices higher than what 80% of other physicians charge for a given service), New York experienced dramatic inflation in healthcare costs.[127] Physicians' "billed charges" are typically many times higher than in-network or Medicare rates.[128] Experts describe billed charges as "totally made up" as providers can set prices "largely unmoored from market forces"[129] By instructing arbiters to consider the 80th percentile of billed charges, New York unintentionally provided incentives for physicians to artificially inflate prices for healthcare services.

These incentives for healthcare providers to raise prices creates a domino effect on the entire healthcare industry. When physicians can attain higher reimbursements for surprise bills through arbitration, they have greater leverage against insurers during the negotiation stage.[130] As previously mentioned, final-offer arbitration's strength as a dispute resolution tool is that it encourages parties to voluntarily negotiate settlements, for fear they stand to lose everything in arbitration.[131] If insurers have to consistently negotiate higher settlements to avoid the risk of losing even more in arbitration, they may seek to recoup that loss through other means. New York's insurance groups generally responded to providers' newfound leverage by raising premiums for healthcare insurance.[132]

While disputes over surprise medical bills were once offloaded directly onto the consumer, reforms leave providers and insurers fighting over the remaining costs. Insurance groups want to limit the amount of money they are forced to pay out to providers, and healthcare providers want to recoup the out-of-network value of their services.[133] The inclusion of baseball-style arbitration provisions were meant to help the parties reach fair agreements over the value of these medical services.[134] However, when arbitrators are allowed to consider the higher end of physicians' billed charges in selecting a final offer, these costs are still ultimately transferred to the consumer. While individual patients may get a reprieve from the devastating financial effects of surprise bills, all consumers could experience rising insurance premiums and healthcare costs.

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[127] *See generally* Loren Adler, *Experience with New York's Arbitration Process for Surprise Out-of-Network Bills,* USC-BROOKINGS SCHAEFFER ON HEALTH POLICY (Oct. 24, 2019), https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/10/24/experience-with-new-yorks-arbitration-process-for-surprise-out-of-network-bills/.

[128] *Id.*

[129] Appleby, *supra* note 111.

[130] Adler et al., *supra* note 127.

[131] Monhait, *supra* note 29, at 132.

[132] Adler et al., *supra* note 127.

[133] Ollove, *supra* note 102.

[134] *Id.*

As evidenced by the state level impact of arbitration guidelines, the factors governing arbitrator decisions at the federal level have serious implications for healthcare nationwide. In light of these high stakes, the drafting of the No Surprises Act provoked contentious debates among providers and insurers regarding what guidelines the arbitrators should be able to consider when selecting a final offer.[135] Insurers advocated for a standard based on lower Medicare or Medicaid prices, rather than a flexible criteria taking into account billed charges.[136] In contrast, healthcare providers lobbied for Congress to adopt guidelines similar to those in New York, which take into account physicians' billed charges, among other factors.[137] Lawmakers settled on something of a middle ground, barring consideration of billed charges, but also abandoning a Medicare or Medicaid standard benchmark.[138] Instead, the No Surprises Act allows arbitrators to consider the median in-network prices paid by each insurer for the particular medical service in dispute.[139] In addition to the in-network rate, the arbitrator is instructed to consider several relevant factors:

> 1. The "qualifying payment amount," which…. is generally the insurer's median in-network rate for similar services in that geographic region as of 2019, inflated forward by the Consumer Price Index for All Urban Consumers (CPI-U); 2. Demonstrations of good faith efforts (or lack thereof) to reach a network agreement and any contracted rates between the two parties during the previous four years; 3. Market shares of both parties; 4. Patient acuity; and 5. The level of training, experience, and quality of the clinician, or the teaching status, case mix, and scope of services offered by the facility.[140]

In-network rates have the benefit of being set by insurers, who have incentives to keep rates down.[141] However, there still remains a significant amount of uncertainty surrounding the eventual economic impact of these new guidelines. Healthcare policy experts at the Brookings Institute point out that in-network rates are still vulnerable to manipulation because they are typically negotiated between insurers and providers.[142] Arbitrators can also consider factors like past in-network rates, and that would largely benefit physician groups who were once able to leverage surprise billing against insurers in negotiations and secure contracts with higher in-network rates.[143]

Given the uncertainty surrounding in-network rates, Congress ought to have instructed arbitrators to consider the price of medical services based on Medicare or Medicaid rates. Thanks to state level surprise billing laws, researchers and policy experts have access to

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[135] Appleby, *supra* note 111.

[136] *Id.*

[137] *Id.*

[138] *Id.*

[139] *Id.*

[140] Adler et al., *supra* note 109.

[141] Maanasa Kona, Jack Hoadley, & Katie Keith, *Addressing Surprise Billing by Setting Payment Standards for Out-of-Network Providers* (Feb. 27, 2020), https://www.commonwealthfund.org/blog/2020/addressing-surprise-billing-setting-payment-standards-out-network-providers.

[142] Adler et al., *supra* note 109.

[143] *Id.*

data on the inflationary impact of different arbitration criteria. Georgetown researchers found that comparable anti-surprise billing laws passed in states such as California, Colorado, Maine, Maryland, Michigan, and Oregon generally produce less inflationary results using Medicare rates and excluding billed charges.[144] In states that instructed arbitrators to consider the prices of healthcare services based on Medicare and Medicaid, providers had fewer incentives to raise the price of medical services and less leverage to negotiate higher in-network rates.[145]

The ultimate choice to use in-network rates rather than Medicare or Medicaid is likely due to political expediency. Despite bipartisan support for surprise billing protections for consumers, when crafting the bill lawmakers, struggled to identify a method for resolving payment disputes that is acceptable to both providers and insurers.[146] As discussed above, providers typically prefer arbitration over a standard benchmark, because it allows them to secure payments higher than they could normally achieve under a government set rate standard.[147] They are also strongly opposed to guidelines that instruct arbitrators to consider Medicare or Medicaid rates, because they are significantly lower than physicians' billed charges, or even in-network rates.[148] Using a Medicare or Medicaid benchmark, while beneficial for insurance groups and consumers, would have been "anathema" to providers.[149]

When final offer amounts selected by arbitrators are higher than standard in-network rates, it can raise the cost of the out-of-network service if the payer previously limited its payment to the in-network rate, or it can lead to higher in-network rates in future contract negotiations if providers see that they can receive more money from out-of-network rates.[150] Whether these final-offer arbitration provisions will result in higher healthcare prices largely depends on arbitrators' decisions and what insurers currently pay for out-of-network care. Consumers and lawmakers will have to take a wait-and-see approach on the effect of these new arbitration guidelines when the No Surprises Act goes into effect in 2022. If arbitrators largely base their determinations on median in-network rates, experts hope the law will exert some downward pressure on health care costs and premiums.[151] But if arbitrators generally favor providers, the legislation might result in no savings or even potentially increase healthcare costs in the coming years.

V. CONCLUSION

Baseball or "final-offer" arbitration emerged as a method of salary negotiations in MLB, but its practical applications may extend far beyond its origins. Its recent application to the nationwide problem of surprise medical billing has highlighted its strengths and weaknesses as a method of ADR. Overall, the passage of state and federal surprise billing reform laws, such as the No Surprises Act, are a huge win for consumer protection. Patients

[144] Hoadley & Lucia, *supra* note 124.
[145] Ollove, *supra* note 102.
[146] Kona et al., *supra* note 141.
[147] Hoadley & Lucia, *supra* note 124.
[148] Appleby, *supra* note 111.
[149] Ollove, *supra* note 102.
[150] Hoadley and Lucia, *supra* note 124.
[151] Adler et al., *supra* note 109.

will no longer be saddled with burdensome medical debt from unknowingly receiving out-of-network care. Given surprise medical billing's contributions to medical debt in the United States, these laws could lead to a reduction in overall rates of medical debt and bankruptcy. However, they also have the potential to create an inflationary effect in the healthcare market, leading to soaring insurance premiums and increased healthcare costs for all consumers. Central to this debate are the guidelines arbitrators can consider, as the nuances of these baseball arbitration provisions can have an enormous impact on the costs of healthcare services and insurance premiums. When applied to disputes between healthcare providers and insurers, just one of the factors arbitrators are instructed to consider can have a domino effect on the entire healthcare market. The impact of arbitration instructions highlights just how central baseball arbitration provisions are to the overall success of surprise billing reform in the United States.