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NO MORE SURPRISES: PROTECTING PATIENTS FROM SURPRISE MEDICAL BILLS

WEDNESDAY, JUNE 12, 2019

House of Representatives

Subcommittee on Health

Committee on Energy and Commerce

Washington, D.C.

The subcommittee met, pursuant to call, at 10:02 a.m., in Room 2123 Rayburn House Office Building, Hon. Anna G. Eshoo [chairwoman of the subcommittee] presiding.

Members present: Representatives Eshoo, Butterfield, Matsui, Castor, Sarbanes, Lujan, Schrader, Kennedy, Cardenas, Welch, Ruiz, Dingell, Kuster, Kelly, Barragan, Blunt Rochester, Pallone (ex officio), Burgess, Upton, Shimkus, Guthrie, Griffith, Bilirakis, Long, Bucshon, Brooks, Mullin,

Hudson, Carter, and Walden (ex officio).

Also present: Representative Soto.

Staff present: Waverly Gordon, Deputy Chief Counsel; Tiffany Guarascio, Deputy Staff Director; Zach Kahan, Outreach and Member Service Coordinator; Josh Krantz, Policy Analyst; Una Lee, Senior Health Counsel; Aisling McDonough; Policy Coordinator; Meghan Mullon, Staff Assistant; Kaitlyn Peel, Digital Director; Samantha Satchell, Professional Staff Member; C.J. Young, Press Secretary; Mike Bloomquist, Minority Staff Director; S.K. Bowen, Minority Press Assistant; Adam Buckalew, Minority Director of Coalitions and Deputy Chief Counsel, Health; Jordan Davis, Minority Senior Advisor; Margaret Tucker Fogarty, Minority Staff Assistant; Melissa Froelich, Minority Chief Counsel, CPAC; Peter Kielty, Minority General Counsel; Bijan Koohmaraie, Minority Counsel, CPAC; Ryan Long, Minority Deputy Staff Director; and Brannon Rains, Minority Staff Assistant.

Ms. Eshoo. Good morning, everyone.

The Subcommittee on Health will now come to order. The chair now recognizes herself for five minutes for an opening statement. Welcome to all of our witnesses. That's quite a table -- quite a lineup, and we are eager to hear from you.

Today is a bipartisan hearing about solutions to end surprise medical billing. Patients receive surprise bills when they receive care from providers who are not part of the health plan they are insured by, often referred to as out-of-network providers, and they are caught between insurers, hospitals, and doctors.

[Sounds gavel.]

Ms. Eshoo. The committee will come to order, please. There are staffers that want to have a great conversation. We have lots of side rooms for them.

These are often people who play by the rules. They bought an insurance plan, they paid their premiums, and they go to providers in their network.

Now, we all expect to receive medical bills, but the "surprise" in a surprise bill is a shock -- it should be called shock billing -- because it can amount to more than what most people have in a savings account, if they even have one.

In a recent Kaiser Family Foundation poll, 67 percent of the American people said they are worried about being able to afford their own or a family member's unexpected medical bills.

And it makes sense for them to be worried because receiving a surprise bill~~ing~~ -- medical bill -- is incredibly common, regrettably. It has become incredibly common.

One in five emergency department visits result in a surprise medical bill. If you need a ground or air ambulance, you are at an especially high risk for a surprise bill.

More than half of all ambulance rides are billed out of network and the GAO found that nearly 70 percent of air ambulance trips were billed out of network.

In my region, a young woman by the name of Nina Dang broke her arm while she was riding her bike. Paramedics took her to the emergency room at Zuckerberg San Francisco General Hospital.

According to Vox reporter Sarah Kliff, who wrote a series of articles exposing surprise bills, Nina Dang left with a cast and a few months later received a bill for $20,243.

That's because Zuckerberg San Francisco General was not

in her insurance network. Under current federal law, providers are permitted to bill privately ——insured patients for the balance not paid by the insurance plan.

California, New York, and several other states already haves strong state protections for out-of-network emergency patients. But state law cannot regulate self-funded employer plans that cover about 100 million Americans, thus, our joint presence here today.

That means that without action from Congress, millions of Americans will be left unprotected from surprise bills.

Today, we will hear testimony from those who represent each part of the system that produces surprise bills, and we welcome each one of you.

In reading the written testimonies, —I found that there was a tendency to confuse the surprise billing issue with other concerns: large deductibles, narrow networks, or the pressure of high health care costs for both patients and what it costs our country.

I think that those are all big concerns and I want our subcommittee to tackle them. But they are not today's agenda. Our work today is not exactly simple, but I think that it is very clear. We have to protect every American from a surprise medical bill.

I am proud of the bipartisan work our subcommittee has tackled so far on this Congress. In our drug pricing hearings, we were able to put the finger pointing aside and get to the root of the issue and pass legislation to help patients, and I believe we will continue to do that.

So here is my ask of our witnesses. We need you to help us to find the best policy. We all look forward to your testimony and look forward to working -- I look forward to working with my colleagues to develop a bipartisan solution to end surprise billing.

With that, I would like to now recognize Dr. Burgess, the ranking member of the Subcommittee on Health, for five minutes for his opening statement.

[The prepared statement of Ms. Eshoo follows:]

**********INSERT 1**********

Mr. Burgess. Thank you, and good morning to all of our witnesses and thank you for being here today to testify on this important topic of out-of-network billing.

It is an issue that has hit home in our districts and our states and, certainly, it's a topic of conversation when I go home to Texas.

One of the most prominent out -- of -- network billing stories in Texas is that of Drew Calver, a 44-year-old high school teacher in Austin, Texas, who suffered a heart attack and was rushed to the emergency room at St. David's Medical Center. Good for them.

He was stented and his heart muscle was saved. And so this was an individual who was otherwise healthy. He had competed in an Ironman triathlon earlier in the year, and he was told at the outset that the hospital would accept his insurance.

He has insurance through his school district and he was billed a total of $110,000 for his four-day hospital stay. That's more than two times his annual pay.

So problems with out-of-network billing is not an easy problem to solve but it's one where many of the stakeholders disagree on the solution.

But it is quite intentional that we have called those

stakeholders who might not agree to testify at the same table today. If there is anything upon which we should all agree it is that the patient should be held harmless so that they can avoid massive bills like the one Mr. Calver received, especially in emergency situations.

And I just want to underscore what the chairwoman of the subcommittee said, and while you all are ~~all~~ very smart -- you have differences of opinion about this -- we need your help. We solicit your help.

That is why you are here today. And if you don't help us solve the problem, we will solve the problem and none of you will like it.

In addressing this issue, I hope that the stakeholders here today -- physicians, insurers, hospitals, and patients -- come to an agreeable conclusion, even if it is not their first choice.

My state of Texas just passed a new bill in the state legislature because the first legislative fix passed two years ago did not adequately address out-of-network billing.

While Texas and numerous other states have made efforts to mitigate the billing issues, states are unable to legislate what happens in cases involving multi-state employer-sponsored plans.

This is why the Energy and Commerce Committee is looking to address this issue and why the president has been so vocal in putting forth a set of guiding principles in addressing surprise medical bills.

President Trump's principles include protecting patients without increasing federal health expenditures while maintaining choice for patients. I, largely, agree with President Trump's principles and I hope that Congress can come to a consensus upon the best way to execute a legislative effort and send something to the president's desk.

As a physician I understand the payment issues at hand when it comes to billing for health care services and I am really grateful that we have two physicians on our panel today.

It is important that throughout this conversation we consider the potential effect of shifting payment incentives for physicians, for insurers, for hospitals, and that we are not driving payment rates too far in one direction or another.

I do think it is critical that on such an important issue we take into account the various perspectives of the stakeholders and I am encouraged that we do have such a

robust panel before us this morning.

The committee released a discussion draft a few weeks prior to this hearing and my understanding is the committee has received a lot of comments on the discussion draft.

So I am hopeful that this subcommittee will lead the charge on addressing out-of-network billing. But I think the number of proposals that members have produced shows there is serious interest to accomplish something legislatively.

Patients deserve better than to receive bills they were not expecting for the care that they needed, especially when that care is non-elective or emergent in nature.

Again, I want to thank all of our witnesses for being here today and look forward to a lively and productive discussion.

Thank you, and I will yield back.

[The prepared statement of Mr. Burgess follows:]

**********INSERT 2**********

Ms. Eshoo. I thank the gentleman, and he yields back.

The chair now recognizes Mr. Pallone, the chairman of the full committee, for five minutes for his opening statement.

The Chairman. Thank you, Madam Chair.

I came in when Dr. Burgess was giving his opening statement and I thought, well, maybe I have to revise my remarks to be more evil. I am not usually playing good guy to his bad guy, but whatever. Maybe I didn't hear everything correctly.

[Laughter.]

The Chairman. But anyway, it's long past time for Congress to take decisive action to protect patients from the unreasonable and unacceptable practice of surprise billing.

Every day we hear new stories about American families being devastated financially and put through the tremendous emotional toll of surprise medical bills.

Stories like Stefania Kappas -- Rocha of California who went to the emergency room for a kidney infection at Zuckerberg Hospital in San Francisco. She spent one night in the emergency room and was sent home a day later with Ibuprofen. Two months later, she received a bill for more than $27,000.

Then there's a story in my county of Joseph from Sea Girt who went to an in-network hospital for an emergency surgery on his leg, only to later receive a $60,000 bill from a surgeon who was out of his network.

And then there's the story of Drew Calver of Dallas, Texas, who received a $108,000 surprise medical bill from St. David's Medical Center after treatment for a heart attack.

These stories highlight a clear market failure. I know we will see a lot of finger pointing today about who's at fault for this failure, and this is the same finger pointing that has resulted in patients going into debt, ruining their credit, and questioning whether they should take their child to the hospital.

But let me be clear. I am interested in fixing this problem for consumers, not for the stakeholders who have allowed this problem to persist for decades while consumers continually paid the price.

It is clear that the private sector is not going to fix this problem on its own and that Congress needs to step in and provide relief to consumers.

That being said, I want to commend~~t~~ the stakeholders here today for all agreeing that it's no longer acceptable to have patients in the middle of their disputes. People who

need emergency care who were treated by a doctor they did not choose should be held harmless.

Now, fortunately, there's a bipartisan agreement on the~~at~~ committee that we must act. Ranking Member Walden and I have worked together to craft a common sense bipartisan solution for the problem of surprise billing.

Our draft legislation would ensure that consumers with all types of private insurance are protected from surprise bills. It holds the patient harmless in surprise bill situations by ensuring that an individual's cost sharing for out-of-network care is limited to what the individual would have paid if the services were provided by an in-network provider.

This would ensure that patients are no longer penalized by the provider and the insurer's failure to contract, which is no fault of their own.

Providers would no longer be able to balance bill patients for out-of-network emergency services or for scheduled services from providers the patient was not aware would be involved in their treatment.

For the vast majority of cases, our discussion draft is simply asking providers to be more transparent about their billing practices and charges.

Insurers and hospitals also have a large role to play in making sure consumers understand their coverage. It is critical that we build some basic transparency and fairness into a system I think we all agree is incredibly difficult for consumers to navigate.

Providers, hospitals, and insurers should share this goal because the status quo is severely damaging the reputation and trustworthiness in the eyes of consumers.

Now, the discussion draft proposes resolving the payment dispute between the provider and the insurer by requiring the insuring plan to pay at a minimum the median in-network rate for that service in that geographic area.

This ensures that in the absence of balance billing every provider will be guaranteed some payment for their services and this would also create a predictable transparent means of resolving these disputes between providers and insurers who have failed to contract. It would also place little or no administrative burden on states, the federal government, or the parties involved in the dispute.

So I look forward, Madam Chair, to hearing constructive feedback in the draft proposal. But I strongly believe that any viable solution in this space cannot result in rising health care costs.

This debate has shed light on the fact that some providers' charges and hospital fees are inexplicably high and I worry that if Congress chooses the wrong approach, consumers will simply end up paying those costs through higher premiums and we simply can't allow this to happen.

So I hope that today we can have a productive discussion without pointing fingers and passing the buck. We should instead focus on policy solutions that protect consumers. Ideally, such a solution will not only take the patient out of the middle and hold him financially harmless from surprise billing.

It'll also help create a lower cost, more rational health care system for all Americans, and I believe that the discussion draft accomplishes these goals and look forward to the feedback from our witnesses.

Obviously, Madam Chair and Dr. Burgess, you know, this discussion draft doesn't have to be the end all, and that's the reason we are having the hearing today and will continue to have discussions with people who may have alternative ideas or, you know, improving on what this discussion draft has here today.

[The prepared statement of The Chairman follows:]

328 **********INSERT 3**********

So thank you, Madam Chair, and I -- back to Dr. Burgess again, I am not used to being -- he was like the bad guy today and I felt like I was --

Ms. Eshoo. No, he wasn't.

The Chairman. He wasn't?

Ms. Eshoo. No.

The Chairman. Oh, then I misunderstood then. Oh, very even tempered. Okay. All right. Thank you. I yield back.

Ms. Eshoo. He was in great form today, even better form. He's always in good form.

The gentleman yields back. Now I'd like to recognize my friend, the ranking member of the full committee, Mr. Walden, for five minutes for his opening statement.

Mr. Walden. Well, thank you, Madam Chair, and thanks to Dr. Burgess and you for this hearing and to Mr. Pallone for working in the bipartisan way we are to address this surprise billing issue.

The hearing really is about patients, first and foremost. We are actually going to put them first. We have all heard the stories and you heard some more today.

Patients who followed the rules, they pay their premiums, and then through no fault of their own following some sort of emergency situation or surgery, receive a six-

digit bill in the mail weeks later, which they have no way of paying.

It is not fair. It should not happen and we are going to put a stop to it one way or the other. We must protect patients from these bills and we want to get it right.

Since we released this draft last month, Chairman Pallone and I have received more than 60 comment letters on this draft from stakeholders across the health care industry.

That feedback is critical as we work to take the patient out of these surprise billing scenarios without raising overall health care costs.

I'd also like to thank all of our witnesses for being here today, many of whom have provided helpful feedback on this legislation and I'd particularly like to thank Ms. Wilkes.

Unfortunately, you have had to become an expert on this topic the hard way by living through it with your children. As a parent, I share your frustration and your desire to fix surprise billing once and for all.

Unfortunately, as you know, your experience is not unique, and I recently spoke with a doctor whose daughter's case has become pretty well known. The president had her down at the White House.

She had been in the hospital and on the way out her provider suggested she take a simple drug test. Little did she know that that test then was sent to an out-of-network lab and she soon received a bill for $17,850 in the mail. She had no reason to know or even to think to ask if the lab was in or out of network. She was just following her doctor's advice.

Situations like hers and yours, Ms. Wilkes, are why we are here today. We are going to stop this and it's why Chairman Pallone and I are moving forward with legislation to protect patients.

I am also pleased the president has taken on this issue. He was very serious about fixing surprise billing when we had a bipartisan event at the White House a couple weeks ago and I am encouraged our draft legislation lines up pretty well with the principles the president has set forth for a solution that could get his signature and into law.

So we are moving forward on this. The draft before us today, the No Surprises Act, would take a number of steps to address surprise medical bills.

First and foremost, this bill prohibits balance billing of patients and limits a patient's bill to their in-network cost-sharing amount in emergency situations.

This is common sense when a patient has little or no~~t~~ control over who gives them lifesaving care and can hardly be expected to make sure everyone is in network.

For scheduled care like elective surgeries, patients must receive both verbal and written notice of any out-of-network providers who will be involved in their care, and if they don't consent to that notice they cannot be balance billed.

Under our draft bill, providers who would currently balance bill the patient will instead be paid by the~~to~~ patient's insurer at the median in-network rate for the service they provided in that geographic area.

And by the way, my home state of Oregon passed legislation on surprise billing last year with a similar approach and other states have passed their own models that create an arbitration process for providers and insurers to come to an agreement on a reasonable payment, and there are combinations of the two.

Under our draft, these state laws, by the way, would remain in effect, and we know what many of the organizations represented in this room said when Oregon took up its law and what they've said since, and we know how it's playing out.

There are a number of options on how to deal with the

payments to providers and I look forward to hearing from our panel on their experience with these different models.

In closing, I want to stress again this is an issue that is important to us and to our constituents and to all consumers in America. I understand there are competing interests here today. I expect we will have plenty of back and forth on the policies in this draft and that's what we are seeking.

Protecting patients, however, must be put at the forefront of this discussion and I'll continue to work with my colleagues on both sides of the aisle to do just that. We are going to resolve this once and for all.

With that, I yield back.

[The prepared statement of Mr. Walden follows:]

**********INSERT 4**********

Ms. Eshoo. The gentleman yields back. The chair would like to remind members that pursuant to committee rules, all members' written statements -- opening statements will be made part of the record.

I now would like to introduce all of our witnesses that are here today.

Ms. Sonji Wilkes, who is a patient advocate -- thank you very much for being here; Dr. Sherif Zaafran, thank you for you being here -- he is the chair for Physicians for Fair Coverage; Mr. Rick Sherlock, the president and CEO for the Association of Air Medical Services -- thank you to you; Mr. James Gelfand, executive -- senior vice president to health policy, the ERISA Industry Committee; Mr. Thomas Nickels, the executive vice president of the American Hospital Association -- it's nice to see you again; Ms. Jeanette Thornton, the senior vice president of product, employer, and commercial policy, America's Health Insurance Plans -- welcome to you and thank you; Ms. Claire McAndrew, director of campaigns and partnerships at Families USA -- thank you to you and the work that the organization does; Dr. Vidor -- is it Vitor or Vidor?

Dr. Friedman. Madam Chairwoman, it's Vidor.

Ms. Eshoo. Vidor.

Dr. Friedman. Thank you.

Ms. Eshoo. Thank you. Vidor Friedman. Dr. Friedman, president of the American College of Emergency Physicians.

So we thank all of our witnesses for joining us today and we look forward to your testimony. The chair is going to begin by recognizing our first witness.

Each one of you have five minutes to give your opening statement, and you're probably all pretty familiar with what the light system.

The one you really have to pay attention to is red because it's over then, okay? So when it's yellow you have one minute remaining to wrap up your point.

So, Ms. Wilkes, again, thank you for being here. Tell us your story. You're recognized for five minutes.

STATEMENTS OF SONJI WILKES, PATIENT ADVOCATE; SHERIF ZAAFRAN, M.D., FASA, CHAIR, PHYSICIANS FOR FAIR COVERAGE; RICK SHERLOCK, PRESIDENT & CEO, ASSOCIATION OF AIR MEDICAL SERVICES; JAMES GELFAND, SENIOR VICE PRESIDENT, HEALTH POLICY, THE ERISA INDUSTRY COMMITTEE; THOMAS NICKELS, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION; JEANETTE THORNTON, SENIOR VICE PRESIDENT OF PRODUCT, EMPLOYER, AND COMMERCIAL POLICY, AMERICA'S HEALTH INSURANCE PLANS; CLAIRE MCANDREW, DIRECTOR OF THE CAMPAIGNS AND PARTNERSHIPS, FAMILIES USA; VIDOR E. FRIEDMAN, M.D., FACEP, PRESIDENT, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

STATEMENT OF MS. WILKES

Ms. Wilkes. Thank you, Madam Chairwoman.

My name is Sonji Wilkes and I am a mom from Englewood, Colorado. I would like to thank the chairwoman, Congressman Burgess, and members of the subcommittee for the opportunity to discuss my family's experience with surprise billing and ask you to end this practice.

When my husband and I became first-time parents as health 20 somethings, neither of us had much experience with insurance. But we had a valuable lesson when we received a bill double what we expected.

Seems the insurance company counted me and my newborn daughter as two separate patients. Though surprised, we paid the claim and moved on.

Two years later, we decided to grow our family. A little wiser, we made sure to ask specifically if we would incur two co-pays. We double checked that our OB/Gyn and the facility that we were to deliver at were in network.

Per the documentation from our insurance provider, we were covered. My son, Thomas, was born full term. By all appearances he was a healthy boy.

Several hours after Thomas was circumcised, our pediatrician called to say that he was concerned that the circumcision site continued to bleed. The next day he called us in tears to say that Thomas had severe hemophilia A, a genetic disorder that prevents his blood from clotting.

Our doctor told us that hemophilia was a rare -- excuse me, Thomas was taken to the neonatal intensive care unit so that he could be closely observed. Within the hour, a specialist from the local hemophilia treatment center was standing in our hospital room and, after asking if we had good insurance, spent the next few hours explaining hemophilia to us.

She brought a dose of clotting factor for Thomas to stop

the bleeding as the hospital did not stock that medication. In the NICU, the hematologist started an IV line in my son's scalp while the NICU staff intently watched. They had never treated hemophilia.

While the hematologist was not part of the hospital or the NICU staff, we never saw a bill for the medication she administered or for her time or services.

Thomas remained in the NICU overnight for observation. Neither my husband or I left our son's side, and other than monitoring his vitals, there was no direct care give to Thomas. As a nearly 10-pound baby, he was a bit out of place in the NICU.

We were discharged within the normal post-partum period and went home to come to grips with an unexpected chronic disorder diagnosis for our baby boy.

A few weeks later, we received another shock -- a $50,000 bill for Thomas' stay in the NICU. We were dumbfounded. We had been at an in-network facility. How could we possibly be responsible for that amount?

My husband and I felt we should not be held responsible. We did some research and found out that the hospital had subcontracted the NICU out to a third party provider. This third party provider was the one demanding payment.

We had made a good faith effort to stay in network. We refused to pay the bill and, subsequently, were sent to collections. Our credit was ruined.

Sometime later our minivan lease was expiring. As we headed to the dealership we knew we wouldn't qualify for a new lease. I had to have a car. Thomas was being seen at the hemophilia treatment center multiple times a week. At the finance manager's desk, my husband and I explained the surprise bill. As I emptied the Kleenex box sitting on his desk, he started tapping on his computer, wiped a tear of his own, and said, we will make something happen for you. It might be at a crazy high interest rate and you'll have to keep the car until the day it dies. But I understand your situation because something similar happened to my family.

I am still driving that minivan.

When you are told your baby's body lacks the ability to stop bleeding and that he needs immediate specialized treatment, your first reaction isn't, gee, I wonder if that's in-network.

Your first reaction is, do whatever it takes to save my baby. Why would I check if the NICU, just 50 steps away from the room that I gave birth in, was in network? I think any reasonable person would assume it to be because it seems

reckless and cruel that it would not be.

No family should face financial ruin because they are duped into thinking that they are at an in-network facility or because the in-network provider contracts out services like radiology, lab services, imaging, or more without the patient's knowledge.

While transparency and disclosure of any out-of-network subprovider is critical, it's not enough. Navigating health insurance is extremely difficult and especially so in crisis or for the inexperienced.

According to a recent Kaiser Family Foundation poll, four out of 10 respondents said they had received an unexpected bill from a hospital, lab, or doctor in the past year.

But surprise billing is not a new issue. My personal story is from 2003. Patients need you to pass protections to stop these harmful practices.

I wish this wasn't mine or anyone else's stories to share. Please protect Americans from excessive bills and medical debt by ending this surprise billing.

My family and millions of others thank you in advance.

[The prepared statement of Ms. Wilkes follows:]

589 **********INSERT 5**********

Ms. Eshoo. Thank you, Ms. Wilkes.

How is your son today?

Ms. Wilkes. He's very good.

Ms. Eshoo. Good. That's great.

Ms. Wilkes. Fifteen years old and learning how to drive in that minivan.

Ms. Eshoo. Isn't that wonderful? Isn't that great? Isn't that great? I just want to make a suggestion. I think that the witnesses all need to direct their comments attached to Ms. Wilkes' story. I mean, this is -- I don't know -- I don't think there's anyone here that can defend it. But it's just a suggestion.

I am now pleased to recognize Dr. Zaafran for five minutes for his testimony. Thank you and welcome.

STATEMENT OF DR. ZAAFRAN

Dr. Zaafran. Thank you. Good morning, Chairman Eshoo, Ranking Member Burgess, and distinguished members of the committee.

Thank you for inviting me to testify today on behalf of Physicians for Fair Coverage. My name is Sherif Zaafran and I serve as chair of the board of PFC and I am a practicing anesthesiologist.

PFC is a non-profit nonpartisan multi-specialty association of tens of thousands of physicians partnered with patient advocates to end surprise medical billing.

We are committed to finding a solution that creates strong patient protections, ensures access to care, and improves transparency.

To be clear, PFC-affiliated physicians prefer to be in-network and are actually in-network with the vast majority of the patients we see. These numbers are actually representative of the larger market for emergency medicine, anaesthesiology, radiology, and other hospital-based physicians.

On behalf of PFC, I want to commend all of you for working to address out-of-network surprise billing for our

patients. As a physician, I live and work by the creed do no harm and believe that any solution to surprise billing should meet this test as well.

In this spirit, PFC believes that protecting patients from potential financial stress by eliminating balance billing for unanticipated out-of-network care and ensuring patients pay no more than their in-network cost sharing is the right thing to do.

It is important, however, to understand what causes surprise billing before we talk about the solution. There are two key factors: an increasing proliferation of high deductible plans, many of which can be $5,000 or more, which has resulted in a significant financial burden on patients that is unanticipated; and two, complicated plan designs with tiered and narrowing networks which force doctors to be out of network and in many instances not by their choice.

Understandably, a federal solution is key to solving the problem of unanticipated out-of-network costs. We want to recognize the leadership of Congressmen Ruiz and Bucshon for putting for a very thoughtful proposal, and we appreciate the proposal offered by full committee Chairman Pallone and Ranking Member Walden.

PFC does have concerns, however, that the median in-

network benchmark currently in the full committee's discussion draft could have the unintended consequences of potentially driving more patients and their physicians out of network.

Our recommendation is to turn the benchmark payment concept into an interim payment with the ability of either side to go to a baseball-style independent dispute resolution process if there is a disagreement.

The care provided by different physicians is not always uniform. There can be variability in quality and the cost of providing high-value care, especially when providing certain types of care in different geographical areas.

While there may be a desire by some to reduce spending in critical pinnacle areas for patients in order to increase their own profitability, physicians would prefer to decrease overall health care costs by investing in resources that allow for better patient outcomes.

To be sure, the best arbitration process is one that does not need to be utilized. We believe an appropriate interim payment will resolve most disputes. For those that it does not, IDR provides the opportunity to appeal the payment in a fair and expedited way.

And this cuts both ways. Plans and providers alike will

have the opportunity to appeal. PFC has been very involved in the debate on this issue in the states and we note that solutions incorporating IDR such as New York and, most recently, in Texas, have proven successful.

Indeed, in New York, such a process resulted in out-of-network rate dropping from 20.1 percent to 6.4 percent after IDR solution was put in place. According to a recent study by the Georgetown University Center on Health Insurance Reforms, the independent dispute resolution process has resulted in a decrease in out-of-network claims, a dramatic decline in consumer complaints about surprise bills, and no indication of an inflationary effect on insurers' annual premium rate filings.

The law has also led to stronger protections for patients and more patient-centric health plans, enhanced transparency from health insurers, and increased network participation and fewer out-of-network claims.

We believe a federal solution should build on this proven success and we encourage the committee to include the IDR process in future iterations of the legislation.

Doing so will preserve existing in-network arrangements, ensure both providers and payers have the ability to achieve a fair rate, take the patient out of the middle, and avoid

significant disruption that would result from moving the market to a set benchmark rate.

On the other hand, a poorly constructed untested solution could threaten patients' access to quality care and the provider's ability to serve their communities.

For example, the experience in California shows that a benchmark approach does not work. The law has had unintended consequences, resulting in insurers refusing to renew longstanding contracts or offering significantly reduced rates that undermine good faith contracts.

Insurers in the state now have little incentive to contract with physicians.

Finally, we urge you to reject the false narrative advanced by some that arbitration necessarily involves a choice between so-called reasonable rate and providers' full billed charges.

Arbitration guardrails can and should be designed to guide the parties to market-based rates while preserving appropriate variation based on performance and local conditions which economic studies have shown is the outcome produced with baseball-style former in particular.

In conclusion, PFC advocates for and supports a ban on balance billing for unanticipated out-of-network care with

strong patients protections, fair reimbursement backed by an IDR process to ensure access to care, greater network adequacy standards, and improved transparency for all patients.

Madam Chair, members of the committee, we appreciate your leadership on this important issue and thank you for the opportunity to testify.

PFC stands ready to work with you in the best interests of our patients and physicians who care for them, and I am happy to answer any questions you may have.

[The prepared statement of Dr. Zaafran follows:]

**********INSERT 6**********

Ms. Eshoo. Thank you, Doctor.

The chair now is pleased to recognized Mr. Sherlock for five minutes for your oral testimony, and thank you for being here again.

STATEMENT OF MR. SHERLOCK

Mr. Sherlock. Thank you. Good morning, Chairwoman Eshoo, Ranking Member Burgess, and distinguished members of the subcommittee.

On behalf of the association of Air Medical Services, we look forward to working with you to ensure everyone in America has access to lifesaving emergency air medical services when they need it most.

Emergency air medical services are highly effective medical interventions appropriate in cases where getting a patient directly to the closest most appropriate medical facility can make a significant difference in their survival and recovery.

Today, because of air medical services, 90 percent of Americans can reach a level one or level two trauma center within an hour. However, since 2010, 90 hospitals have closed in rural areas and an estimated 20 percent more are at risk of closing.

Our members fill the gap created by closures but this lifeline is fraying as 31 air medical bases have also closed in 2019. Emergency air medical providers never make the decision on who to transport. That decision is always made

by a requesting physician or medically trained first responder.

Air medical crews then respond within minutes, 24 hours a day, seven days a week without any knowledge of a patient's ability to pay for their services.

Our members are unique in the health care system. The service is heavily regulated by the states for the purposes of health care as ambulances and the federal government for aviation safety and services as air carriers. It is their status as air carriers that allow rapid transport of patients over significant distances.

Over 33 percent of our flights cross state lines every day. For that reason, the Airline Deregulation Act's uniform authority over the national airspace is essential to the provision of this lifesaving service.

Exemption air medical services from the ADA would allow states to regulate aviation services including where and when they are able to fly, limiting access to health care for patients in crisis.

Congress took significant action on emergency air medical billing in 2018. In the FAA reauthorization act, Congress established the Advisory Committee on Air Ambulance and Patient Billing.

Congress would benefit from reviewing the work of the Advisory Committee, which was tasked to recommend actions to provide relief for patients while taking into account the unique operational, regulatory, and financial aspects of emergency air medical services.

To prevent balance billing, our members are actively negotiating with insurance companies to secure in-network agreements. One member alone has increased their participation from 5 percent to almost 43 percent in the last three years.

Despite that, some insurers have refused to discuss in-network agreements. That hurts both patients and caregivers. Air medical services are not a cost driver for insurance. According to testimony before the Montana legislature Joint Economic Affairs Subcommittee in 2016, supported by national health insurance data, covering air medical services in full represents about a $1.70 of the average monthly premium. More than 70 percent of the 360,000 patients transported by helicopter air ambulances each year are covered by Medicare, Medicaid, or are uninsured. According to a study conducted by Xcenda in 2017, $10,199 was the median cost of providing a helicopter transport, while Medicare paid $5,998, Medicaid paid $3,463 and the uninsured paid $354.

This results in an ongoing imbalance between actual costs and government reimbursement and is the single biggest factor in increasing costs.

AAMS strongly supports legislation that would increase transparency regarding air medical services and reform the Medicare reimbursement system for those services, which is a primary driver of balance billing.

Legislation introduced in the 115th Congress supported on this committee by Congressman Ruiz and Johnson and co-sponsored by Chairwoman Eshoo, the Ensuring Access to Air Ambulance Services Act, would mandate 100 percent industry reporting of comprehensive cost data to the Centers for Medicare and Medicaid and then rebase Medicare fees for emergency air medical transport using that data, which would address the gap between reimbursements and costs.

Additionally, there are reported incidents where individuals receive high bills for cases of prescheduled nonemergent private airplane transports. AAMS refers all such inquiries and reports to the Department of Transportation consumer protection division in the hopes that the agency exercises its already existing authority to protect consumers.

Finally, AAMS would ask the committee to recognize the

tremendous commitment our industry members and caregivers make who have dedicated their life's work to serving others and to ensure critical emergency medical response is always available to the communities they serve.

AAMS believes in protecting patients. Our members protect them every day. AAMS thanks the committee for the opportunity to offer this testimony and asks the committee to recognize the unique aspects of this essential service and not to curtail access to health care for patients in crisis.

[The prepared statement of Mr. Sherlock follows:]

**********INSERT 7**********

Ms. Eshoo. Thank you, Mr. Sherlock.

Now I would like to recognize Mr. Gelfand for five minutes for your testimony.

STATEMENT OF MR. GELFAND

Mr. Gelfand. Chairwoman Eshoo, Ranking Member Burgess, and members of the subcommittee, thank you for this opportunity to testify.

I am James Gelfand, senior vice president for health policy at the ERISA Industry Committee, a trade association representing large employer plan sponsors.

Our member companies offer comprehensive health benefits and as self-insured plans pay around 85 percent of health care costs for our beneficiaries. About 181 million Americans get insurance through a job and surprise billing fundamentally frustrates the goal of providing quality affordable employer-sponsored coverage.

The vast majority of our employees are not doctors, HR executives, or medical billing experts, nor should they have to be. But patients are falling victim to impossible complexities. Employers are ready to work with Congress to right the ship. We are focused on three scenarios in which patients end up with big bills they couldn't see coming or avoid.

Number one, a patient receives care at an in-network facility but is treated by an out-of-network provider.

Number two, a patient requires emergency care but the provider's facility or transportation are out of network. And number three, a patient is transferred or handed off without sufficient information or alternatives. It is usually not the providers you're planning to see.

It is the anesthesiologists, radiologists, pathologists, or emergency providers or transport for an unexpected trip to the NICU.

Many work for outsourced medical staffing firms that have adopted a scam strategy of staying out of networks, practicing at in-network facilities, and surprise billing patients. It is deeply concerning but the problem is narrowly defined and therefore we can fix it.

ERIC applauds the committee for taking the lead on solving this. The No Surprises Act nails it. It takes patients out of the middle and creates a market-based benchmark rate to pay providers fairly.

The benchmark is not developed by government and it is not price setting. The committee might also consider network matching. It is simple.

If a provider practices at an in-network facility, they take the in-network rate, or they go work somewhere else. Or base the benchmark on Medicare. You could set the rate

higher, say, 125 percent of Medicare, and still make the system more affordable, sustainable, and simpler.

These approaches will eliminate the surprise bills. That's a huge win for patients and improves the system by creating certainty for payers and fair pay for providers.

But not everyone wants to stop surprise bills. Some provider specialties are saying, let us keep doing what we are doing -- just use binding arbitration to make someone else pay these bills. They're asking for a nontransparent process that could force plans and employers to pay massive and fake medical list prices.

It is essentially setting money on fire. Funds that would have been used to pay for health care will instead be spent on administrative costs such as lawyers, arbitrators, facility fees, and on unreasonable settlement amounts. Make no mistake, patients will pay these costs.

The ground and air ambulance companies are asking Congress to let them keep surprise billing, too. Do nothing, wait for another study, another report, and there have already been four.

They know patients cannot shop for them and many participate in no networks. State insurance commissioners are begging for help with air ambulances. But Congress has

tied their hands.

Employers think Congress should end this. Treat medical transport the same as emergency care. We should end surprise billing in the ER and on the way there.

Other providers figure they're willing to stop surprise billing but only if they can increase in-network rates. They're calling for network adequacy rules to force insurers and employers to add more providers to their networks, even if those providers demand astronomical payments.

Does anyone here actually believe that these hospital-based doctors whose services cannot be shopped for, who are guaranteed to see our patients, are begging to be included in our networks but nobody will return their calls? That they have no choice but to go and join these out-of-network Wall Street-owned firms?

It doesn't make sense. Employers design health benefits to help our beneficiaries. We don't sell insurance. We want networks that meet our patients' needs. Why would we want to cover an operation but leave out the anaesthesia?

We want our employees to be able to afford their health insurance, too, and that means we must be able to say no when providers are gaming the system. We are here to solve a specific problem, not to create new ones. Network adequacy

is a distraction. Let's focus on protecting patients from surprise medical bills.

In conclusion, thank you for this opportunity to share our views. The ERISA Industry Committee is eager to work with Congress towards a bipartisan comprehensive solution that protects access to care and ends the surprise billing crisis without driving up health insurance costs.

And I am happy to answer any questions.

[The prepared statement of Mr. Gelfand follows:]

**********INSERT 8**********

Ms. Eshoo. Thank you, Mr. Gelfand.

Mr. Nickels, you are now recognized for your five minutes of testimony.

STATEMENT OF MR. NICKELS

Mr. Nickels. Thank you, Madam Chair. I appreciate the opportunity. My name is Tom Nickels. I am executive vice president of the American Hospitals Association here representing our 5,000 member hospitals and health systems.

Our bottom line is that we must protect patients like Ms. Wilkes from surprise medical bills and the AHA supports federal legislation to do so.

Congress must act, as has been mentioned, to protect the 60 percent of Americans who are in employer-sponsored plans under ERISA and those who live in states that have not enacted protections to address the issue of surprise medical bills.

Patients should not be subject to balance billing when they have access to emergency services outside their network or have acted in good faith to obtain in-network care. They also shouldn't be surprised by coverage denials from their insurers when they access any emergency services in network or out of network.

I would like to respond to a few of the ideas put forward in the Energy and Commerce discussion draft. First, we agree with that legislation should explicitly prohibit

balance billing in the scenarios I just outlined and make sure that patients are kept out of the process to determine reimbursements between the payer and the provider. I would encourage you to also improve the standards for provider networks and ensure adequate oversight to prevent instances of out-of-network care.

Once the patient is protected, we believe Congress should allow providers and payers to determine fair and appropriate reimbursement.

We oppose a national rate or benchmark for out-of-network services such as a median contracted in-network rate even if geographically adjusted as it would not be able to capture the many factors that specific health plans and providers consider.

We are also concerned at setting a reimbursement standard in law would serve as a disincentive for insurers to maintain adequate provider networks.

We've already seen an increase in the use of no-network reference-based pricing models in the commercial market and this could accelerate should insurers have the option to default to a government-established out-of-network rate.

Health plans should not be absolved of their core function of establishing provider networks including

negotiating rates with providers.

The committee's discussion draft provides $50 million grants for state-level all payer claims databases -- APCD -- that would presumably assist in determining a median contracted in-network rate.

While we appreciate the committee's efforts to develop APCDs, we do not believe that the committee should rely on them for the purposes of this policy.

While the AHA believes that hospitals and payers are able to negotiate reimbursement for out-of-network claims without government involvement, there may be a role for a dispute resolution process not for hospital services but for physician claims.

The baseball-style of arbitration similar to what New York State has implemented, which does not include hospitals, appears to be an inefficient process that places the responsibility to initiate the request with the provider or health insurer and not the patient.

Studies have shown a 34 percent reduction in out-of-network billing. Physicians have been largely split between the providers and payers, and there has not been a noticeable inflationary impact on premium insurance rates.

The National Association of Insurance Commissioners has

also put forward a model act that outlines a mediation process to resolve disputes. Again, these are state-level solutions. They do not resolve surprise bills under ERISA.

However, they could be successfully deployed at the federal level with some modification. The committee's discussion draft requires providers at the time of scheduling to give patients both oral and written notice about the provider's network status and any potential charges they could be liable for if treated by an out-of-network provider. While we believe providing the patient with this information on network status is important, it is not in and of itself a solution to surprise medical bills.

Should the committee move forward with legislative language requiring notice and disclosure, we would ask that you include physicians and insurance plans in any requirements as they also have a role to play in keeping patients informed about their status.

Lastly, I would like to address the concept of network matching, which is not in the committee's draft but has been suggested previously, in surprise medical billing. In this scenario, the facility-based practitioner will be required to contract with every plan for which the facility has a contract.

AHA opposes this approach because it would interfere with the fundamental relationship between hospital and physician partners and severely limits providers' ability to negotiate contract terms with insurers.

If you require hospitals to enforce this approach it would raise anti-trust concerns as it could be seen as an effort by hospitals to restrict the physicians' ability to practice.

Madam Chair, we have an opportunity to protect patients from surprise bills as a consensus has developed among all parties. We should not risk moving forward by adding other policies that could put passage at risk.

I look forward to working with the committee and the subcommittee to make sure that patients are protected from surprise medical bills.

Thank you very much.

[The prepared statement of Mr. Nickels follows:]

**********INSERT 9**********

Ms. Eshoo. Thank you, Mr. Nickels.

I know would like to recognize Ms. Thornton for five minutes for your testimony.

STATEMENT OF MS. THORNTON

Ms. Thornton. Thank you.

Chairwoman Eshoo and Ranking Member Burgess, and members of the subcommittee, I am Jeanette Thornton, senior vice president of product, employer, and commercial policy for America's Health Insurance Plans.

I appreciate this opportunity to testify on solutions to protect the American people from surprise medical bills. We want to end surprise medical bills so that patients like Ms. Wilkes and her family have the peace of mind in an emergency that they will not receive inflated bills from doctors they did not seek out for care.

We applaud the leaders of the House Energy & Commerce Committee for developing a bipartisan discussion draft of the No Surprises Act. This draft bill takes important steps to protect patients, ensure that doctors are paid fairly, support health plan networks, and use market-based approaches to ensure affordable high-quality care.

Our written testimony focuses on the following: a review of how surprise medical bills occur along with data demonstrating the frequency and magnitude, recommendations we support to protect patients, information on how surprise

medical billing legislation will not weaken health plan networks, our concerns regarding arbitration and how this approach would increase health care costs for everyone, and a discussion of state laws in California, Texas, and New York that provide important lessons for federal legislation.

We have all heard personal stories that demonstrate the need for federal legislation to protect patients from surprise medical bills: the Yoder family whose child experienced a $142,000 snake bite at summer camp, including a $55,000 air ambulance ride; Nellie Lu, who faced a $28,000 bill for her fall on her gym's climbing wall from a hospital at which at that time did not contract with any private insurers and was her only option; Dr. Kahn, whose ride in the ATV resulted in a $56,000 air ambulance ride and a balance bill of $44,000. He was one of dozens of patients across the country who have faced air ambulance bills from $28,000 to $97,000, and we have all heard the stories of American families who are afraid to seek treatment for fear of the high bills they will experience.

These stories make it clear that surprise medical bills are creating financial hardship for the American people and that federal legislative action is needed.

Here is what we support. First, a balance billing

should be banned in situations where patients are involuntarily treated by an out-of-network provider. This includes ER services provided at any hospital, any health care services that are provided at an in-network hospital by an out-of-network provider, and ambulance transportation in an emergency.

Second, health insurance providers should be required to reimburse out-of-network providers an appropriate and reasonable amount in these scenarios.

Third, states should be required to establish a dispute resolution process that works in tandem with the established payment benchmark.

And fourth, hospitals and other health care providers should be required to furnish advanced notice to patients of the network status of treating providers.

These protections must apply for self-funded plans and for people who live in states without adequate protections. The reason surprise medical bills are a problem is not a lack of network adequacy that some may suggest.

Surprise bills are caused by a small subset of medical specialists who lack the financial incentives to participate in health plan networks.

We urge you to reject proposals that would use

arbitration to determine payments to out-of-network providers. This approach imposes administrative burdens on the entire health care system including employers that offer self-funded coverage.

It also fails to address the root cause of surprise medical bills -- exorbitant bills from certain specialty doctors.

We appreciate that the committee's discussion draft and the Trump administration have rejected arbitration in favor of a market-based approach -- an in-network payment benchmark.

It is also important to look at state laws addressing this issue. Based on our analysis of laws enacted in California, Texas, and New York, we urge Congress to pursue a California style solution that both protects patients and consumers with common sense rules, does not undermine networks, and does not lead to higher cost-sharing or premiums.

I thank you for this opportunity to testify. AHIP and our member health plans stand ready to work with the committee to alleviate the financial burdens imposed by the American people by surprise medical bills.

Thank you.

[The prepared statement of Ms. Thornton follows:]

**********INSERT 10**********

Ms. Eshoo. Thank you.

Dr. Vidor Friedman, you have five minutes for your testimony.

STATEMENT OF DR. FRIEDMAN

Dr. Friedman. Thank you, Madam Chair and members of the Health Subcommittee.

On behalf of the American College of Emergency Physicians -- ACEP -- and our 38,000 members, I would like to thank you for the opportunity to speak with you today about this critical issue of surprise medical bills.

The reason emergency physicians like myself do what we do first and foremost is to take care of patients in their moments of greatest need. This is not the time where patients should be worrying about verifying who their provider is, are in network, or what their deductible is, or what the cost of -- the total cost of treatment might be.

I care for each and every one of the patients that comes to my emergency department regardless of ability to pay. I do this not just because of the oath that I took as a physician but because it is appropriately required by federal law.

Unlike most physicians, emergency physicians are prohibited by federal law from discussing with a patient any potential costs of care or insurance details until they are screened and stabilized.

This important patient protection, known as EMTALA, ensures physicians focus on the immediate medical needs of patients. However, it also means that patients cannot fully understand the potential cost of their care or the limitations of their insurance coverage until they receive the bill.

We understand that this can cause frustration, confusion, and, frankly, even be scary for patients. We agree with the committee's commitments to take patients out of the middle of surprise billing disputes and I would like to emphasize three key principles that ACEP urges Congress to consider as it works to address surprise billing.

The first, and above all, is protecting patients. Congress should limit patients' out-of-pocket responsibility for emergency care so they won't pay any more than the in-network amount.

Currently, this protection only applies to co-payments and co-insurance, not to deductibles. We support the committee's intent on this provision in the discussion draft but urge you to go further than simply counting co-payments and co-insurance towards any deductible or out-of-network max.

Rather, we urge you to require deductibles for out-of-

network emergency services to be treated as if they were in network.

The second principle is to improve transparency. While EMTALA prohibits me from discussing potential costs of care with my patients in advance, there are other ways Congress can improve transparency for emergency patients. Insurers should more clearly convey plan details to their enrollees. This will help patients better understand the limitations of their insurance coverage and all potential out-of-pocket costs.

Insurers should also be required to explain to enrollees what their rights are under federal law related to emergency care in easy to understand clear language.

Third, now that we have taken the patient out of the middle, Congress should ensure fair and transparent dispute resolution between physicians and insurers. The goal should be a system in which everyone is in network or essentially that.

That requires a level playing field between providers and insurers. Insurers are concerned that bench marking even median charges favors providers. Providers are concerned that bench marking the median in-network rates favors insurers. What's Congress to do?

ACEP supports a system that has already proven to be balanced between insurers and providers. That is a baseball-style independent dispute resolution process similar to that used in New York and noted in the legislative proposal put forth by Drs. Ruiz, Roe, and Bucshon.

In New York this simple and effective solution has almost completely eliminated surprise bills. It incentivizes physicians to charge reasonable rates and it also incentivizes insurers to compensate at appropriate levels. Insurance premiums and health care costs in New York have actually grown more slowly than the rest of the nation.

This model would be the least disruptive to the current system. It is the only model with empirical data detailing the positive impact it has had for patients and all stakeholders.

To be clear, this model has not been extraordinarily bureaucratic, costly, burdensome, or inflationary. More must be done to protect patients and their families from unexpected medical bills and we stand with you in this regard.

On behalf of the 150 million Americans my members care for every year, I thank you for your consideration and the opportunity to speak with you today.

[The prepared statement of Dr. Friedman follows:]

**********INSERT 11**********

Ms. Eshoo. Thank you, Doctor.

Now I have the pleasure of recognizing Ms. McAndrew for five minutes for your testimony.

STATEMENT OF MS. MCANDREW

Ms. McAndrew. Chairwoman Eshoo, Dr. Burgess, and members of the subcommittee, I am Claire McAndrew, the director of Campaigns and Partnerships at Families USA, where I lead the organization's work on surprise billing.

For nearly 40 years, we have served as a leading voice for health care consumers and our mission is to ensure that every individual can access the health care and the best health in order to ensure that no matter where you live or who you are you can have the life that you need to -- based on achieving the best health and health care.

And so high and rising health care costs are truly an affront to our mission as they are forcing people to choose between getting the health care they need and affording their other most basic necessities, and we heard about that from Ms. Wilkes.

Surprise bills are a particularly egregious form of health care costs because families who are doing everything they can to navigate our overly complex health care system, working to go to only in-network providers, going to only in-network facilities are still receiving these egregious bills.

And, unfortunately, these bills are incredibly common.

One in five emergency visits results in a surprise bill. But these bills are also occurring outside our emergency situations.

For examples, families who welcome a new baby, ensuring that they're getting an in-network OB/Gyn in an in-network facility are still getting surprise bills 11 percent of the time.

So what's causing these bills? Surprise bills are the result of a systemic problem in our health care system placing families directly in the middle of a tug of war between health care providers and health insurers fighting over the price of services.

While health systems and insurers are vying for leverage including because of consolidation, consumers are completely trapped between these industries.

What does not cause surprise bills, despite claims by some stakeholders, evidence does not conclude that narrow networks are a driving factor behind surprise bills.

We know that people who are covered in plans that tend to have narrower networks and people covered in plans that tend to have broader networks are actually getting surprise bills at about the same rate.

And so I want to be clear that Families USA does support

network adequacy standards. It is something we have advocated for. But we understand that in this particular situation around surprise bills network adequacy standards aren't going to solve the problem alone.

Another common misperception I want to raise that we heard about from Ms. Wilkes is the fact that this is not a new problem. Consumers have been subjected to unexpected and unaffordable costs from surprise bills for literally decades, and the proof is real for us because Families USA has been working on this for decades.

We actually joined with other stakeholders in 1997 recommending banning surprise bills in emergencies as part of President Clinton's efforts around the Consumer Bill of Rights. So this is a very longstanding problem and for far too long it's warranted congressional action.

Only Congress can fix this, because even when states address this problem, many consumers are left out because they are in ERISA-regulated plans.

So we commend the Energy and Commerce Committee for responding to this urgent need with the release of the No Surprises Act. This legislation takes really important steps.

It holds consumers harmless from surprise bills and it

sets a reasonable benchmark to pay providers from insurers at a rate that's not inflationary so that families don't experience increased premiums.

We support the No Surprises Act but we are concerned. So much of this debate has been about making insurers and providers happy based on a payment rate. This legislation is supposed to be about consumers.

And so we want to ensure that this discussion is not consumed about what makes powerful industries happy and that the needs of consumers are not lost and the pace of this legislation is not slowed based on appeasing insurers and providers.

And so we want to make two recommendations about the needs of consumers. First, we urge the subcommittee to broaden the scope of the providers included in the legislation so that no loopholes remain.

We want to make sure that there's not just a discrete set of providers and facilities subject to the legislation but that any facility or provider that could incur a surprise bill is included.

And second, we urge the subcommittee to strengthen the bill's notice requirements. We are concerned that just 24 hours' notice could be too short for a consumer to find out

that nonfacility-based providers are out of network.

We would urge looking at more like a week because if you have scheduled medical leave, if you're about to undergo an important medical procedure, 24 hours might be too short of a time to learn that you have to find another option.

We are so grateful to the subcommittee for taking on this issue. This is such an important hearing. We urge Congress to very swiftly take action. Our number-one recommendation is not to wait.

This legislation must pass this year. I really appreciate what you said, Chairwoman Eshoo. If stakeholders can't agree, Congress has to solve the solution because consumers cannot wait any longer and Families USA is with you to help you solve this problem in any way possible.

Thank you very much.

[The prepared statement of Ms. McAndrew follows:]

**********INSERT 12**********

Ms. Eshoo. Terrific. Thank you very much to each one of our witnesses. So now we have concluded all the statements and move to members' questions.

Each member will have five minutes to ask questions of our witnesses and I will begin by recognizing myself for five minutes.

To the panel, does everyone here agree that patients should not receive surprise billing? Is there anyone that disagrees with that?

A hundred percent. Well, that's a good beginning.

Mr. Nickels, are there hospitals in your association that send patients surprise medical bills and, if so, why?

Mr. Nickels. The statistic that we like to quote the most is most of our member hospitals are in network. The Federal Trade Commission did a study recently that showed --

Ms. Eshoo. Well, do you have any hospitals in your association that send surprise medical bills, yes or --

Mr. Nickels. You mentioned one a little earlier, I believe -- San Francisco General.

Ms. Eshoo. Uh-huh.

Mr. Nickels. To the best of my knowledge, they are the only ones who were doing what you described.

Ms. Eshoo. And how many hospitals do you represent in

the country?

Mr. Nickels. Five thousand.

Ms. Eshoo. Five thousand. So 4,999 do not send any surprise bills?

Mr. Nickels. Where the hospital services -- the facility charge, no, they do not, and coming to one of our --

Ms. Eshoo. Do you have any hospitals that have -- well, you're saying that 4,999 of your hospitals have successfully stopped sending surprise billing?

Mr. Nickels. For the facility -- for the hospital facility fee, that is correct.

Ms. Eshoo. What does that mean, what you are saying? I don't get it.

Mr. Nickels. Well, the examples that have been given have been physician examples and we are not absolving ourselves from responsibility here. These are physicians who practice in our institutions.

Ms. Eshoo. Well, using your own words in the way you describe your systems -- your hospitals -- how many actually do surprise billing?

Mr. Nickels. If you're saying are there -- are you asking if there are physicians in our facilities who are surprise billing?

Ms. Eshoo. You're representing hospitals.

Mr. Nickels. Right. Hospitals --

Ms. Eshoo. Hospitals are a part of the problem, right?

Mr. Nickels. Well, the --

Ms. Eshoo. We have hospitals, we have insurance providers, we have physicians. You're one of the stakeholders. So I don't want to spend all of my time questioning you but it doesn't seem to me that you can give me -- perhaps you can give me a better answer in writing.

Mr. Nickels. Sure.

Ms. Eshoo. Let me go to Dr. -- to the Drs. Zaafran and Dr. Friedman. Have you or any physician you know billed a patient with what we would consider a surprise bill --

Dr. Zaafran. So the company that I work --

Ms. Eshoo. -- and why, if you have?

Dr. Zaafran. The company that I work for has a policy of not sending surprise bills. What I will tell you, though, is that in instances where we don't know that we are actually out of network, and that's one of the things that I wanted to make sure that I brought up is that this out-of-network providers concept is a little bit of a misnomer.

I may be in network with every single insurance carrier out there but happen to be out of network with one plan of

one carrier, and in many instances I may not know that.

And as much as we try to know if we are out of network with that specific plan, we may not know that right away and we may actually inadvertently send a bill.

But once the patient contacts us, we take care of that right away. So that's where there's some discrepancy as far as whether we know we are actually in network or not out of network with a specific plan of a specific carrier.

Ms. Eshoo. I can't help but wonder what Ms. McAndrew and Ms. Wilkes are thinking so far in terms of the question I asked and the answers we have gotten. Think about it for a moment.

To Ms. Thornton, I want to ask you the same question. Are there any health plans in your association that where patients are not protected from surprise billing and, if so, why?

Ms. Thornton. Yes. So patients who receive coverage through their employer through a self-funded plan are not protected by the various state laws that are out there.

Ms. Eshoo. Which is one of the main reasons that Congress has to act. Right. But there is surprise billing, though, in terms --

Ms. Thornton. Yes. There have been widespread reports.

Yes.

Ms. Eshoo. Yes. Right. So I want to go to the patient advocates. Tell us what you think -- I think I know what you think but it's worth stating it for the record. We've heard a lot of testimony. They're all stakeholders. These are all good people with a system that's really messed up.

So what would you like to tell the committee? You want us to do it pronto. We all agree with that. Patients are being subjected to absurdities. What else would you like to say, having heard everyone else's testimony?

Ms. Wilkes. Well, I believe that, as I said, insurance is very, very difficult to navigate. My husband and I consider ourselves to be pretty health literate and we still don't understand our insurance plan.

So in the case of an emergency, that's not your first thought. Your first thought is take care of my baby -- take care of myself, and I feel like it should just be go to your doctor, get the care that you need, and not have to worry about the business side of things.

Ms. Eshoo. Right. Ms. McAndrew?

Ms. McAndrew. I think the data speaks for itself. This is happening in urban areas, rural areas, non-profit hospitals, for-profit hospitals. Everyone agrees the patient

should be held harmless but the patient isn't being held harmless. This is not going to stop unless we have a policy solution.

So I understand that everybody, you know, wants to stop this problem. But there's money involved. There's not going to be any voluntary cessation of this problem unless we have a congressional solution.

Ms. Eshoo. It is always about money. That's just the way it is.

I now would like to recognize the ranking member for his five minutes of questioning, Dr. Burgess.

Mr. Burgess. Thank you, and Ms. Wilkes, let me just say your testimony was very compelling this morning and it underscores why not just this discussion this morning is important but we are also having discussions on drug pricing.

I guess the good news in the realm of illnesses such as your son's is there are some very promising therapies right on the horizon with gene therapies. These may be single administration therapies that produce long-term benefits, and we have no frame of reference on how to price.

And the work we are doing on drug pricing becomes so important because everyone on this committee voted for a bill called CURES for the 21st Century. We want those cures to be

put in the hands of doctors. They don't do any good if no one can afford them when they arrive.

So the work that this subcommittee does, yes, on this issue is important and on the larger issue of drug pricing in general and how do we -- how do we price these new breakthrough therapies -- hemophilia, sickle cell disease, spinal muscular atrophy. All of these are big deals that are happening, and we are grateful that they're happening.

They're happening largely because of work done in this subcommittee. We've got to be -- the same type of forward-leaning thought that went into CURES for the 21st Century also needs to be there on the pricing of those therapies.

So, Dr. Zaafran and Dr. Friedman, let me just talk to you all for a moment. Now, I had a medical practice. I didn't use a billing service in my medical practice. I just billed through -- we had our own billing department.

I never turned anyone over to collections because you never knew down the road when someone's going to have a problem and if they got a bill the same day they would say, hey, it's your fault, and being an OB I practice defensive medicine as one of my specialties.

But you have -- Dr. Zaafran, I am going to assume that you're -- you have got a big anaesthesia group -- you have a

billing service, correct?

Dr. Zaafran. Correct.

Mr. Burgess. And, Dr. Friedman, in your ER group?

Dr. Friedman. That's correct.

Mr. Burgess. So are you doing anything with the billing services that you employ to at least begin to mitigate this issue or do you have a patient ombudsman who will look into these things if they're brought to your attention?

Dr. Zaafran. Dr. Burgess, we have a customer service line to make sure that if Ms. Wilkes ever received a bill that she was not expecting that we would work with her directly to make sure that if it was an out-of-network bill, for example, in the very, you know, small percent of cases where it might be the case that we would -- that we would not let her have to get involved in that.

There are other instances where because, again, of high deductible plans where if we happen to be one of the first ones who have billed and the patient's responsibility for the deductible is the entire amount that's there, there may be some difficulties there.

And part of the problem is that physicians are responsible, or hospitals, are responsible for having to collect those deductibles and co-pays, and as those numbers

have been increasing, as those deductibles have been increasing to, in many instances, more than $5,000, it has put a significant burden on us having to work with patients to collect that.

I mean, I think since it's a contract between the payer and the consumer, it would be better for the payer to collect what they contractually agreed to collect and not have to put that burden on us where I may not have any idea at what portion of the deductible that patient has been paid.

Mr. Burgess. Yes. You never want to be first. That's right.

Dr. Friedman?

Dr. Friedman. Yes. The companies that I've worked for -- and I've worked for three -- we have all had customer service folks that will work with people when they get an out-of-network bill.

One of the things that I want to emphasize to the committee I happen to work in Orlando, Florida at the hospital closest to Disney World.

Forty percent of my patients come from out of the state.

Mr. Burgess. Sure.

Dr. Friedman. So 40 percent of my patients are out of network.

Mr. Burgess. And can you just comment a little bit on EMTALA and how that intersects with all of this discussion, having --

Dr. Friedman. Well, as I mentioned in my testimony, both my written and my oral, EMTALA prohibits us from discussing anything about payment.

In my 30 years of practice as an emergency physician, I've never asked a patient if they have insurance. I take care of the patient.

I get them to the place they need to be, whether that's home or admitted to the hospital or an observation unit, and then afterwards they get a bill.

But I don't know if they're in network. I don't know if they even have insurance, and that's the way we operate in emergency medicine.

And one of the concerns that we have is that while folks have talked about the fact that high deductibles may not be the root cause of this, high deductibles, unfortunately, give an incentive for insurers to not negotiate in good faith with emergency providers.

They know we are going to take care of their enrollees. We are obligated by federal law to do that.

Mr. Burgess. And you do obligate then the downstream --

the cardiologist, the OB/Gyn to whom you refer -- they also are obligated under those -- without having a contract?

Dr. Friedman. The boundaries in EMTALA are a little bit --

Ms. Eshoo. Please wrap up. The gentleman's time has expired. Just quickly.

Dr. Friedman. Oh, okay.

Mr. Burgess. Please answer the question.

Dr. Friedman. The boundaries of EMTALA are complicated. It would make it a lot simpler if it was when the patient was discharged from the hospital that EMTALA ended.

Mr. Burgess. All right. Thank you.

Ms. Eshoo. The gentleman yields back.

I now would like to recognize the chairman of the full committee, Mr. Pallone, for his five minutes of questions.

The Chairman. Thank you, Madam Chair.

Health care costs are one of the top issues on the minds of all our constituents and this discussion has really highlighted the shocking costs people are dealing with, and when you look at some of these bills they're very unclear about what services were provided and why the services cost as much as they do.

So I wanted to ask some questions. Ms. Wilkes, when you

received that $50,000 bill, was it easy to understand what you were being charged for and were you able to compare costs and determine if you were being billed fairly?

Ms. Wilkes. No. The bill was not itemized at all. It just was a dollar amount.

The Chairman. You know, I have to say, you know, this is, totally anecdotal but a few years ago -- it might be, like, 15 years ago -- I remember talking to one hospital administrator who told me that, you know, that basically they just assign costs, you know, on a bill without any reference to what the actual cost is.

And so that's why you can have an ice bag that's, you know, $150 at one place and $15 at another because it's really not based on the actual cost.

But who knows? You know, hopefully that's not true.

Dr. Zaafran or Dr. Friedman, could you briefly explain who determines provider charges and how they are set? Start with Dr. Zaafran.

Dr. Zaafran. Thank you, Mr. Pallone.

Our charges are based on an aggregate cost of what it costs us to deliver service. So in anaesthesia it's a little unique because it's time based. So we charge based on a unit of time for every 15 minutes.

So it's not an arbitrary cost. We know exactly how much we are billing, depending on whether the surgeon takes 15 minutes or an hour or hour and a half.

We, from our standpoint, because we try to focus on quality care, our expenses include nursing, having an opioid-free type of perioperative type of environment because we know it reduces overall cost. So all of that is built into how much we charge per unit of time.

The Chairman. And it's not broken down?

Dr. Zaafran. Actually, if a patient calls us and asks us what that is, we do break it down because, again, it's based on the specific type of surgery. We can tell them exactly --

The Chairman. They'd have to ask you?

Dr. Zaafran. We can provide it, and if it's on a piece of paper it may not make sense because we don't know how long a surgery is going to take. But we tell them that it took about an hour and a half, it was this kind of surgery, it was this many units and this much unit per time, and this is what the total cost was.

The Chairman. Okay.

Dr. Friedman?

Dr. Friedman. So in emergency medicine, Chairman, it's

a little bit different. We bill typically by what's called E&M codes, which are levels of service.

There are five E&M codes from a level one, which is we hardly ever use -- it's basically a suture removal or recheck on something minor -- up to a level five, which would be someone that would be going to a critical care unit.

Maybe you are having a heart attack. You're receiving significant amounts of care. And then we can also bill a critical care charge, which would supersede that if you do receive critical care treatment in the emergency department.

The Chairman. All right. Thanks.

Now, we have all heard stories about patients being billed for hospital fees. One Vox article tells a story of a man who took his one-year-old daughter to the emergency room after a minor accident, as many worried parents do. For five minutes of the provider's time, water, gauze, and a Band-Aid for his daughter's finger, led to a $629 bill from the hospital's emergency department.

So I am going to go back to Dr. Nickels. But, again, I use the example where, you know, a few years ago a hospital administrator told me, you know, we just assign these things -- they're not actually referencing, you know, actual costs for the -- you know, in this case for the Band-Aid or the

gauze or the water or the provider's time.

You know, could you give us a sense, Mr. Nickels, of how much hospitals charge and facility fees on average and what are hospitals doing to make these fees more transparent?

And, you know, maybe if you want to dispute what I just said, you know, like in this case would they actually figure out how much it costs for these different things, or not?

Mr. Nickels. Yes. I mean, the charge system is obtuse, to be kind, and I think it's a broken system. We are trying to work -- we have a committee.

We are working with the Trump administration. We need to figure out a way to fix it. But most people, almost anyone who is insured is not paying charges. The government doesn't pay us charges. We negotiate with insurers. They don't pay charges --

The Chairman. Well, I only -- 30 seconds. So it's very possible that in this case, or using my example, you know, there's really no breakdown for those five minutes of the provider's time, the water, the gauze, the Band-Aid. It is not done that way.

Mr. Nickels. Correct. It may be but it may not, if that's --

The Chairman. Right. So very possible that what I

talked about, you know, 10 or 15 years ago, we just assign things -- very possible.

Mr. Nickels. Yes.

The Chairman. All right. That's pretty sad, Madam Chair.

But thank you.

Ms. Eshoo. Thank you, Mr. Chairman.

I now would like to recognize my friend, the ranking member of the full committee, Mr. Walden, for his five minutes of questions.

Mr. Walden. Thank you, Madam Chair, and we have this other hearing going on upstairs I had to go up to on FERC -- Federal Energy. So we are back.

Ms. Thornton, the comments submitted to the committee as well as Dr. Zaafran's testimony providers have argued that California's benchmark has led to payers refusing to renew long-standing contracts or offering lower rates.

But in your testimony you mentioned that California's benchmark has led to an increase in network participation and the Blue Shield of California has told us that current state laws on network adequacy still apply and, in fact, since their surprise billing law went into effect they have increased their number of contracted physicians by 5 percent

overall and 6 percent specifically at acute care hospital facilities.

Can you help this committee better understand what's taking place in California by sharing a bit more about those preliminary reports? And what about other states such as mine, Oregon, with benchmark solutions? What can you tell us about that?

Ms. Thornton. Thank you. So yes, so there's been a lot of debate around the California law, and the California law just took effect in January of 2019. So it's very new.

Mr. Walden. Right.

Ms. Thornton. And so we have been talking with our plans and their experience with implementation of the law and they have not reported to us that they've seen, you know, decrease in network participation.

In fact, as you have mentioned. One of our plans has actually seen an increase in providers participating. So I don't think the California law can be used as a reason why we'll see decreasing networks. We want strong networks for our members.

Mr. Walden. And have you seen something similar in Oregon?

Ms. Thornton. No, I have not.

Mr. Walden. Okay. So you don't have any data on what's happening in Oregon? All right.

Doctor, do you want to address this from your point of view?

Dr. Zaafran. Yes, sir. Thanks, Mr. Walden. We know of actually two of the largest groups in California. One of them who has been in network for many, many years have not had actually any kind of cost of living increase or anything like that.

We were told point blank that they're going to have to take a big cut or they can simply just go out of network and they'll be paid a very low benchmark based on Assembly Bill 72.

We also know of a very large group in the northern part of California where they have not been in network, have wanted to be in network, have been told that they have no desire to be allowed to be in network and, again, that they would be paid a very low benchmark based on Assembly Bill 72.

Again, I know that it's a new law that just started in January. But the anecdotal evidence that we have from the groups that are being affected by this is that they've been impacted.

Mr. Walden. And who is telling them that?

Dr. Zaafran. The specific insurance carriers that they're negotiating with to try to be in network.

Mr. Walden. I suppose you don't really want to identify those specific insurers here before us today?

Dr. Zaafran. I would rather just talk in general statements, but yes.

Mr. Walden. Uh-huh. All right. Several stakeholders suggest requiring plans to update their provider network directories in a more timely manner. Seems pretty practical. I think Texas was working on -- oh, you're no longer from Texas.

[Laughter.]

Mr. Walden. You're changing out on me. I know Texas was working on some of that disclosure language as well. I don't know where that ended up through the system.

But how regularly do plans update their directories right now? And I've heard from people that go, great, I signed up for the plan. I am in the system. The provider is in the system.

Then something changes and I can't change my insurance and now I am stuck in a plan that my provider used to be in and now they are not. Now I am out of network. Now I am going to get one of these nutty bills. That is not putting

the consumer first. Ms. Thornton, can you address this, please?

Ms. Thornton. Sure, of course, and I think one of the things I first want to set aside is that in an emergency situation we don't want anybody to have to worry about the provider directory. We want the patients to be protected in that situation.

But I will say to your question it is very important to our plans that we have accurate and reliable data for consumers for -- in the provider directories when they are seeking care, scheduled care, et cetera, and are working very hard to make sure that that occurs.

Mr. Walden. Can you put all of that online on a regular basis? How do these directories work? Do I have to get a printed copy sent to me in the mail?

Ms. Thornton. Oh, they're all online. You can also call our plan's customer service to get information via the phone if you don't have access online.

Mr. Walden. Do you notify policy holders when things change?

Ms. Thornton. If a patient has been seeing a particular provider there is also often a notification that takes place.

Mr. Walden. Often. All right. Because I think you

ought to be notified. I think you ought to -- how do you know? How do you keep up with this stuff? You think you're covered. I am just telling you that you're headed to a big train wreck here.

Ms. Thornton. Information changes daily. I understand.

Mr. Walden. And you know it because you know how to send a bill out. The consumer ought to know it because they're the ones getting the surprise bill.

That's where I am coming from here, as a consumer and representing consumers. How do we know? I will tell you one quick story, and I know I am going to go over. Just a second, Madam Chair, with your indulgence.

A guy at a think tank here -- this is second hand -- who goes in for a colonoscopy, is on the table prepped and ready to go -- and those of you who are old enough to have been through this you understand what's at stake here -- asked the doc, is the anesthesiologist in my network. I don't know. Well, before I sign this I need to know.

Well, I can't tell you -- I don't know. Do you want the procedure today or not, because I've got five more of these to do. The guy signs it, goes under, boom, done. Is that what we are doing to consumers? I think this is nuts.

Ms. Thornton. I mean, that's horrible and that's why we

need this legislation.

Mr. Walden. And this is going on every day in America and it shouldn't be. You forgot who you serve and it's the consumer.

Thank you, Madam Chair, for your indulgence.

Ms. Eshoo. Thank you for your important questions. I don't know -- I just want to throw something out here. This business of notification, and you just put a spotlight on it. Who's going to be notified when, and then what the heck do they do once they're informed?

What, you're in labor and then you find out that the -- whomever, the anesthesiologist is -- exactly -- well, I will hold on to this child and try to get to another place. I don't know what this notification -- most of this is in an emergency room setting, at least that's what the statistics show.

So I don't know if it's really very smart to be focusing on notice. Yes, people should be noticed. But let's use some common sense about how notice is -- how effective, quote, "notice" is going to be.

I mean, given the settings, it's not making too much sense and it's making it sound as if if we throw that in there that it's, boy, is this really going to do something.

So I am not -- you can tell I am not convinced.

All right. With that, I would like to recognize a total gentleman from North Carolina -- yes, it's you. It is you. Mr. Butterfield for five minutes of his questions.

Mr. Butterfield. I will wake up, Madam Chair. Thank you. Thank you so very much for those kind words. Thank you for convening this very important hearing today.

Thank you to the eight witnesses for your testimony. Like Mr. Walden said, I've been bouncing between hearings today and knew that my time was coming up pretty soon and so I am back here with you.

While I am on the thank you trail, let me also thank Mr. Pallone and Mr. Walden for their bipartisanship in putting forth this discussion draft. I think it's going to lead to good legislation which is ultimately going to protect every consumer in America.

Let me begin with Mr. Nickels. Mr. Nickels, I represent a very low-income district in eastern North Carolina. It is not unlike any other rural community in America. We face unique challenges when it comes to health care.

In some areas in my district there isn't a hospital for many, many miles, and you have heard that before and it's not a surprise. These markets have little competition.

Residents have few facilities to choose from.

The small hospitals that do serve these areas are often operating at a loss or near loss and they rely on reimbursements as their primary revenue source.

In your opinion, how would the imposition of statutory rates impact small rural hospitals?

Mr. Nickels. Yes. We do worry about, as you said, the imposition of those kinds of rates. One-size-fits-all won't work because there are unique circumstances --

Ms. Eshoo. Can't hear you.

Mr. Nickels. Okay. I certainly agree with what you're saying there. One of the reasons we don't like national rates is because they don't take into consideration local conditions like the ones you describe and it's really important that that be more of a function of negotiation between the hospital and the insurer who will be, hopefully, persuaded of the importance of those facilities. And there is a crisis in rural America. There's a crisis of rural hospitals. It is a whole different issue but it's another one that we need to solve.

Mr. Butterfield. We have competing interests here between small rural hospitals and the need to protect the consumer, and as legislators we have got to work through that

tension and find a good solution.

Mr. Friedman, can you help me with that a little bit?

Dr. Friedman. Well, I would agree with you that there is a conflict there. But I would suggest that one of the things that the Congress consider is that access is vital.

If you have a mechanism that goes into place, as you suggested, that would decrease access, particularly in rural communities, that doesn't serve consumers either.

If they can't get -- they don't get a surprise bill but there's no provider or hospital to provide that service we have done them a service.

Mr. Butterfield. Ms. McAndrew, can you help us with this?

Ms. McAndrew. I would just call attention to the fact that the reason we are having this discussion right now is that this is already a problem in rural areas. I actually pulled some data in advance of this hearing and I just want to draw attention to how many consumers are already suffering because there are not in-network providers and consumers are getting surprise bills in rural areas.

I looked at your state of North Carolina and already consumers are -- in-network hospital admissions are getting out-of-network claims more than 10 percent of the time. So

what that tells me is that providers are staying out of network already and consumers are suffering.

So while I acknowledge the fact that we want to study this as we move forward on the legislation, I would urge against hesitating because consumers are suffering from this problem in rural areas. So we already know status quo this is a problem.

And so while we can worry about unintended consequences, we know the current consequence is that consumers are getting out-of-network bills in rural areas. That's also true more than 10 percent of time. Consumers in in-network hospitals are getting out-of-network claims and rural states like Indiana, Kentucky, Oklahoma are represented on this committee so I would not hesitate to solve this problem because of unintended consequences in this.

Mr. Butterfield. Well, you know, I've seen both consequences. I've seen rural hospitals close for lack of revenue. That's at one end of the debate. I've seen consumers go bankrupt because of their inability to pay those statements when they arrive. I've seen it from both extremes and, as legislators, we have got to reconcile those two interests.

Ms. Thornton, let me -- let me conclude with you. What

role does the lack of network adequacy play in the occurrence of surprise bills?

Ms. Thornton. Thank you. So health plans need networks to function. We want our members to have access to a large and high-quality network.

However, you cannot control when you have an emergency, you know, where you are across the country. And so we really don't think the network adequacy is directly related to the issue of surprise billing.

Claire -- Ms. McAndrew, excuse me -- mentioned that you're just as likely to experience a surprise medical bill if you're in a large employer plan with a broad network in a narrow -- more narrow network individual market plan.

Mr. Butterfield. Thank you.

Madam Chair, I yield back and right on time. Thank you.

Ms. Eshoo. I thank the gentleman.

I recognize the gentleman from Illinois, Mr. Shimkus, for his five minutes of questioning.

Mr. Shimkus. Thank you, Madam Chairwoman.

Madam Chairwoman, I also asked -- I was happy that you asked about Ms. Wilkes' son. I am sure he's very proud of you today, and if he's not have him talk to me because you did a wonderful job.

1990 I would also like to ask unanimous consent that this
1991 letter sent to me on June 10th by the Illinois Hospital
1992 Association be submitted for the record.
1993 Ms. Eshoo. Without objection, so ordered.
1994 [The information follows:]
1995
1996 **********COMMITTEE INSERT**********

Mr. Shimkus. Thank you, Madam Chairman.

You know, a lot of this debate and a lot of testimony referenced specific state attempts to address this issue and baseball, apparently, and we are getting close to the congressional game so a lot of us are focused on baseball.

For example, Illinois does use the baseball-style arbitration method in the event a dispute arises between providers and health plans. Each party must submit a proposed best and final offer to the arbiter who then chooses one of the two without modification, thus keeping the consumer out of that fight. You really have different sizes of big versus the small individual in that process.

However, these state laws don't apply to self-insured ERISA plans, as has been highlighted by the testimony, used by, roughly, 100 million Americans.

I was also interested to hear a number of witnesses mentioned another federal law involved in this debate, the Emergency Medical Treatment and Labor Act -- EMTALA.

I talk about it quite a bit because it -- we all need them. We all use emergency rooms. Cost shifting at the hospitals to help pay for the emergency room, and what's occurred, as you all know because you live in this world, is that we are really pushing our citizens and constituents to

go to urgent care centers, you know, if they're not emergent.

We need emergency rooms but we need -- we need to encourage that.

But EMTALA, the federal law right now is unique to emergency care and it's an important element of our nation's safety net.

But in choosing to require providers to treat patients regardless of their ability to pay presents unique challenges of its own in some states like Texas and Colorado through free-standing emergency center operations with a state license, not a federal license.

So, Dr. Zaafran, in states with free-standing emergency centers do those facilities have to abide by a similar standard to EMTALA since they're not federally licensed?

Dr. Zaafran. If they are licensed as an emergency center, they do. Urgent care centers, of course, have a little bit of a different definition. They're not necessarily looked at as emergency centers by that definition so they wouldn't fall under that category.

Mr. Shimkus. Yes, and I am following guidance by staff and I talk about urgent care centers, but I really was interested about state-licensed emergency centers not under the federal guidelines and that's what I am trying to get to.

Dr. Zaafran. State-licensed emergency centers are -- they have to abide by EMTALA. That's correct.

Mr. Shimkus. You also referenced the difference between hospital-based physicians and physicians not bound by EMTALA. Can you please walk the committee through the justification for having one resolution process for facilities and another for providers?

Dr. Zaafran. Yes, sir. One of the things that EMTALA does very specifically is that it asks for emergency room physicians to make sure that they have to see every patient regardless of costs or anything like that.

But, again, you have a patient who may come in and the emergency room physician decides that this person needs to be seen by a surgeon because they have an infected appendix.

Well, that person is going to have to have surgery by the surgeon. They're going to have to have anaesthesia by the anesthesiologist and, you know, they many not necessarily be specifically bound by EMTALA but once you're admitted into that hospital and you're in an emergency setting where it is impractical, unreasonable, and unsafe to transfer that patient, all the physicians that are on call during the time period where that physician has been admitted and has to be treated in a very short fashion by all those different

providers, all those different physicians have to be -- it has to be done in a timely fashion.

So even though EMTALA may not directly apply to them, we have to take care of them and the way we operate as anesthesiologists is you're taking care of many of these facilities 24 hours a day, seven days a week, regardless of whether they have insurance, don't have insurance. We don't even ask.

Mr. Shimkus. So my final question for you -- in supporting a benchmark concept with an arbitration backdrop you mentioned that four recent state adoptions enjoyed the support of providers, insurers, and patients.

So I want to clarify if your hospital partners supported these state efforts, too.

Dr. Zaafran. So yes, they did. In Texas, specifically, which the bill recently passed several weeks ago, all the stakeholders -- emergency room physicians, Texas College emergency physicians, the Texas Medical Association, the Texas Society of Anesthesiologists, the Texas Association of Health Plans, the consumer advocacy groups including AARP -- all supported the bill.

It was a consensus bill. It was an excellent bill that was passed that involves baseball-style arbitration with

specific guardrails to make sure that costs were contained within that framework.

Mr. Shimkus. Thank you, Madam Chairman. I yield back my time.

Ms. Eshoo. The gentleman yields back.

The gentlewoman from California is recognized for five minutes for her questions -- Ms. Matsui.

Ms. Matsui. Thank you very much, Madam Chair.

I thank you all for being here today. This is a very important issue. I kept hearing about it in my roundtables back home.

As you may know, my home state of California already has some of the country's most robust protections against balance billing patients for certain procedures.

In my district, I've already heard from many hospitals that in an increasingly fragmented health care system there is concern that a federal policy that may further discourage contracting between insurers and providers will have the unintended consequence of decreasing innovation and partnerships that are facilitating better and more coordinated care and reducing costs.

As Congress considers solutions modelled after California law, I would like to discuss how our state effort

is working to influence market dynamics between health care purchasers and providers and how those changes are ultimately impacting patients.

Specifically, the reimbursement model in California benchmarks payments for out-of-network physicians at the greatest of 125 percent of Medicare, or the average contracted rate.

Dr. Zaafran, can you discuss how using a median in-network rate as a benchmark may put downward pressure on future contracted rates offered by insurers?

Dr. Zaafran. Yes, ma'am. Thank you for that question.

So median, by definition, means that you have certain contracts that are above that number and certain contracts that are below that number, and there's a reason for that.

As I have mentioned in my testimony, there's a differentiator for why certain physicians have contracts that pay more than others.

In fact, in Washington State my specific company, Blue Cross Blue Shield, actually put out a press release touting a value-based contract that they signed from the standpoint that they're paying a premium but they understand that the overall cost of care is actually less.

So the ability to make sure that you're able to

differentiate based on quality metrics that a higher payment is due is something that has to be preserved. If you keep everything at the median and not allow for those differentiators to exist, you're essentially kind of bringing everybody down to that number.

And the other problem is, is that as new contracts are negotiated, if they're negotiated in a downward fashion, that median actually starts going down also.

Ms. Matsui. Okay.

Dr. Friedman and Mr. Gelfand, from each of your perspectives, if Congress were to establish a federal default fixed rate, what benchmark metric should we consider that would preserve the incentive for future contracting between plans and providers?

Dr. Friedman? Mr. Gelfand?

Dr. Friedman. Yes, thank you for the question, Congresswoman Matsui. We firmly believe, as I pointed out in our testimony, that it would be virtually impossible to find the perfect rate, one that both providers would be happy with and insurers would be happy with, and that's why we think that going back to a independent dispute resolution to work out agreements between providers of care and the insurers -- the payers of care is the most cost effective and evidence-

based model that we have.

Ms. Matsui. Mr. Gelfand?

Mr. Gelfand. Congresswoman, we support the California model. The perfect should not be the enemy of the good. The data bears out that the California model is working and, in the end, a benchmark that works is a benchmark that is rarely used because it brings parties to the table to get in network and that's our goal.

Ms. Matsui. Mr. Nickels, from the hospital perspective, is setting a default rate for emergency and other services necessary to stop patients from being balance billed?

Mr. Nickels. Yes. I mean, I think there should be no balance billing in the emergency department. There should be no balance billing when a patient in good conscience and knowledge comes in to an in-network facility. They should not get anything from an out-of-network physician where they don't have to pay any more than their in-network co-insurance.

Ms. Matsui. Okay. What effect might a federal fixed payment rate have on a hospital's ability to ensure adequate staffing and patient access to care?

Mr. Nickels. Yes, we are not supportive of any kind of benchmark or any kind of rate like that, and I think it would

have all the negative consequences that were outlined already.

I mean, our members negotiate with insurers. We talk quality. We talk volume. We talk all kinds of things that, I think, would -- especially with innovation would be really hindered by kind of a one-size-fits-all approach.

So we do not support that. If Congress is going to do anything, we do think that the baseball-style arbitration approach is the best one. But let's let, you know, the negotiation between us and the insurers continue.

Ms. Matsui. Okay. Probably I am running out of time here to ask the next question, but I wanted to ask about ERISA. You know, states like California are taking on important steps to address surprise bills.

Congress needs to enact a federal solution to expand these protections to all privately-insured patients. But some 25 states have already enacted some form of balance billing protections at payment dispute resolutions.

And I am running out of time, but when crafting a federal balance billing solution how should Congress consider existing state laws for determining out-of-network payment for surprise bills? Should state law always supersede a new federal law? And I am out of time.

Anyone want to comment on that in one second?

Ms. McAndrew. So we do acknowledge that some states have done a good job, including California, of enacting comprehensive legislation. However, there are consumers who would be left out.

We also worry that if laws that are less comprehensive were to be allowed to supersede federal law, you will have a race to the bottom. You pass a comprehensive law here in Congress, you will see a flood of lobbyists trying to pass less comprehensive laws in the state if they are to supersede it. So we recommend that federal law take precedent unless a state law is more comprehensive. Also, federal law wraparound to cover ERISA when state law cannot.

Ms. Matsui. Thank you very much, and thank you, Madam Chair.

Ms. Eshoo. Thank you.

Pleased recognize the gentleman from Kentucky, Mr. Guthrie, for his five minutes.

Mr. Guthrie. Thank you very much, and it's -- thanks for everybody being here. Thanks to Ms. Wilkes for being here with your story.

And, you know, it's kind of frustrating. It gets to kind of a larger thing. I am on Oversight investigations.

We are looking at insulin pricing and it kind of looks at the difference in net price and list price, and it seems here -- I have an incidence -- we all have instances in our area. Emergency situation, wasn't emergency room physicians where a person in my district who's actually an insurance broker so he's very sophisticated -- talk about insurance literate. Had an emergency situation with his son and was billed over $30,000 for a service, and if he had an insurance that had been in network it would have been less than $10,000. And he actually sat down -- he wanted to. They would refuse to do it.

He said, if you will sit down with me and show me your price and your charge and some kind of reasonable return I would pay it. But they wouldn't sit down and go through the pricing charged.

So that's just a big issue. He said, I will write you a check today if you will let me -- if you can show to me that it's really part of it, and that's the source of the problem that we are getting at, just the overall system here.

Mr. Gelfand, getting back to the notice of out of network, in your testimony you mentioned the need to tighten the requirements in the discussion draft on patient consent for out-of-network procedures.

Could you elaborate what you think this should be?

Mr. Gelfand. Yes. We associate ourselves with the remarks of Families USA in that you cannot simply give 24 hours and allow the physician to surprise bill as long as you have 24 hours' notice that a surprise bill is coming because oftentimes you may be going to a facility but you literally have no choice about some of those ancillary providers that will be present at that facility.

Mr. Guthrie. So I guess to Ms. Thornton, Ranking Member Walden said that a person asked about is the anesthesiologist, before I sign this form, in network and the provider there didn't -- I am sure it was the gastroenterologist or whoever is doing -- didn't know.

I mean, how do the health insurance plans fit into notice? How -- we are trying to figure out how this would work. Somebody walks in, I need service. If they're out of network how do we know and how would the health insurance plans be involved in this?

Ms. Thornton. So in the first place, it's important -- when you have an emergency or you're at a in-network facility patients are protected, right. The federal -- this federal law would sort of swoop in.

So you wouldn't have situations where consumers are

getting that bill because they would be protected by the payment benchmark that we are talking about today.

Now, in scenarios that aren't covered by the bill we do think there is an important role to get notice, to be able to call the health plan and say, hey, I've got this procedure next week -- can you let me know, you know, what the network status of my provider will be, and we think that process can work for more things that are scheduled in advance, and not emergency care when you have no control over who's going to see you and you're in no position to have that discussion.

Mr. Guthrie. Well, it couldn't be just in the emergency room because Ms. Wilkes wasn't in -- she was in a labor and delivery room, I assume, and next thing you know you're in a NICU. So, I mean, it's not just EMTALA type of situation.

Ms. Thornton. No, exactly.

Mr. Guthrie. I understand that, you know, we talk about just don't look at unintended consequences -- we just have to move forward. But it is an issue with emergency room physicians because they have to take care. They can't talk about price, and that is different than other things, moving forward.

I do have a question, Ms. Thornton. You're subject to the medical loss ratio requirements, and those are

requirements that require a minimum percentage of premium dollars taken to be spent on paying claims.

Can you speak to how an arbitration system might have an impact on MLR requirements?

Ms. Thornton. Sure, happy to do that.

So there are two different components of a medical loss ratio -- sort of what we are spending on medical care and what we are spending on administrative costs.

On the medical cost side, it's really important here that any solution that we are talking about to end surprise billing does not increase medical spending. That $30,000 bill that you mentioned, right, that's reflected in people's premiums that they pay every month for coverage. So that's sort of one piece.

But on the other side, if you're taking kind of a bureaucratic process and inserting it into the health care system -- Dr. Friedman mentioned 150 million ER visits a year. Even if you took a percentage of those and threw that to arbitration with those administrative costs, that would be adding a lot of costs to the system.

Mr. Guthrie. So we would have to -- your argument would be that we'd have to take that out of the medical loss ratio calculation?

Ms. Thornton. It would be administrative costs borne by the health plan, yes.

Mr. Guthrie. Okay. So this really isn't for everyone but I just have a few -- less than a minute. But so once a bill is put into place, there's a federal -- if there is becomes a federal arbitration system, what do you think congressional oversight should be and I don't know if that would be something Ms. Wilkes wants to talk about or --

Ms. Wilkes. Well, I've been sitting here listening, thinking, I pay my insurance premiums. I do my part and I expect the bill to be paid. I mean, there's only so much I can do to control that.

I don't really care how the reimbursement works and, quite frankly, I think the insurance industry is doing probably better in their bottom line than my bottom line. I want to go to the best provider possible and I want the best care. I don't really care how the payment works.

Mr. Guthrie. Okay. Thanks. And I won't go on down the list because my time has expired. But I do hope things are going well, and the other part of our area we are looking at genetics and things like that and some really great things that are happening in hemophilia. So, hopefully, your son will qualify for those as well as they -- his genetics will

qualify, not just your insurance. Your genetics will qualify is my point.

Thanks. Appreciate it.

Ms. Eshoo. The gentleman yields back.

I now would like to recognize the gentlewoman from Florida, Ms. Castor.

Ms. Castor. Well, thank you, Madam Chair, for holding this important hearing and thank you to the witnesses for your expert recommendations to the committee.

Ms. Wilkes, thank you so much for sharing your personal story. My home state of Florida adopted a balance billing law in 2016 and my understanding of the law is that first and foremost it works to protect the patient and then establishes a process for the payer and the provider to resolve a payment issue.

So that if a patient receives care from a provider that is out of network, the patient will only be responsible for in-network cost sharing and then providers and the insurance plans have to go through a state-arranged voluntary dispute resolution process where a penalty is assessed to the party that refused to accept an offer that was close to the final arbitration order.

And I understand that the negotiation is based on the

usual and customary rate in that particular geographic area and then it binds the parties, going forward.

Florida's law is relatively new but I wanted to see if any of the witnesses have feedback on how my state is doing.

Dr. Friedman, you practice in the state of Florida. What's your view?

Dr. Friedman. Yes, thank you for the question, Congresswoman Castor.

It is untested, frankly. The history of balance billing in Florida and dispute resolution in Florida is not necessarily one that is particularly good and the pervious -- we have had a balance billing for a long time for HMO products in Florida and there was an attempt to -- some time ago to add PPO products to that.

The dispute resolution process as the state used turned out to be very insurer friendly and providers refused to use it after a while. So this new law has been tweaked and we hope that it will be more provider friendly and it will be one that both providers and insurers are happy to use.

It has not been tested yet. I know that within the emergency medicine community at least it is due to be tested very shortly and we look forward to seeing the results of that experiment.

Ms. Castor. So what will happen if the Pallone bill with Mr. Walden passes in my --

Dr. Friedman. Some of that refers to the earlier question around federal pre-emption of state law and we believe, first of all, that the federal law should apply if the state law does not have at least the same level of protections, certainly for patients, but also for the providers' system.

We have to support our providers that are taking care of patients.

Ms. Castor. Ms. McAndrew, what's your view of the -- a dispute resolution process versus bench marking?

Ms. McAndrew. Thank you very much for your question, Congresswoman Castor.

At Families USA our preferred approach would be the benchmark approach. I think the initial reports on a CBO score of the various approaches were quite telling -- that the benchmark approach is -- produces the largest cost savings, and cost savings that come from these various approaches trickle down to consumers.

The reason that we think this matters to consumers is that when we have any surprise bill law that could potentially result in any inflationary costs within the

system, those will trickle down to consumers in their premiums.

So our goal is to have a payment rate that is as least inflationary as possible. However, I will say, you know, at the end of the day what matters most to us is the consumer protection part of this.

And so while we prefer the benchmark rate, when it comes to discussing an arbitration system, the devil is in the details. The bottom line for us is that billed charges should not be considered in this.

Ms. Castor. So how do we -- how do we ensure that what we do to protect patients from surprise medical bills doesn't cause higher premiums?

Ms. McAndrew. Well, I think that goes back to what's considered in the payment rate. So at the end of the day, whatever the system is as long as it's not based on billed charges I think that's what matters most because as some discussion has alluded to before, charges can be quite arbitrary. Sometimes I compare them to, like, the list price of a prescription drug. Nobody really pays it, as Mr. Nickels said before. So we wouldn't want to bake it into our system.

Ms. Castor. Does anyone else want to comment on dispute

resolution versus bench marking?

Dr. Zaafran. I would. So, you know, we have data in New York already as to how this has been proven and the premium increase in New York has been actually very commensurate with the premium increase in California.

So, you know, you have bench marking in one area. You have dispute resolution in the other, and the premium increases have not been any different.

But you have a decrease in New York from the standpoint of how many out-of-network providers you have from 20.1 percent down to a 6.4 percent.

What I do want to emphasize, though, because cost has come up here several times, in New York the average cost of a dispute resolution process is about $300. It takes an average of two weeks. It is all entered in electronically, and the resolution is adjudicated within those two weeks. It is a very seamless, quick, and easy process and it has worked.

What I would say also from the standpoint of bench marking versus a dispute resolution is it is not a one-size-fits-all. My company invested a tremendous amount of resources to make sure that we do opioid-free anaesthesia so that we don't have folks who are on opioids a year later

after they've had surgery or that they don't have surgical site infections that have them to be readmitted back into the hospital after they've been discharged. Those actually decrease the cost of care, and as referenced earlier, we have insurance carriers who are willing to pay us a premium because they understand and they know that the overall cost of care does down.

Ms. Eshoo. I thank you. Your time has concluded, Doctor.

Ms. Castor. Thank you.

Ms. Eshoo. I thank the gentlewoman yielding back.

I now would like to recognize Dr. Bucshon from Indiana.

Mr. Bucshon. Thank you, Madam Chairwoman, and I was a cardiovascular surgeon prior to coming to Congress and I think we can all agree it's about patients here.

That said, the current draft of the No Surprises Act, although well intended, in my view is not completely the right solution.

Again, we can all agree that we -- the liability of surprise out-of-network bills should not be on the patient. We need a solution. However, in my view, the draft legislation would lead to a reimbursement race to the bottom.

It would encourage narrow networks and lower provider

reimbursement, limiting patient access, and ultimately is going to continue to result in further physician shortages.

Since the late 1980s, physician provider reimbursement has continually been cut in an attempt to control health care costs -- and you can see that hasn't worked -- while other areas of the health care system including large publicly-held companies continue to earn record profits.

The draft legislation would ultimately, I believe, ask again for providers to shoulder the financial responsibility of a health care system that costs too much. As long as we have a system that allows the business side of medicine to march on while cutting reimbursement to those who are actually providing patient care, our problem doesn't go away.

An approach similar to the state of New York or a hybrid combination of bench marking and arbitration, in my view, could help solve the problem and not lead to a reimbursement race to the bottom.

So with that said, Dr. Friedman, based on my experience, physicians who accept lower in-network payment rates may get additional benefits from the health plans, preferred -- preferential referrals, things like that. Considering that there still could be an incentive to take a lower rate offered by an insurer, can you talk about what reasons a

physician may not be part of an insurance network?

Dr. Friedman. Well, I think, you know, from the standpoint of my members, we want to be in network. We actively try to contract with insurers. The only time that an emergency -- most of the emergency physicians that I know and most of the groups that are part of my organization are out of network is when we cannot reach a reasonable negotiated rate with an insurance company or the example that I used before where I work in Florida and I take care of a lot of folks from out of state because those contracts are regional. They're not national, even for the ERISA plans.

So I think that we want to -- as providers, we want to be in network. We want to be in contract. We don't want to be sitting here talking about patients that have been harmed by out-of-network billing.

Mr. Bucshon. Right, and that's the point I wanted to get at is that physicians -- we want to be in network. We don't want patients to not be in network, and that's why my concern about setting a benchmark could lead to an incentive from the plan's perspective just to not renew contracts, and we have heard that from Dr. Zaafran today -- and make everybody out of network and then we have this lower benchmark and then, of course, as the higher contract --

reimbursement contracts all of a sudden go away, the benchmark lowers and then you get this race to the bottom in provider reimbursement, which is -- which is, I think, the concern the state of New York had when they put in an arbitration model, which is working. We've heard from people from the state of New York.

So that's my main concern. So that's what I wanted to get at. Providers want to be in network. We don't want people to be stuck with these bills.

So in Indiana, in the largest group market last year the largest insurer had 65 percent of the market share. The next largest at 21 percent and the third only 5 percent. Considering the limited competition, what leverage do physicians have when negotiating reimbursement rates with insurers? And I guess, Dr. Zaafran, you might comment on that.

Dr. Zaafran. Well, again, as Dr. Friedman said, we always try to negotiate and be in network. But in many instances when a large carrier does not necessarily need to because they're narrowing their networks, they just simply won't negotiate.

And that's why, frankly, network adequacy standards are so important. I understand that some folks may not. But I

can give you a very specific example in Texas where it was extremely important.

We had one specific carrier a year ago between February and August essentially drop all the anaesthesia groups in the state -- mainly, the five largest cities -- out of network. These are all mid-contracts. These were not being in the midst of renegotiating contracts. They just dropped them.

The medical associations and societies found this out. They realized it. They took it to the Texas Department of insurance and based on network adequacy laws, the Texas Department of Insurance brought this carrier in, found out that they were not meeting those standards, put a fine on them of $700,000 and a rule that within 90 days that they have to make sure that they bring back their network into adequacy, and it did.

Mr. Bucshon. Thank you very much. My time has expired.

Ms. Eshoo. The gentleman yields back.

The gentleman from New Mexico, Mr. Lujan, is recognize for five minutes for his questions.

Mr. Lujan. Thank you, Madam Chair, and I thank you and the ranking member for bringing us together today on an important issue facing our constituents all across America.

Mr. Sherlock, can you explain to me what the average

charge per air ambulance service is?

Mr. Sherlock. Excuse me. Thank you for the question.

According to a study conducted by Xcenda in 2017, the median charge for a helicopter or medical transport is $10,199.

Mr. Lujan. So can I ask a follow-up there? In your testimony you described the $10,199 amount as the median cost. Is the median cost and the average charge the same thing?

Mr. Sherlock. No, they're not. When you look at --

Mr. Lujan. So the question that I ask you was what is the average charge today of an air ambulance.

Mr. Sherlock. The charges are not -- I don't know that there is an average charge.

Mr. Lujan. So the --

Mr. Sherlock. The charges -- when you look at the fact that 70 percent of our patients are covered by Medicare, Medicaid, or are uninsured and the fact that Medicare, according to the same study, reimburses at less than $0.60 of those charges -- of those costs, rather -- Medicaid is always less and the uninsured virtually pay, you know, $350. Yet that cost of uncompensated care is what needs to maintain network adequacy because --

Mr. Lujan. So if I may, Mr. Sherlock, what the study is that you quoted in your report by Xcenda in 2017 states that the median cost of providing one helicopter transport is $10,199.

What the Government Accountability Office found in 2017 is that the median price charged is $36,400. A study that was conducted in the state of New Mexico showed that in 2015 the average amount charged per flight was $45,000.

I think it's an increase of about 300 percent from 2006 to 2015 in the state of New Mexico alone. I am just trying to get my hands around why this is costing so much and why so many of my constituents are hit with surprise bills when it comes to air transport across the country.

What is it that is -- is it in fact that you agree that the average cost then is $10,199 for an air transport?

Mr. Sherlock. The median cost. If you look at the fact that some --

Mr. Lujan. Let me ask the question differently then. I apologize. We don't have so much time. What's the break-even point?

Mr. Sherlock. The break-even point, depending on the -- on the area of the country is based on the fact that you have Medicare that reimburses at less than $0.60 to the cost of

providing the services, Medicaid that reimburses at less than $0.35 on the dollar to the cost of providing services, and uninsured.

That cost of uncompensated care then raises the cost of transports in order to be able to maintain access to health care for millions of Americans who would not be able to get to a level one or level two trauma center in an hour or less --

Mr. Lujan. Are you able -- are you able to give me the cost breakdown, exclude Medicaid and Medicare, what the cost breakdown is for an hour transport for that aircraft. Could I submit that to you and you get that to me?

Mr. Sherlock. Yes. The transport is also based on the fact that our members, our programs, are ready to respond 24 hours a day seven days a week.

Mr. Lujan. Well, whatever it may be -- whatever it may be, Mr. Sherlock, I just want you to give me that breakdown, because in your testimony you argue that there has not been a study looking at the breakdown of costs.

I just would argue that when the median cost is $10,199, GAO says that the average charge is $36,000, in the state of New Mexico they say the average charge is almost $46,000, something is broken. There is something that's terribly off

there.

But I want to go to someone else. I think we need to rein this in and the concern that I have in this area is that the Airline Deregulation Act of 1978 pre-empts states' ability to regulate air ambulance services. We need to do something about this and I hope the act that we have does.

My next question, though, is for Jeanette Thornton. Ms. Thornton, who gets to make decisions about medical necessity? Insurance companies or medical doctors? Who makes that decision?

Ms. Thornton. Thanks for the question. It typically is a joint discussion between --

Mr. Lujan. Shouldn't my medical doctor make the decision about what's medically necessary for me when I am in a hospital room as opposed to some insurance company say, I am sorry, but your doctor didn't mean to fix our heart -- we are not going to cover that cost -- they should have only fixed your toe?

Ms. Thornton. Sure. We want our members to have really high-quality care and a lot of times things like medical necessity and prior authorization are really getting at safety issues related -- opioid prescriptions is a great example of that. And so, you know, we welcome that

conversation.

Mr. Lujan. Madam Chair, as my time has expired, I would like to ask unanimous consent to submit into the record a few pieces of information, the first being a study by the New Mexico Superintendent of Insurance on air ambulance information, and the second an article by Larry Barker, published February 21st, 2019, about medical emergency could end in bankruptcy, which also talks about medical necessity and who's making those decisions.

Ms. Eshoo. So ordered.

[The information follows:]

**********COMMITTEE INSERT**********

Mr. Lujan. Thank you.

Ms. Eshoo. The gentleman yields back.

I would like to recognize the gentleman from Florida, Mr. Bilirakis, for five minutes for his questions.

Mr. Bilirakis. Thank you. Thank you, Chairwoman. I appreciate it very much. Thanks for holding this hearing as well. Thanks to the ranking member.

Ms. Thornton, I believe it's safe to say that we would all like to see patients held harmless in any final proposal on surprise and balance billing.

A question -- we have heard a lot about the merits of various proposals. Could you discuss the key differences between New York and California -- their models?

Ms. Thornton. Thank you. Happy to do so.

So the different proposals out there are really aligned based on either having a payment benchmark. So in one of these situations where someone does see an out-of-network provider in an emergency where they're at an in-network facility, there would be a quick and easy way to determine what payment should be for that out-of-network provider.

We want that to be fair and reasonable, based on what similar providers are paid in that geographic area. So that's sort of the benchmark approach and that's been

implemented in California at the beginning of this year, as I mentioned.

The contrasting approach that's been mentioned on our panel is arbitration and this is where different parties come to the table if they disagree with the payment that was made and produce information as to why they should be paid a different amount, and that goes to an independent person.

Our concern with that -- and this has been used in New York, as was mentioned -- our concern with that is it gives equal weight to these excessive charges that have been talked about at the hearing today as well as information from the health plan and it adds unnecessary administrative costs to the system.

Mr. Bilirakis. Okay. Thank you.

Dr. Zaafran, what could be the potential long-term consequences of reducing the number of physicians in network -- if you could maybe describe what the consequences would be long term. I will give you some time to elaborate too because that's so important.

Dr. Zaafran. Thank you. You know, access to care would be significantly affected. I mean, number one, first of all, when you're out of network, your cost sharing is much higher.

So even though my charge or rate may be the same, the

patient's responsibility for a deductible and co-pay is much higher in an out-of-network setting versus an in-network setting. So that right away would put the patient at a disadvantage.

Again, there are costs to providing care, and if there is a race to the bottom, that access to care is going to be affected because if you have to have a physician open an office and be able to deliver that high-quality care that's going to be affected.

And, again, from the standpoint of not a one-size-fits-all thing that I really want to talk about -- we talked about opioids a second ago -- and other types of things that provide high-quality care, if a physician is providing that high-quality care it has to be -- it has to be taken into consideration.

One thing that, like I said, we did in Texas, which I would call New York 2.0 -- New York's law was absolutely fantastic and we just tried to take it one step further, which, again, brought the health plans along and actually agreed to the bill, is that we wanted to reference previous history of in-network contracted rates in the arbitration criteria along with charges.

So the arbitrator would be able to look at a contract

that may have just been terminated and said, well, you know, you just terminated a contract that was in existence for the last 10 years -- at least give the contracted rate that was there for those last 10 years, and from that standpoint the score of the bill actually decreased significantly because what you're trying to do is preserve the 90 to 95 percent of the in-network market that already exists and not break that while at the same time addressing the 5 to 10 percent that is out of network and fix that and not have the unintended consequence of pushing those in-network providers into a situation where they're having to be paid less and not be able to deliver the kind of care that they expect to be able to deliver.

Mr. Bilirakis. Very good. Again, you touched on this, but have any states tried to create standards for network adequacy and track plan performance? If so, what has the result been for patients in those states?

Dr. Zaafran. So, again, I referenced earlier the state of Texas has excellent network adequacy laws. We strengthened it in this last legislative session by changing it from a self-reporting mechanism to an automatic audit by the Texas Department of Insurance every two years to make sure that they are actually able to look at the networks.

I gave the example of a year ago where one particular carrier essentially took all the anaesthesia companies, and this is not one company. This is a variety of different companies -- small groups, big groups -- and put them out of network in existing contracts.

And if it wasn't for that network adequacy law where the Texas Department of Insurance Commissioner was able to hold that carrier accountable, the conversation between that carrier and the providers would have never happened because, essentially, they just refused to talk to the providers and say, you're out of network -- that's it -- end of story. The network adequacy law basically forced them to create an adequate network again and those conversations happened.

Mr. Bilirakis. Very good. Okay. I yield back, Madam Chair. Thank you.

Ms. Eshoo. The gentleman yields back.

I now would like to recognize the gentleman from Oregon, Mr. Schrader, for his five minutes of questions.

Mr. Schrader. Thank you, Madam Chair.

Dr. Zaafran, curious about evidence with the frequency of surprise billing. I mean, is it a big chunk of the marketplace reimbursement or is it a small piece of the reimbursement puzzle, and does it -- does it vary

dramatically from network to network and does it vary geographically? We've heard some testimony.

Dr. Zaafran. Thank you for that question and, you know, first of all, one out-of-network bill to Ms. Wilkes is one too many, and that's why we have to address that.

But the overall incidence of out-of-network providers is actually fairly low. It is in the 5 to 10 percent range. I think nationally, if you look at all the different services provided, it's 80 to 95 percent. So there's a little bit of variation there.

But, again, going back to the point of preserving the in-network providers or physicians that are already in network, we don't want a system that's going to disincentivize carriers or incentivize carriers not to continue those networks.

Again, we started to anecdotally see that happen in California. We've seen the exact opposite happen in New York where you had 20 percent of emergency rooms physicians out of network and it went down to 6.4 percent.

So the evidence that is out there shows that with a good arbitration style that is fair and expedited you actually can have the effect maintaining that in-network market but adjudicating out-of-network market in a fair manner.

Mr. Schrader. Mr. Nickels, would you agree with those comments in the relative states and the results we are seeing?

Mr. Nickels. Absolutely, and I would throw Oregon into the mix, too, which, as you know, the law is new there and also I think it's reflective of what New York set up, what Texas have. They're all a little different.

Ms. Eshoo. Could you bring your microphone closer?

Mr. Nickels. Sorry. I keep doing that. So I think the arbitration model, again, the data coming out of New York is very persuasive that it works.

I don't think it's going to be the situation where there is some, like, really high amount and some reasonable amount, and to think that the really high amount is going to win, no arbiter is going to pick the really high amount.

The reason we have arbitration in New York that's successful is it brings people toward the middle. A lot of people settle them beforehand anyway. So I think those approaches are the best and I know our members were supportive of the Oregon law. I know it's brand new. More data needs to be -- you know, come -- more data needs to come forward.

Mr. Schrader. Ms. Thornton, Mr. Zaafran talked about

the incidence of surprise billing and certainly one is too much. I get that. But I want to get a feel from an economics standpoint, you know, what percentage of the insurance industry's health care business is resulting in paying these surprise billing.

Ms. Thornton. Sure, not a problem.

And back to network adequacy, I just wanted to mention that Texas has one of the largest rates of surprise billing in the country, even though it has a robust network adequacy provision.

But back to the economic impact, I included some data in our testimony that was put together by Avalere as New Jersey was considering what changes to make as part of its changes to its out-of-network billing law and it really shows there is quite a large economic impact.

It could be as high as -- and the study showed 4 percent of claims could be as a result of a benchmark that is based on billed charges and is a higher amount than some of the other proposals that are out there. So definitely hitting consumers in their pocketbook in terms of economic impact.

Mr. Schrader. So it seems to me like there's this dynamic tension between making sure that we have a robust provider network, the insurers are encouraged, frankly, to

reach out to providers, and at the same time make sure that providers don't get to raise rates so that the consumers at the end of the day end up paying higher.

So there's going to be this dynamic tension because in the long run. The more robust provider network, in my opinion, market forces will driver those costs down. But we have got to make sure we don't injure the consumer here in the near term.

The other big piece that's out there is transparency. I mean, it'd be interesting to get real good data, and I would ask you, Ms. Thornton, to talk with your insurance plans and get back to me and the committee on what percentage of, you know, your business is surprise billing -- you know, are there different subsets. Some people testified that there may be certain specialties that is occurs more frequently with -- some testimony would indicate that while, no, it's all pretty equal. It would very helpful for the committee, I think, to get that information so we can get perspective on that.

My standpoint, I think the solution is pretty -- a lot simpler than what we are making it out to be where you can encourage a robust network and make things happen.

Take the patient out. Everyone agrees with that. Ms.

Wilkes shouldn't have to deal with these issues. This is an insurer, you know, provider issue and, you know, I think it you just have the insurers providing a little extra -- making sure that they have a robust network we are not going to have this problem at the end of the day.

So appreciate everyone being here and I yield back.

Ms. Eshoo. The gentleman yields back.

I now would like to recognize the gentleman from Oklahoma, Mr. Mullin, for his five minutes of questioning.

Mr. Mullin. Thank you, Madam Chair.

I want to talk a little bit more about -- Ms. Thornton, about the surprise billing. Can we get a little bit more specific about what the surprise billing ratio is in rural parts of the country, specifically, maybe in Oklahoma?

And Ms. McAndrew, I saw you just kind of wiggle in your seat like you might have some of that information too. So I don't care which one wants to answer that.

Ms. McAndrew. Thank you for the question.

Yes, over 10 percent of in-patient admissions in Oklahoma result in a surprise bill and that's the case too for other rural states represented on the committee like North Carolina, like Kentucky. And so I think it is important to recognize that already there are instances in

rural states where we have out-of-network providers.

And I think, you know, we talked a little bit about how providers want to be in network. But there's not, you know, an equal incidence of surprise bills across --

Mr. Mullin. What's the biggest issue with the out of network? I mean, we have seen this huge increase of out-of-network billing over the last years. One, what's caused that and what's the biggest issue on that?

Ms. McAndrew. Well, I guess what I was going to say is that we have talked about how providers want to be in network, but I think for certain types of providers, people want to be in network but not as much as they want to get paid far more than --

Mr. Mullin. Well, the point is people want to be in network only if the provider provides what I am asking for them to pay me back. And then they have another choice --

Ms. McAndrew. Providers -- certain providers want to be in network only if they can make very high rates.

Mr. Mullin. Right, and then they have a choice, well, I don't have to be in network because I can still -- I can still have access to the hospital. So why do we see that big increase now? Why are we seeing this big increase on surprise billing?

Ms. McAndrew. So I would say that we haven't always had great data on surprise billing. So the data I have seen hasn't necessarily indicated an increase because the data we have on the surprise billing problem tends to be newer data in general.

And as I indicated, this is a problem that we have been working on for many years, and so it has been a long-standing problem.

Mr. Mullin. Well, let's talk about the data. You were talking about one size doesn't fit all and Mr. Nickels, you're kind of echoing that, too.

I do agree with that to some degree. But I do also understand job costing and as small as my company is, I can still go back through it and find out what my average costs are on certain jobs, because some of them are repetitive.

Is that information not out there? I am not a big -- I am not big into arbitration for sure but there should be a fair road someplace.

I think Ms. Thornton or, Mr. Nickels, you talked about in the middle with arbitration finding out where it is. Maybe that's the legislation that we are looking for that we can provide that data.

If you can't provide the data, we can provide the data

and say, I know what the average costs of a hip replacement is. I know what the average cost of getting two stents put in.

I understand there's special circumstances that take place. I understand what the average costs of delivering a child is. I've got five of them.

I can get those average costs, and is that the starting point of coming up to where the network and the provider should find? Somebody?

Mr. Nickels. I will take a stab at that first. I think that there are some instances where getting the average cost is easier. Hip replacement -- if there are no complications --

Mr. Mullin. No, I get that. There's standard operations. There's nonstandard operations. There's standard jobs that my company does. There's standard jobs that they don't do. I get -- I get the per hour costs and I also get the idea about bidding jobs.

Mr. Nickels. Right.

Mr. Mullin. And that is called flat pricing -- up front pricing. You can't tell me we don't have an average cost of what it takes to do as many surgeries as we do inside this country on as many different parts of the body -- you can't

tell me we can't come up with an average cost on that.

Mr. Nickels. Yes. In most instances, we can.

Mr. Mullin. Okay. Those are the most instances we are talking about. The special cases are special cases on themselves. We can solve the most cases, though.

For instance, this finger right here -- not that I am doing anything bad -- all fingers are up -- it just happened to be this finger right here.

In Louisiana, I cut this finger. Eleven thousand dollars is what it cost me to get stitches put in that finger. This thumb right there, $150 at my local emergency room. Can somebody explain to me the differences in that? Both of them were, by the way, by a knife, which is why I don't carry one.

Dr. Zaafran. Well, I can tell you that from the physician's standpoint -- for emergency room physicians, for example, the average weighted cost of every visit is about $150. That's the average across the board for all services provided and as was indicated --

Mr. Mullin. Okay. There's our -- then that's our starting point.

Dr. Zaafran. So you had your --

Mr. Mullin. So why is it that we can't find an average

when we start negotiating prices?

Dr. Zaafran. My point is, though, it is not -- it's not as high as folks think it is.

Mr. Mullin. Listen, your point I get. But the billing says it is. So your point -- you can say whatever you want to about your point. The fact is the bills that come in our mailboxes say they are very expensive.

So I think it was Dr. Burgess that said if you don't fix it, we will, and you guys probably won't like it, and that's the road that we are going down because we can get access to that data. We can find that average cost. And if you all don't want to solve it then we are going to. All we are saying is is do it. Solve it.

With that, I yield back.

Ms. Eshoo. The gentleman yields back.

We have a vote that we need to go to the floor to take. But before we recess, I want to recognize the gentleman from California, Mr. Cardenas, for his five minutes of questions.

Mr. Cardenas. Thank you very much, Madam Chair, and I appreciate the witnesses sharing your perspectives and, Ms. Wilkes, your personal story. Thank you so much. I am glad to hear that your son got the critical need that he needed in that very moment.

I do have a question for you, Ms. Wilkes. When that provider group sent you that $50,000 bill, was it easy to understand what you were being charged for?

Ms. Wilkes. No. As I mentioned earlier, it was just a dollar amount. There was no specifics as to what services were provided.

Mr. Cardenas. Okay. And what was the process that you felt was available to you or how did you figure out how to deal with that and what options you had?

Ms. Wilkes. So we called the billing -- the person that was giving us the bill -- the entity that was giving us the bill, and they were not willing to work with us on a payment plan. It was -- it was an all or nothing situation, and as we began asking questions that's how we found out that they were a third party provider that was out of network in the facility that was in network.

So it really just was butting heads. We never could come to a solution to be able to even begin to think about paying that off.

Mr. Cardenas. Okay. I mean, I have grandchildren and I still have children on my plan at home, and I was thinking maybe we need to make t-shirts that we need to put on our loved ones whenever they go to the emergency room or to the

doctor or what have you and it says "Only in-network provider! By the way, please don't let me die, happy face."

I am not trying to be funny. What I am saying is Americans should expect when they go see a provider, whether it's an emergency basis or not -- I have a son who's on my plan and he went out of network. We knew it. I, as a policy maker, didn't know to ask more tertiary questions about how much each one would be.

Luckily for me, it was associated -- in this case, I think it had to do with associated with a local university that one of my fine colleagues had been to, et cetera, and, you know, it was another $500 here, another $500 there. Thank God there were no more zeroes on that. My son had already met the deductible for the year.

So that was over and above what my plan had said, okay, you're doing with your deductible -- every time you go in plan then you're going to be okay, family Cardenas.

What bothers me, and you're hearing my colleagues, Republicans and Democrats, saying we need help to understand what's going on out there in the real world; otherwise, we are going to provide a solution and you're not going to like it.

Legislators, collectively, aren't necessarily known --

our track record isn't that great of hitting the nail on the head when it comes to fixing big problems, unless we get tremendous help from experts so that we can hopefully narrow it down and actually make good policy solutions.

I have a question. My understanding is since the '80s -- they may have called it something differently -- since the '80s or so, there have been this surprise billing issue facing American families.

This isn't just five and 10 years old. Is that correct? I think, Ms. McAndrew, can you shed some light on that?

Ms. McAndrew. That is correct. Networks, from our perspective, are a necessary function because they are -- they have an ability to rein in costs for consumers.

But, of course, if you have a network, which was part of the managed care revolution that we saw begin in the '80s and increase in the '90s, you can get either in-network care or you can get out-of-network care.

So if you end up inadvertently going to an out-of-network provider you will get a surprise bill. And I mentioned that this issue is something that our organization, Families USA, has been working on for over 20 years.

We've published on it in the early '90s. So this is absolutely not a new problem.

Mr. Cardenas. Okay. So this has been doing on for decades?

Ms. McAndrew. Absolutely.

Mr. Cardenas. And has anybody here been at the table before Congress to talk specifically about this issue over the last, you know, 40 or 50 years? Oh, you have, Dr. Zaafran?

Dr. Zaafran. Well, not for 50 years. But since 2009 actually we have been addressing it in Texas and it's been a progression. Of course, we addressed it in New York. But --

Mr. Cardenas. So at the state level. But at the federal level?

Dr. Zaafran. Not at the federal level. Correct. Well, there's the greater of three standard that the federal level has -- actually had and has been in place since then and it's probably --

Mr. Cardenas. Since when? Since, roughly, when? Decades?

Dr. Zaafran. It has been -- it has been at least a decade.

Mr. Cardenas. Okay. Got it.

Dr. Zaafran. I wouldn't say decades. But at least about a decade.

Mr. Cardenas. Okay. Right. Okay.

The reason why I want to point that out is because I hope that the dialogue doesn't get mired into, you know, what caused this. It's been going on long enough.

We got to figure out how to remedy it, and I think that if we keep clear heads and we are able to focus on the common denominator -- to me, the common denominator is the patient. That's the common denominator, and then try to figure out how do systems fulfil their obligation to stay afloat and provide services out there in the communities.

I am sorry I overstepped my time. Sorry about that, Madam Chair. I yield back.

Ms. Eshoo. Always nice to listen to you, Mr. Cardenas. You're wonderful.

The gentleman --

Mr. Burgess. Reserving the right to object.

Ms. Eshoo. Now -- the gentleman yields back.

We have a vote on the floor and I don't know if there will be any subsequent votes to the one that's on the floor. If there aren't, I think that we all have a 20-minute break at least and I hope we can just -- that that's what the case will be. So we'll recess now. We'll go to the floor, take our vote, hoping, again, that it is one -- to return. And

but if it is longer you just have to be flexible. I ask you to be flexible. So the subcommittee will recess.

[Recess.]

Ms. Eshoo. All right. The subcommittee will come back to order. I would like to -- the chair would like to now recognize the gentleman from California, Dr. Ruiz, for his five minutes of testimony, and one of our members that has worked very hard to come up with a solution to what we are grappling with.

It's so ludicrous that this could ever be called balanced. It's not balanced. It's totally out of whack billing. But I want to attach that compliment to Dr. Ruiz's name because he's worked very hard since the beginning of this year on the subject matter.

You're recognized for five minutes of questioning.

Mr. Ruiz. Thank you, Madam Chair.

And the reason why I worked so hard is because, as a physician, we try to eliminate the pain and suffering and anxiety from our patients, and then you find out that the patients are getting a surprise bill that is adding to the anxiety, which only makes their health worse. It only makes their health worse.

In addition to being concerned, as Ms. Wilkes was about

her son, she was also concerned to tears in the anxiety of going bankrupt or what do you do and how do you cut costs. That's an outrage. It's unconscionable that families are going through what they're going through, and that's the number one, two, and three reasons why I set out to find this solution.

We have to close every loophole imaginable so that patients are not stuck in the middle of this dispute -- so that patients don't have to decide between, you know, staying in their house, renting an apartment, paying their bills, versus paying their medical bills because of a life-threatening situation for their child.

We need to keep patients out of the middle and, quite honestly, those state models, even with arbitration, don't do enough. There's always a fine print.

There's always a window that a patient has to go through to mail an envelope back or make a call and if they don't -- if they don't understand and they're the ones that are not going to have those protections.

And I am concerned with this current bill that there are -- like you, Ms. McAndrew, that there are too many loopholes that still allow providers to find a way to say, no, it is your fault -- you didn't see the sign, or it is your fault --

you didn't make the effort to look at the online list, or it is your fault because you weren't aware that this hospital or these providers were out of network.

In fact, asking an emergency department patient or an in-hospital patient if they consent to be seen by the on-call physician, if they are out of network doesn't work in the real world and it takes somebody who cares for patients who actually has cared for patients to understand that because those patients will most always choose yes because they're under duress or because their care will be delayed or because they will not understand the implications.

And if they consent to yes in this bill, then yes, I will be seen by the anesthesiologist because I've been in the hospital too long, then that allows the physician to balance bill. It's not good for patients.

And to expect that a physician who's on call that night, who doesn't deal with their bills or doesn't deal with being in-network or out-of-network that's a department -- billing department issue and they've got 15 different people -- to expect them to then just say, no, let me check right now to see if you're in network or out of network or if I am in network or out of network is not based in reality or in the real world.

So creating a loophole where, quote, "adequate information was provided," right, that somebody would say that gives a way to balance bill. It will put the responsibility on the patient to read the fine print or be aware of all the ways the providers can say they were made aware beforehand and it was patient's fault they didn't read it or understand it, and that needs to end.

In the bill that I propose, Protecting People from Surprise Billing Act, has the most robust patient protections out there from any state model or any proposed bill, because that is my number one, number two, and number three priority as someone who cares deeply, who has devoted my entire life during the arduous training to become a physician, to do everything possible to relieve pain and suffering and promote wellness in everyday Americans.

So the second part is how are we going to solve this dispute, and we need to understand that we need to pick a system that is fair -- that we are not picking winners or losers -- that we address the underlying problem.

The concern is cost. So, Dr. Zaafran, talk about cost -- inflationary rates. What does the evidence show in terms of the models that are out there?

Dr. Zaafran. Thank you, Dr. Ruiz, and thank you again

for the effort that you have put into the bill that is out there.

Well, again, if you look at the data that is out there on New York, which has been out there for many, many years, the inflationary costs with that dispute resolution process has simply not been any different than the inflationary cost data in California. I believe the number is somewhere along the lines of 6 to 7 percent, not 67 -- 6 to 7 percent and it has been the same whether you have a benchmark process in California --

Mr. Ruiz. So you're saying that there is absolute data showing that an arbitration does not increase inflationary costs? Because otherwise -- if the data were otherwise --

Ms. Eshoo. The gentleman's -- excuse me. Excuse me. The gentleman's time has expired.

Mr. Ruiz. Thank you so much for your patience.

Ms. Eshoo. Yes. Thank you.

Now I would like to recognize the gentlewoman from Indiana, Mrs. Brooks, for her five minutes of questioning.

Mrs. Brooks. Thank you, Madam Chairwoman. I apologize. I've been going back and forth to other things as well, and at this point I yield my time to Dr. Burgess, the ranking member.

Mr. Burgess. Thank you. We are so glad you came back.

Ms. Wilkes, I would just like to ask you, if I could, there has been state legislation passed in Colorado, correct, dealing with this? How would that have impacted your situation when your son was born?

Ms. Wilkes. Thank you. I actually am not aware if there has been legislation passed in Colorado, to be perfectly honest. But depending on what this legislation said, it maybe would have prevented us from having the bad credit rating that we had.

Quite frankly, it is not just surprise billing in my family's case. It's billing overall. I mean, high cost dollars -- we have gone to arbitration several times to deal with debt to the hospital. So it is not just this.

Mr. Burgess. Because of that initial episode or subsequent?

Ms. Wilkes. It's a chronic disorder. I mean, you know, we are not going to get rid of it. So there's going to be cost. He's about a million dollar a year kid.

Mr. Burgess. Which is why the hope for the gene therapy is -- and when we talk about how do we price that it does have to be in the context of what is it costing us to do nothing and, clearly, in your case the cost is almost

intolerable.

Dr. Zaafran, you were answering a question from Dr. Ruiz a minute ago and the clock ran out on you. While I am very sensitive to that because it runs out on me all the time, but you want to continue your discussion just a little bit?

Dr. Zaafran. Yes. Thank you, Dr. Burgess.

No, I was just reiterating that in New York, where they have had a New York arbitration process and dispute resolution process that is robust and expedited that there has not been any difference in the inflationary costs as compared to other states.

It hasn't increased. It hasn't been any different than it has been before and it has resulted in a decrease in the out-of-network providers.

Mr. Burgess. Mr. Gelfand, you kind of indicated that that was not an acceptable solution from your perspective -- that data that now Dr. Zaafran has shared with us. Does that -- is that good news from your perspective or news that is not -- doesn't necessarily move the needle one way or the other?

Mr. Gelfand. Dr. Burgess, many of the comments that you have heard today are without context of what the markets looked like before these state proposals were brought

forward.

So specifically in Texas and New York the question is could things have possibly gotten any worse. When we look at arbitration models, we know that outside counsel charges us $500 an hour on a good day and we know that the filing fees for many of these arbitration groups are $1,500 per party per claim, right. So we beg you spend health care dollars on health care, not on attorneys.

Mr. Burgess. Can I just ask you about that? Because now, I've been told from my counterparts in the state House that the fact that arbitration is available means the parties move to an agreement before, prior to getting to that arbitration phase. Just the fact that it is out there means that they are going to talk. Is that something that you have seen?

Mr. Gelfand. Dr. Burgess, we would defer to the Congressional Budget Office that has looked at several proposals and said that if you change to an arbitration model it increases costs by $5 billion. That money will be paid by patients.

Mr. Burgess. The Congressional Budget Office isn't always high on my list of my favorite people.

But, Dr. Zaafran, can you comment on that? And Dr.

Friedman, I would like you to comment as well.

Dr. Zaafran. Dr. Burgess, the cost of arbitration in New York is $300 for arbitration and it is split evenly between the insurer and the physician so -- and it is a two-week process. That is all entered electronically and it is adjudicated right away.

So this cost of arbitration being excessive, again, the data in New York and the way it is going to be in Texas it is a very low cost. It's split between the insurer and the provider with very specific guardrails.

And, again, in Texas what we did is we referenced the previous contracted rates, which is basically saying that you don't have to have just charges out there.

There's a teleconference that happens before arbitration that allows for both sides to sit down at the table and try to come up with a fair payment that they both agree on.

If they don't, that final offer is what goes to arbitration. That final offer could be your previous contracted rate before the insurance company dropped you out of a contract.

And so that allowed in Texas the fiscal note, the score, to come down significantly.

Mr. Burgess. I see.

And Dr. Friedman, do you have a thought on that?

Dr. Friedman. Yes. I just want to point out that in New York in 7 million emergency department visits in the year 849 cases went to this dispute resolution process, which is about .01 percent.

So the process in New York, at least, has worked in that people are -- the parties are resolving their dispute before they even utilize the dispute resolution process.

Mr. Burgess. All right. Thank you. I yield back.

Ms. Eshoo. The gentleman yields back.

Now I would like to recognize the gentleman from Vermont, Mr. Welch, for his five minutes.

Mr. Welch. Thank you, Madam Chair. Vermont does have a law. Since 1987 it has banned balance billing in the emergency department settings only. And while that addresses a major issue it still had a number of holes. It doesn't do anything to prevent surprise bills from anesthesiologists, pathologists, or radiologists.

It doesn't protect Vermonters who seek care in other states, and many of our Vermonters get care at Dartmouth Hitchcock right across the Connecticut River, which is in New Hampshire.

And finally, the bill doesn't set a rate of

reimbursement. I want to ask a few questions, but first this whole surprise billing situation -- I think of Dr. Bucshon -- is reflective of how it is so opaque what the billing mechanisms are in the health care industry, and consumers have no power.

And what it feels like on the outside is that all of the providers who are seeking to get reimbursement of the maximum rate and make their claim as to why they need that, the lack of transparency in fact works to their advantage, and this is just one manifestation of it.

And the challenge for consumers they are totally powerless -- totally powerless. So the question I have fundamentally is should the burden to bear the cost of this lack of transparency and opaque billing system be on the consumer, who shows up sick and powerless to affect anything, or should it be on, collectively, the delivery system?

And that would take a lot of cooperation and probably a lot of legislation. But I don't believe it should fairly fall on the shoulders of a consumer who shows up and is absolutely powerless and had nothing to do with creating the mess in the first place.

So just a few questions. I will start with you, Mr. Nickels. How do you see the proposed legislation -- the

Pallone-Walden bill -- affecting our situation in Vermont?

Mr. Nickels. Well, I think it would actually address one of the problems that you currently have in Vermont. It does address, of course, the emergency situation, which you have protection for.

That bill also reaches into situations where a consumer goes into a facility that's in-network and they knew it was in-network and they did it all in good faith and they got a bill from an out-of-network physician.

That situation which, apparently, is not taken care of in your state law, would be taken care of by the Pallone bill.

Mr. Welch. Okay.

Mr. Nickels. That would be an improvement. Now, we have some concerns about the Pallone-Walden bill but on that case it would be better for consumers than what you have in Vermont.

Mr. Welch. Okay.

Ms. McAndrew, what about the situation for Vermonters who get their care across the river in New Hampshire? And that's about 40 percent of people in the region of Vermont that I live in.

Ms. McAndrew. Thank you for that question. One of the

reasons we think a federal solution is ideal is that we believe wherever you live, wherever you receive care, you should be fully protected. We shouldn't be relying on a patchwork state-by-state system for protection.

Mr. Welch. Okay. And while consumers are seeking specialized care, they're bombarded with an enormous amount of information dealing with being sick or injured, and how do we ensure that patients are informed in a clear and meaningful way but one that doesn't put an undue burden on providers? Do you have any thoughts on that, Ms. McAndrew?

Ms. McAndrew. Yes. Well, I think one of the ways the legislation recognizes that consumers shouldn't be bearing this burden is that in facility-based provider situations the legislation actually doesn't rely on notice requirements. If you are getting care from a facility-based provider like an anesthesiologist or emergency provider, my understanding in the legislation is that the protection actually is automatic.

Mr. Welch. Okay. Thank you.

Ms. McAndrew. The 24-hour notice requirements, as I understand them, although I do believe longer notice should be required, are applying in nonemergency situations or nonfacility-based providers.

Mr. Welch. Thank you.

Ms. McAndrew. But I think that can be done to make it even more automatic so we are getting rid of any phone calls, any emails, any going back and forth between insurers and providers is the ideal solution.

Mr. Welch. Thank you for that. I want to yield my last minute to Dr. Ruiz, who's been a leader on this for us.

Thank you.

Mr. Ruiz. I appreciate it. Oftentimes, during negotiations insurance companies have a take-it-or-leave-it approach with no communication in any of -- and no negotiation.

Why, Dr. Zaafran -- what makes baseball-style arbitration so appealing to states that want to impact a fair system?

Dr. Zaafran. Thank you, Dr. Ruiz. Because in that baseball-style arbitration where you have a final offer you have some specific guardrails or specific criteria that the arbitrator is referencing, which is acuity, complexity, quality, previous contract rates, et cetera.

But the key thing is that you have got two numbers. Those two numbers are one -- you only have to choose one of them. You're not trying to pick a number somewhere in between, and it forces both sides to be fair.

Mr. Ruiz. Another question, Dr. Friedman. When New York implemented their solution, many feared that it would allow providers to drive up prices exponentially. Has that been the case?

Dr. Friedman. No, it has not. What we have seen in New York is that providers are charging reasonable rates when they go to arbitration or they go to negotiation and insurers in fact are paying at reasonable rates when those bills come in, for the most part.

What's happened is, is that it has taken care of outliers -- the extraordinary cases that where people -- and there are folks on both sides abusing the system. It has taken care of those.

Ms. Eshoo. The gentleman's time has expired.

The gentleman from Virginia, Mr. Griffith, is recognized for five minutes for his questions.

Mr. Griffith. Thank you very much, Madam Chair, and I apologize to the members of the committee. I've been bouncing between this one and the others.

You have heard several other people say, and the other one is now over -- but I did want to ask some questions and I have -- during the time I have been in the room I have learned a tremendous amount. Appreciate you all being here.

Mr. Sherlock, I want to ask you some questions about air transport, and it comes up and I don't know whether the person that told me this is accurate or not, but I had a child in my district recently that was hit and I know that they were airlifted to a hospital.

About a week later, a constituent comes in with a whole laundry list of things and one of them was he says the family was charged $40,000. So that's where I start my questions with that just as a backdrop.

But you opened your written testimony by referencing the Association of Air Medical Services support for the Air Ambulance Patient Billing Advisory Committee in the 2018 FAA reauthorization.

Now, we don't have jurisdiction over that. But that means that a lot of our members of this committee may be less familiar with how that consensus language became law.

Can you share with us the background of what led to the establishment of the advisory committee and while you're at it also tell us has it actually been established -- because sometimes we put it into law and it doesn't happen -- and have they started meeting?

Mr. Sherlock. Thank you for the questions.

First, the Air Ambulance Patient Advisory Committee was

put into effect because there are -- currently the Department of Transportation has a consumer protection division that has the ability to investigate and look at how charges were determined and hold patients harmless.

We agree with Ms. Wilkes that the medical needs of a patient should be first and no patient should be in the middle of a discussion between payers and providers.

That committee also includes a representative of Health and Human Services and so it is a joint committee. We would encourage Congress to urge them to get that committee seated and started. They have a requirement to investigate and recommend solutions to hold patients harmless as well as to look at the economics of the ambulance industry, and we think Congress would be well served by that.

We also don't believe that -- our industry doesn't believe that any patient should be caught in the middle. We have supported legislation that would increase 100 percent transparency of the industry by mandating 100 percent industry reporting of comprehensive cost data that would then be turned over to the Centers for Medicare and Medicaid, which would then be used and analyzed to actually rebase the Medicare rates for air ambulances at the cost of providing the services.

That Medicare gap is the single largest driver in raising costs in the air ambulance industry and in balance bills. When you get those comprehensive data reported and they get analyzed and they become public data, then everybody will see where everybody falls out on the cost curve, and in addition to that quality of care where everybody will see where programs fall out on the quality of care curve.

So when those become public data, that will increase both the transparency and the accountability of the industry, and we support -- we support that legislation that was introduced and sponsored by Mr. Ruiz and Mr. Johnson and actually cosponsored by Chairwoman Eshoo in the previous Congress.

Mr. Griffith. And my understanding is currently the Medicare and Medicare reimbursement is somewhere between $3,000 and $6,000 but the average for somebody that's paying without that coverage is about $26,000. Is that accurate?

Mr. Sherlock. The median cost of a helicopter air transport is $10,199 according to a study conducted in 2017. If you look at the cost of uncompensated care because Medicare pays less than $0.60 on the dollar of that $10,199 -- about $5,998. Medicaid pays significantly less than that, less than $3,500 on average, and the uninsured pay about

$350. Those make up -- those three groups make up 70 percent of air medical transports.

So when you take that cost of uncompensated care and you add it to the median cost of $10,200, that's the average charge of $36,000 that the -- that the representative from New Mexico referenced earlier.

When you -- when those kinds of situations happen, no one in our industry wants to see a patient or their family placed in jeopardy because they've just had a health emergency.

Our members will sit down with each individual and their families and work out a solution tailored for them, and a comment that was made earlier today about a snake bite victim that was transported across state lines, in fact, that was resolved and that patient and their family received no balance billing in that because our programs will work with each patient to develop a solution tailored for them.

Mr. Griffith. All right. I appreciate it and I yield back.

Ms. Eshoo. The gentleman yields back.

Now I would like to recognize the gentlewoman from Delaware, Ms. Blunt Rochester, five minutes of questioning.

Ms. Blunt Rochester. Thank you. Thank you, Madam

Chairwoman.

And I think you have coined a new term -- shock billing. I wrote that one down. I want to also thank the witnesses especially for your flexibility and your patience with all that we have -- many of us have been through today. But thank you for your time.

Investigative reporting by journalists like Sarah Kliff for Vox and Kaiser Health News and NPR's Bill of the Month series have really shed a light on how patients, often at their sickest and most vulnerable, get stuck in the middle of payment disputes between providers and insurers.

We've heard countless times today that patients shouldn't serve as an intermediary between these two entities.

Holding the patients harmless should be the crux of any legislative solution that Congress puts forward, and I was really encouraged today by the discussion, the fact that there seems to be bipartisan and across the panel support that something needs to be done and it needs to be done now, and this No Surprises Act also maintains that standard.

In a May 2018 article by Sarah Kliff, a 34-year-old man received a surprise $7,924 medical bill from an emergency oral procedure after a violent attack the night before.

Kliff noted that this bill was a case she saw regularly -- patients who had large medical bills because they went to an in-network hospital but were seen by out-of-network doctors.

The good news is that the entire bill was reversed. The bad news is that it was after the news article.

So, Ms. McAndrew, I am sure I know the answer to this question, but should patients have to rely on news coverage of their surprise medical bill in order for them to negotiate a lower bill?

Ms. McAndrew. Thank you very much for that question and, of course, the answer is absolutely not, and we, you know, indicated in our testimony that this problem has been going on for a very long time.

But, unfortunately, before consumers had advocates like reporters or their members of Congress to reach out to, a lot of consumers don't know to take that recourse or are too sick to take that line of recourse and are sometimes paying these bills, going into bankruptcy, going into debt.

And so there should be policy in place that automatically protects consumers so they don't have to take these great lengths to get protection.

Ms. Blunt Rochester. Thank you.

I've also heard stories from emergency care physicians

in my state where patients delay their care because of their concerns about surprise medical bills.

Ms. McAndrew or any other member of the panel, have you seen this where people are afraid to get care because they're afraid that they might be -- receive a shock bill?

Ms. Wilkes. I would like to respond to that because it just happened within the last couple of months for my family.

Thomas fell at school and broke his arm, and I legitimately did not know where to go. I didn't know whether to go to the urgent care or to the ER.

So, ultimately, we went to urgent care, got an x-ray. Sure enough, the arm was broken, and ended up in the ER because of his chronic illness.

That delayed his care. He was in pain for a number of hours while we were making that transfer.

Ms. Blunt Rochester. Thank you.

I want to transition to the question of transparency. Even when patients are diligent about making sure that they're receiving in-network care they can still end up with a surprise medical bill.

Often, this is because they're unable to ultimately know if every physician involved in their episode of care is in-network, and I am going to ask -- direct this to Dr. Zaafran.

How can we increase transparency for consumers and make sure that they're able to easily find out what providers are in-network?

Dr. Zaafran. Thank you.

So the short answer to that is that the insurance industry has to have directories that are updated in a real-time fashion. Again, there is no such thing as an out-of-network provider. There is a provider who may happen to be out of network with that specific product.

So the only one who knows what that product is is, of course, the patient and the insurance carrier and they're the only ones who really have the information as to whether they're in network or out of network.

Ms. Blunt Rochester. I just want to close by saying I commend the committee and everybody who are involved with this. I recall when my husband passed away unexpectedly to receive bills not when I was living in Delaware. You're already going through a tough time, and then to be surprised with these kind of unexpected costs are unacceptable, and I am glad to see in this committee that we are looking at this, we are taking leadership and that there is a sense of urgency because people are counting on us.

Thank you, and I yield back.

Ms. Eshoo. The gentlewoman yields back.

I now would like to recognize the gentleman from Georgia, Mr. Carter.

Mr. Carter. Thank you, Madam Chair, and thank all of you for being here. I know it has been a long day. So you're almost home. Just hang in there.

You know, this is a very complex issue. We all understand that. But it is a very important issue, and Ms. Wilkes, I want to thank you for being here today and for your testimony. It's certainly compelling and certainly something we have to work with.

Full disclosure -- currently, I am the only pharmacist serving in Congress and I have experienced the wrath, if you will, of the insurance companies.

At the same time, I understand where they're coming from, too, and that's what makes it such a complex issue. One of the things that we deal with, and Dr. Zaafran and Dr. Friedman, I will tell you that we use the old adage that misery loves company. I am in misery with you.

So, you know, it is tough. I deal with PBMs and, oh by the way, what we have in common with PBMs is that they're owned by the insurance companies.

So, nevertheless, one of the things that we have in

pharmacy, though, is, you know, we have any willing provider and that is if we're -- you know, quite often we are shut out. Patients don't have a choice. If they come to me and I am out of network or I am not a member of that network they can't get their prescription filled under their insurance. They'd have to pay for it out of pocket. But some states have laws that say if you're willing to accept what the insurance company is willing to pay, then you can participate.

Well, the insurance companies don't want to do that because then they can't go out and build networks, is what they're telling me, because if anybody's going to accept it then the companies -- the pharmacies that are agreeing to be in that network and bidding to be in that network -- aren't going to get the volume that they are anticipating.

It seems to me like this is just the opposite of what the economics are on why you would not want to be a part of that. Can you help me out, Dr. Zaafran, as far as the economics of how that works when you have -- when you have the insurance company paying you out of network like that?

Dr. Zaafran. So what I would first say is, again, in our organization, Physicians for Fair Coverage, 90 to 95 percent of us are in network.

We want to be in network. We strive to be in network. We negotiate with insurance companies to be in network. In many instances the times we are out of network is when it is a patient coming from another state or, in some instances, we are in network with everybody but there may be one specific plan or one carrier that is not really negotiating with us in good faith.

Typically, most of them are and we are in network with all of them. It is in our interest to be in network. The volume, the cost of providing that service, the cost of billing, the timeliness of payment from the insurance carrier -- these are all factors that actually strive to make all of us as physicians want to be in network because it is so much easier.

Mr. Carter. Okay.

Well, let me ask you, Dr. Friedman, and by the way, yours is somewhat of an unusual circumstance. Yours is kind of an outlier, if you will, because, as you say, you're in Orlando and you got a lot of people coming but, even more so, why we should be addressing it. Can you speak to the economics of it?

Dr. Friedman. Well, I think for all emergency providers, whether you work in Orlando where I work or

anywhere else in the country, we want, as Dr. Zaafran has mentioned and I have as well, we want to be in network. It is -- we want to take care of patients.

I became an emergency physician to take care of patients. I didn't take care of -- go to medical school to do billing. I, frankly, didn't think I would ever be in Congress talking about anything like this. We want to take care of the patients and --

Mr. Carter. Right.

Dr. Friedman. -- we want the -- we would like the back end, the business side, to take care of it as well. In emergency medicine, we have a unique circumstance in that I can't tell the patient what the cost is going to be.

I don't even know if they have insurance when I take care of them. So everything happens afterwards. I can't identify the insurance product.

Sometimes my billing company doesn't know if they're out of network for a couple of weeks because it is so difficult. I have a United Healthcare card. Nothing against United Healthcare, but all it says on there is what my co-pay is. That's it.

Mr. Carter. Right. Right. And, oh by the way, United Healthcare owns their own PBM and they also own their own

mail order pharmacy.

Dr. Friedman. Right. But I don't know where I am in network with that card.

Mr. Carter. Right.

Dr. Friedman. And, you know, if I am in D.C. if I try to find a doctor --

Mr. Carter. Sure.

Dr. Friedman. -- I have no idea.

Mr. Carter. Well, and thank you for that. Now, before -- my time is about up, but Mr. Nickels, I have to tell you, out of all due respect, sir, the chairlady asked you a question at the first of this hearing that I thought you tried to dodge and I will tell you that whereas I respect the Hospital Association I do think you have more of a responsibility to be a mediator, if you will, between the insurance companies and the providing physicians to try to help them to avoid the surprise billing that we are seeing.

So I think that is a responsibility that I hope that you will take -- that you all take seriously and I hope that we can count on you to do just that.

Mr. Nickels. Definitely. I know the time has expired but I totally agree with that. We do our best to work the insurers and the physicians --

Mr. Carter. Well, as I say, I thought you avoided her question. But nevertheless --

Mr. Nickels. Well, I could -- I could try --

Mr. Carter. -- and the last thing is one thing about the Pallone bill that I do like is that they would let states decide, because we do know that there are states where it's working what they're trying to do. I hear New York is working with arbitration, and I hope that we don't precede that with any legislation that we pass.

And I yield back.

Ms. Eshoo. I thank the gentleman and he yields back.

I just would like to add something to Mr. Nickels. This business of anti-trust and what the hospital association keeps referring to it, I think that when you answer members' written questions that you take another look at this.

I don't understand how anti-trust can be thrown around in this. But maybe it's because I don't know enough about it.

Mr. Nickels. Be glad to answer that.

Ms. Eshoo. We have -- thank you.

Mr. Nickels. I would be glad to answer it. Thank you.

Ms. Eshoo. Is Mr. Sarbanes still here? No? He left? Anyone else?

Mr. Burgess. Why don't we let Mr. Nickels -- are you willing to speak to that now -- the anti-trust issue?

Ms. Eshoo. If he can in a succinct way.

Mr. Nickels. I will do my best. The anti-trust concerns we raised goes along with so-called network matching where requirements which is not in the Pallone-Walden bill but I wanted to mention it because it's in other bills -- where there's an attempt to put a requirement on hospitals to get -- to make the doctors be in network with them, with us, and we believe that that would raise -- I think a physician would be forced to adhere to a third party contract. Could very easily come after us on anti-trust grounds. We are more than willing to work with them to --

Ms. Eshoo. I don't get that. I don't get that. I mean, I chaired a hospital board of directors. We had -- it was our own county hospital. It was a public hospital. We had docs from the community that worked there and the contract that we had was for the ER and those docs. And so I don't know what you mean by you can't do this, you can't do that. You already have all these different groups that you contract with.

Mr. Nickels. Right.

Ms. Eshoo. I mean, the out-of-network starts when

they're in your network.

Mr. Nickels. If we employ the docs then that's not a problem. There is no anti-trust concern of any kind. The concern is, and again --

Ms. Eshoo. What's the difference between employee and contract?

Mr. Nickels. Well, if it's contracted then if they work for us one of the things we do is if we are in a network you're in a network. That's required. The issue is we can persuade. We can try to work with the physicians to get them to do what I just described. But the issue that concerns us is what if we try to --

Ms. Eshoo. When was the last time you tried real hard and it failed?

Mr. Nickels. Say that again. I am sorry.

Ms. Eshoo. When was the last time you tried real hard and it failed?

Mr. Nickels. I could get you examples of people -- my members who have tried to do that. Again, my view is -- our view is we want those docs --

Ms. Eshoo. And then was there -- were there -- was there the threat of anti-trust as a result of trying to work it out?

Mr. Nickels. There have been -- I can give you examples where there has been threatened litigation if you tried to do that. I can also give you examples of where it worked -- where we were able to persuade the doctors --

Ms. Eshoo. All right. Well, I am going to have several questions for you. I appreciate it, and now I would like to recognize the gentleman from Maryland, Mr. Sarbanes, for his five minutes of questioning.

Mr. Sarbanes. Thank you very much, Madam Chair. Thank you all for being here much of the day.

Your perspectives, obviously, on this issue are very valuable. You have got a lot of expertise you have brought to bear with respect to this issue of surprise billing, and it's incredible, I guess, but not totally surprising that it's affecting as many as one in seven patients in America. We all hear stories from family members and friends of this kind of gotcha moment that they face.

And the thing is even when patients are trying to anticipate a situation and do their homework to make sure they're getting the services in network and so forth, they can still get caught short and be surprised with medical bills and, you know, these can total tens of thousands of dollars and it can wipe somebody out, again, even though

they're taking every precaution that they can -- they can manage to do.

And as we heard from Ms. Wilkes, the impact of those bills, the examples of how devastating it can be to patients and their families is very sobering.

I am glad we are here talking about different kinds of responses to this problem and solutions. I am sort to attracted to the No Surprises Act right now because I think it achieves that balance in a way that works best for patients, which is the perspective I am bringing to bear for the most part here, and it would take them out of the middle of these out-of-network payment processes, set that benchmark rate for out-of-network payments, as you know, to resolve payment disputes between providers and insurers.

Maryland, the state I represent, has chosen to address the surprise billing through this benchmark approach and in 2011 implemented that system which requires out-of-network bills to be sent to insurers and not to patients and define a formula that could be used for those out-of-network payments.

The goal was to reduce patients' financial burden while still paying providers at an adequate rate and maintaining network adequacy.

To monitor the success of the benchmark plan, the

Maryland Health Care Commission was looking at out-of-pocket costs, reimbursement rates before and after the implementation of the law to see what the effect would be.

Ms. McAndrew, would you agree that the rates agreed to between providers and insurers for medical services are in fact a consumer issue and would setting a benchmark rate for out-of-pocket costs go a good way towards protecting patients from unexpected and exorbitant medical bills?

Ms. McAndrew. Thank you very much for question. We absolutely do believe the rate between insurers and providers is a consumer issue. Consumers, of course, ultimately do bear the costs of health care and they bear them both out of pocket, which has been the crux of our discussion today, but they also bear them in their premiums.

And so if the legislation to affect surprise bills ultimately inflates health care costs in the system, that will affect consumers' premiums.

And so we do prefer a benchmark methodology. We believe that is what will ultimately lower costs the most for consumers. Other methods can be better than the status quo but they can have less of an effect on lowering costs for consumers, and costs are rising and rising. We see that voters care about that more than anything else about health

care, and so it's important to us as patient advocates.

Mr. Sarbanes. Well, that's certainly my perspective. As a matter of fact, the Maryland Health Care Commission from its study found that in three years after implementation of the benchmark system the total amount of out-of-network payments decreased from 20 percent to 11 percent, and those patients that had still had out-of-network charges saw their total spending decrease as well. So I think it shows the benefits of that.

Some groups have expressed concerns that setting a benchmark rate could lead to providers leaving networks and the networks shrinking over time. Have you see evidence of like a dramatic negative effect that way or not really?

Ms. McAndrew. We have absolutely not seen evidence that benchmark rates will cause problems in networks. Our colleagues in California who have worked very deeply on the implementation of this law have not reported any such effects.

I would caution making any conclusions about the California law since it's so early. But I think you have also presented very strong evidence from the state of Maryland, and I would also, you know, acknowledge that the reason this law is being implemented is because right now

people can make very large amounts of money by going out of network through balance billing. And so once that's no longer possible that is a very big deterrent for remaining out of network. And so I think that will have a very positive effect on networks.

Mr. Sarbanes. Well, I appreciate that and what you just said certainly aligns well with the experience in Maryland because, again, from the study that was done and the monitoring the Maryland Health Care Commission found that although out-of-network payments decreased, as you would expect, in the three years after a benchmark was set, overall provider participation in those networks did now show a decline. So I think there's a lot of promise there in terms of the response we need to see to this surprise billing issue.

With that, I yield back my time. I thank the panel.

Ms. Eshoo. The gentleman yields back, and I think that is it. I don't see any other members on either side.

On behalf of all the members of the subcommittee, I want to thank the witnesses. You have been patient. You have been here since before 10:00. It is now -- well, you have been here for four hours, and we are very grateful to you.

You have had to field some tough questions but that

makes for a good hearing. None of it is personal and we have to -- I always first try to remind myself that there has to be a great deal of friction wave action to -- for the sand in the shell to produce a pearl.

Now, the pearl we are looking for is good solid legislation for consumers in the country. So that friction in terms of tough questions and testing each case the best we know how, the best we can, is to benefit the American people. So we all thank you.

I want to remind members, whoever is left in the room, that pursuant to committee rules they have 10 business days to submit additional questions for the record to be answered by the witnesses who have appeared.

I ask each witness to respond promptly -- we need that in terms of our considerations here -- to any such questions that you may receive. So I don't think any of you are going to purposely drag your feet but I think it's worth underscoring that we would like a timely response.

Now, I would like to ask unanimous consent to enter into the record the following: a statement from the National Observation Stays -- S-T-A-Y-S -- Coalition, statement from the American Medical Association, a statement from the College of American Pathologists, a statement from the

Association of American Medical Colleges, a statement from the American College of Radiology, a statement from Blue Cross Blue Shield Association, from the Partnership for Employer-Sponsored Coverage, from the American Federation of State, County, and Municipal Employees, a statement from AARP, and from Business Group on Health, SEIU, United Healthcare Workers West, and Blue Shield of California.

So I ask unanimous consent to enter this into the record. I hear no objections.

[The information follows:]

**********COMMITTEE INSERT**********

Ms. Eshoo. And at this time, with your -- with all of our thanks, the subcommittee is adjourned.

[Whereupon, at 2:00 p.m., the committee was adjourned.]