positives, etc. I can tell you we have had several positives. We haven't done any kind of formal analysis yet, but we've been really pleased in terms of the demographics. A good percentage of the people that we screen have never been screened before. Also, a large percentage had at least one major risk factor for HIV.

JAMA: Do you want to expand beyond DC?
COPLEY: We want to be in about 6 cities in the next 3 years. But shorter-term, PG County's health department reached out to us. That's Prince George's County, where risk is really high, prevalence is really high. It's a great spot for us to be. University of Maryland is right there. They have about 40 500 students. Prince George's Community College has 44 000 students—a ton of potential volunteers there. Because PG County's in Maryland, all [our] licenses will apply in Baltimore as well. We're thinking about being in Baltimore at the beginning of next academic year.

JAMA: One Tent Health is a nonprofit, but do you have any plans eventually to monetize it?
COPLEY: We brought on a fantastic COO (chief operating officer), Lindsey Sawczuk. She was a former One Tent volunteer. She's covering all the screening right now. It's freed up our time to focus on fundraising, because for a long time we've been self-funded. We got a small amount of donations, about $6000, after *Washingtonian* [magazine] wrote an article about us. But apart from that, One Tent has brought in no money. We've paid no salary to anyone. Thankfully, ever since I got to go full time on fundraising and board creation, we've had a lot of success there. And we just heard from Gilead, the makers of PrEP (the preexposure prophylaxis drug Truvada), that they're going to give us a grant. David was walking dogs for a little while to make money. And even this past Friday and Saturday, I was working as a barback (bartender's assistant) until 3 AM at a rum bar. We'll have salary [from One Tent Health] pretty soon.

JAMA: David, did your work on One Tent Health influence you as far as what specialty you wanted to pursue?
DR SCHAFFER: I think it certainly played a role. My work with One Tent goes back before I had decided on emergency medicine. I think part of what drew me to emergency medicine as a career is that it can be just as much about being an advocate for the local community as it is about treating emergency medical conditions. And that part about advocacy is a lot of what got me interested in One Tent. So right now, I am practicing emergency medicine as a resident, and I'm also working with One Tent, and I care about both very, very much, and I'm planning on staying on top of both for the foreseeable future. ■

Note: Source references are available through embedded hyperlinks in the article text online. Accompanying this article is the JAMA Medical News Summary, an audio review of news content appearing in this month's issues of JAMA. To listen to this episode and more, visit the JAMA Medical News Podcast.

The JAMA Forum

Curbing Surprise Medical Bills Can Be a Window Into Cost Control

Andrew Bindman, MD

One way that health plans attempt to control costs is by creating networks of clinicians and health care facilities with whom they negotiate discounted rates on behalf of their enrollees. This is known as selective contracting. Enrollees have a financial incentive to use in-network clinicians and health care facilities. They face higher cost-sharing with their health plan and a financial risk of additional charges (balanced billing) submitted to them directly by clinicians when they use services that are out of network.

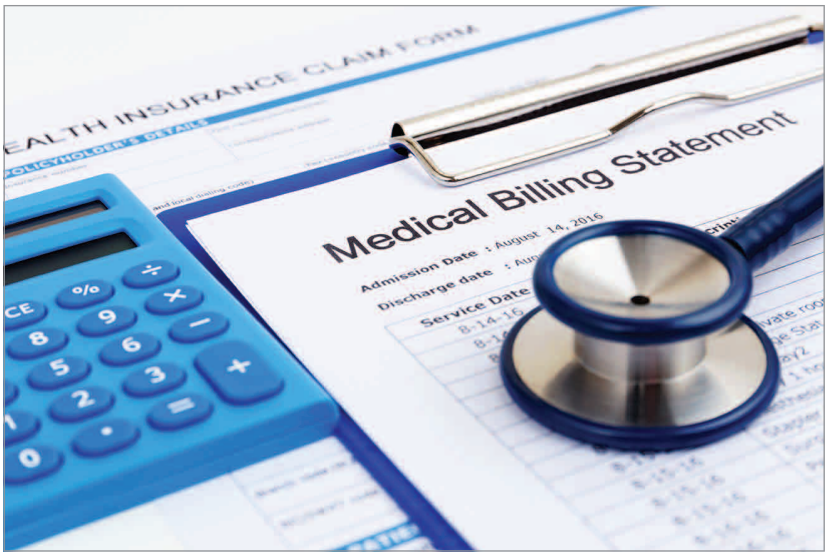
But individuals do not always have a choice of an in-network facility, such as when an ambulance transports patients to the closest hospital regardless of whether it is in network. Further complicating the situation is that individuals may mistakenly believe that all physicians at in-network facilities are in-network clinicians, when in fact many—particularly those who furnish radiology, pathology, anesthesiology, and emergency services—are not.

When privately insured patients receive unanticipated medical bills related to their receiving services from out-of-network clinicians—either unknowingly at an in-network facility or when receiving emergency services at an out-of-network facility—these charges are called "surprise medical bills." These bills can be extremely high in states that do not set limits on what health plans and clinicians are allowed to charge patients. They are also quite common.

State Laws to Protect Patients

Consumer outcry about these surprise medical bills, which are generally regarded as outside of a patient's control, have resulted in several states enacting laws to financially protect privately insured individuals from paying a higher amount for certain out-of-network services. For example, there has been legal precedent in California for almost a decade protecting patients from balanced billing for out-of-network emergency services. The responsibility for paying any excess charges for these emergency services falls to the plan, with few limits on what out-of-network hospitals and clinicians can demand in payment from the plans.

In 2016, California also passed legislation protecting commercially insured patients from balanced billing by out-of-network clinicians furnishing nonemergency services at an in-network facility or having to pay their health plan any more for that service than they would have paid for an in-network clinician for the same services. Unlike the California law governing out-of-network emergency services, this legislation, which became effective on January 1, 2017, specifies that out-of-network clinicians furnishing nonemergency services can bill insurers the greater of either the average contracted rate or 125% of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services are provided. A few other states have enacted legislation related to surprise medical bills, but none of these state laws protect individuals



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who are in self-insured plans, which are regulated under the federal Employee Retirement Income Security Act of 1974 (ERISA).

There is currently a draft bill in the US Senate to create a federal law to protect consumers with private insurance in all states, including those in self-insured plans, from surprise medical bills. The focus of this legislation is to protect patients from financial risks for out-of-network emergency services as well as for charges for care furnished by out-of-network clinicians at in-network facilities. In each case, consumers' cost-sharing responsibilities to a plan would be no greater than what it would have been had services been delivered by in-network clinicians. Clinicians would also be barred from seeking additional payment from patients for the out-of-network service through balanced billing. In the case of emergency services, which could include a need for a hospitalization, the protections would apply until the patient was stabilized, at which point the patient would be given the option to remain at the out-of-network facility at their own expense or transfer to an in-network facility.

Equally important, the federal bill would set some limits on how much insurers would be required to pay out-of-network clinicians, similar to what California does for out-of-network nonemergency services. This is critical for ensuring that out-of-network emergency service charges that plans are required to pay on behalf of their enrollees do not become a cost driver for health care premiums.

A recent study in California describes how hospitals currently use high out-of-network emergency service prices to pressure health plans. Hospitals set extremely high out-of-network prices for emergency services, knowing that they will care for (because of geography) a substantial number of a health plan's enrollees. This gives hospitals leverage with health plans to include them in a network, even if prices for their other hospital services are not as competitive as alternatives in a local market. This, along with other anticompetitive practices, such as requiring plans to contract with all or none of the hospitals in a chain, undermines the ability of health plans to use selective contracting with health care facilities to deliver higher value for their enrollees. This has contributed to marked increases in health plan premiums over time in California, and most likely in other states as well.

Combating Anticompetitive Practices

Setting a limit on what both patients and insurers pay health care clinicians and facilities for out-of-network emergency and related hospital services could help combat hospitals' anticompetitive practices and result in lower costs for patients. The experience in Medicare Advantage plans demonstrates how this can be done. Medicare uses its fee schedule to set an upper boundary on what Medicare Advantage plans are required to pay for out-of-network services. This creates negotiating room for Medicare Advantage plans to extract lower prices from in-network hospitals, and studies suggest that this works. On average, Medicare Advantage plans pay hospitals 92 cents for every dollar of what these hospitals would receive according to the Medicare fee schedule.

The upper-limit health plan responsibility for the specified out-of-network services in the proposed federal legislation is set at either what is already specified in state law or the greater of either the median payment rate for the service among all plans in a geographic area or 125% of the average allowed amount for the service in a specified geographic area. Some analysts have already suggested that this might be too high and could potentially drive up prices paid to in-network clinicians and facilities. The key will be to set an out-of-network facility payment rate that is not so low that it would create a sudden financial crisis for hospitals and physicians, but not so high that it does not alter the ability of health plans to negotiate lower rates for facilities and clinicians within its network. Using a multiple of Medicare's fee schedule as a benchmark as the California law does for nonemergency out-of-network clinicians furnishing services at in-network facilities has the built-in advantage of geographic adjustment.

Hospitals and clinicians will resist attempts to have limits placed on what they can charge commercial payers for out-of-network services. They might argue that this is the cost of doing business for plans that rely on narrow networks to limit enrollees' access and utilization. But states use network adequacy standards to hold plans accountable for how well they provide their members with access to care, and there is nothing in the proposed surprise medical bill legislation that would alter that. The bigger question is whether the financial windfall plans might gain from limits on what they must pay for out-of-network care translates into lower premiums or just larger profits. ■

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