August 30, 2019

Additional Questions for the Record

Subcommittee on Health
Hearing on
"No More Surprises: Protecting Patients from Surprise Medical Bills"
June 12, 2019

Responses from Jeanette Thornton

The Honorable Michael C. Burgess, M.D.

1. **Ms. Thornton, from the plan perspective, do you anticipate that insurers would behave in a way that would drive down reimbursements?**

The data have been abundantly clear that certain hospital-based provider specialties have increasingly demanded highly inflated reimbursements from patients and payers. Tying out-of-network reimbursements to the locally negotiated rates paid to in-network providers will drive down costs by requiring payments to more closely reflect both the actual cost of providing care and traditional free market forces. Health plans have every incentive to negotiate lower costs that are in the interest of health plan enrollees while ensuring that high quality providers have the necessary incentives to participate in their networks. These market realities will remain should benchmark-based legislation pass.

We do not anticipate any reductions in health plan reimbursement to providers given the larger trends that continue to drive healthcare spending. The Healthcare Cost Institute's (HCCI) 2017 Health Care Cost and Utilization Report provides insightful data on insurer health care spending. HCCI reports that provider price increases drove per-person spending growth among the employer-sponsored health insurance (ESI) population between 2013 and 2017. In fact, while utilization of services declined 0.2% between 2013 and 2017.[1]

   a. **Or are there incentives to ensure network adequacy that would prevent this from happening and maintain a physician's ability to negotiate?**

Health plans are required by law to maintain certain network adequacy standards. Beyond the legal requirements, the simple fact is that without ample providers participating in a health plan network, the health plan business is not viable. Health plans need health care providers. They have every incentive to ensure that providers are adequately compensated for their skills and expertise as enrollees value access to high quality providers. The regular course of business for health plans is to routinely negotiate with new and existing providers to develop robust provider networks; physicians will continue to have both the incentive and the ability to negotiate reasonable terms in good faith.

[1] https://www.healthcostinstitute.org/research/annual-reports/entry/2017-health-care-cost-and-utilization-report

This is in stark contrast to the status quo and what would remain under an arbitration approach where – particularly for hospital-based providers – there is little, if any, incentive to negotiate. Under both scenarios – the status quo and government-mandated arbitration – hospital-based physicians know they can extract more money by remaining out of network. We firmly believe that when the private market is able to properly function, both sides in a negotiation fare better, as opposed to the market failure that is the status quo. Indeed, we have a clear example from the state of California where – in the nation's largest insurance market – the enactment of a benchmark-based surprise billing law has led to marked increases in provider participation in health plan networks across the board – for all physician groups among all commercial payers in the state. A recent comprehensive study published in AJMC.com, the website of The American Journal of Managed Care, by AHIP, shows that since California passed its legislation to end surprise medical bills in 2016 (AB 72), the number of in-network doctors has increased by 16% and has not threatened provider networks.[2]

2. **I think everyone agrees that the patient should be held harmless and that their out-of-pocket costs should be kept to a minimum. Can you explain the existing process that hospitals and insurers go through in balance billing a patient and how you determine how much they must pay?**

We agree that patients should be held harmless and that their out-of-pocket costs should be limited to what they would have been if they were treated by an in-network provider or hospital. It is critical that policymakers recognize who sends balance bills. Insurers negotiate on behalf of their patient-enrollees and pay on their behalf according to the terms of the contract. Insurers do not bill patients. Health insurance providers are not necessarily aware when a member is balance billed. When a non-participating provider (out-of-network) submits a claim to a health plan, and the health plan adjudicates that claim according to the member's benefits, the interaction between the provider and the payer is complete. Health insurance providers, therefore, do not know if a provider then proceeds to balance bill a patient or for what amount. Health insurance providers are made aware of balance bills when a member contacts the health plan about the receipt of a balance bill through the grievance and appeals process. The way this is cataloged and tracked may vary by insurer and/or market.

Health plans routinely pay in excess of what the contract requires of them in an effort to get the hospital or provider to treat that payment as satisfying the patient's debt. These amounts are often far beyond the actual cost of care and often above in-network rates. For example, Drew Calver's experience receiving a surprise bill has received much public attention. Mr. Calver received a $164,941 bill from the hospital for a four-day hospital stay.[3] The hospital where he was treated was out-of-network with his health plan. Despite being out-of-network, the health plan tried to negotiate with the medical center and ultimately paid more than twice what an independent analysis of the bill determined would have been a reasonable cost. Health plans look to experts and past experience to identify the actual cost of care and what going market rates are

[2] https://www.ajmc.com/contributor/america's-health-insurance-plans/2019/08/can-we-stop-surprise-medical-bills-and-strengthen-provider-networks-california-did
[3] https://www.npr.org/sections/health-shots/2018/08/27/640891882/life-threatening-heart-attack-leaves-teacher-with-108-951-bill

in that region for the services and treatment provided. This process includes comparisons to the in-network rates at those facilities, third-party databases that include other payers, the Medicare rates for the same services, and independent analyses of the cost of care. In Mr. Calver's case, the hospital sent the patient a bill for more than $108,000 despite the health plan paying well above reasonable market rates. A process whereby hospitals or providers may invent charges and stick the patient with an exorbitant bill is not sustainable, nor is a system where good faith negotiations and market-based payments by health plans are not enough to satisfy those inflated bills.

The Honorable Gus M. Bilirakis

1. **Despite the patient no longer receiving a surprise or balance bill, could patients still be harmed by arbitration? If so, how and how could we address?**

Patients would undoubtedly be harmed by an arbitration process. Arbitration is a time consuming, administratively burdensome process that will drive up overall health insurance costs and increase patient premiums and cost sharing. An arbitration process will delay resolution for patients and reduce pricing certainty when setting health insurance rates. Arbitration also places the onus for action on the patient or their health plan, instead of protecting the patient.

We cannot stress enough that independent experts have looked at arbitration proposals and found that not only will this fail to rein in health spending, it will likely increase the cost of health care in the United States. This is a time when every effort by every stakeholder in health care must be focused on reducing the unsustainable cost of care. Arbitration proposals that would increase health costs by even a single dollar take us in the wrong direction.

Instead of arbitration, legislation that addresses surprise medical bills should focus on applying free market principles that avoid government-rate setting and look to negotiations between doctors and health insurance providers. This benchmark approach is known to reduce health costs and increase network participation by providers. A fair and reasonable benchmark based on existing market rates will result in transparency for patients, health plans, and providers.

2. **Have there been any observable trends in surprise or balance billing? Are some places or patients more likely to see surprise or balance billing than others – if so, why?**

Certain physician specialties such as anesthesiologists, radiologists, pathologists, and emergency physicians are more likely to balance bill than their peers. For these specialties there is little need to participate in health plan networks as these physicians will always see a steady flow of patients. In terms of the magnitude of these balance bills relative to Medicare anesthesiologists charge an average of 5.8 times that of Medicare rates, radiologists charge 4.5 times, and pathologists and emergency physicians at least 4 times. In many places these rates are even higher.

Surprise billing is also more common at hospitals that use outside staffing firms to staff their

emergency departments. For example, in a National Bureau of Economic Research paper published in 2017, researchers found that once EmCare, a large physician staffing firm, took over the management of emergency department services at a hospital, out-of-network billing rates increased over 80 percent. This increased insurer payments by 122 percent and patient cost sharing by 83 percent.[4] There is a direct link between the influx of private-equity owned physician staffing firms buying emergency departments and other hospital practices and them taking providers out-of-network and electing to code services at a higher reimbursement rate. There is a reason surprise billing is not a widespread problem at every hospital; it is a significant problem where these physician staffing firms have identified surprise billing as a profit-earning strategy.

Another trend important to highlight is that the prevalence of out of network billing has been increasing; among emergency room visits for example, surprise medical bills increased from 32.3% in 2010 to 42.8% in 2016, and the financial responsibility associated with these bills increased from a mean of $220 in 2010 to a mean of $628 in 2016.[5] This trend is not by accident and eliminating the financial incentive to remain out of network – accomplishable by requiring payments to be based on negotiated network rates – would help halt this trend and rein in health costs for patients nationwide.

3. Patients in the same location can have a different risk for receiving a surprise bill depending on which insurance plan they have: What differentiates these plans? Does federal law ensure that networks provide adequate and transparent choices for patients?

Patients who are in plans governed by the Employee Retirement Income Security Act (ERISA) are preempt from state laws regulating insurance. For example, if a patient resides in a state that has enacted surprise medical legislation yet is covered by an ERISA-governed plan the state's legislation on surprise medical billing will not apply to this individual. As such, patients in the same location may experience varying levels of risk of receiving a surprise medical bill depending on whether their plan is provided through a self-funded plan covered by ERISA versus a plan that is fully-insured and covered under state insurance law and regulation. These plans could be offered through the individual health insurance market (on or off Exchange), the small group health insurance market, or be plans sold strictly to large employers.

Health plans are subject to strict licensure requirements in order to sell health plans in the various states, and a key requirement is having an adequate provider network. Health plans use provider networks as a tool to improve quality and control costs. Through selectively contracting with credentialed providers, health plans can create networks that provide consumers with lower cost, high-quality care. When contracting with providers health plans must negotiate rates and set up contracts with each provider separately.

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[4] Cooper, Z.; Morton, F.; Shekita, N. January 2018. Surprise! Out-of-Network Billing for Emergency Care in the United States. *National Bureau of Economic Research.* Retrieved from: https://www.nber.org/papers/w23623.pdf

[5] Sun, E.; Mello, M.; Moshfegh, J.; & Baker, L. August 2019. Assessment of Out-of-Network Billing for Privately Insured Patients Receiving Care in In-Network Hospitals. *JAMA Internal Medicine.*

Different types of plans allow consumers to decide what type of network flexibility best fit their needs; Preferred Provider Organizations (PPOs) and Health Maintenance Organizations (HMOs) are two examples of plans that give consumers different network flexibility options. It's important to highlight that we see similar rates of surprise billing in both broad PPO networks and narrow HMO networks.

Finally, it is worth noting that the state of Texas has some of the strongest network adequacy laws in the country and yet its residents are more likely to receive a surprise medical bill than residents of any other state.

4. Can you discuss some perverse incentives that could lead to the creation of narrow, inadequate networks?

When it comes to health plan networks, narrow does not mean inadequate. Consumers have a number of choices when deciding which plan works best for them whether that be a PPO with a broader network or an HMO with a more limited network. Individual consumers and employers often elect a more limited network as a means of restraining costs and our members offer options for large provider networks or less expensive options depending on the needs and choice of the consumer. The problem we see with surprise billing is not one of network adequacy, and academic experts have reached that very conclusion.[6] We do, however, see a real problem in terms of provider participation. Hospital-based providers have recognized and exploited a market failure wherein they need not participate in networks to see patients and by not participating they can charge more money. Regardless of the network flexibility choices, all plans are subject to strict licensure requirements based on the state they are operating in--one of those requirements being adequate provider networks.

Under a benchmark approach to surprise billing, networks will continue to be adequate and held to the same standards they are now. We also know from experience in California – the nation's largest insurance market – that a benchmark approach results in increased provider participation in health plan networks, including marked increases among hospital-based physicians. A recent comprehensive study published in AJMC.com, the website of The American Journal of Managed Care, by AHIP, shows that since California passed its legislation to end surprise medical bills in 2016 (AB 72), the number of in-network doctors has increased by 16% and has not threatened provider networks.[7] A benchmark reimbursement approach works for consumers and physicians alike.

[6] https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/05/10/the-relationship-between-network-adequacy-and-surprise-billing/
[7] https://www.ajmc.com/contributor/america's-health-insurance-plans/2019/08/can-we-stop-surprise-medical-bills-and-strengthen-provider-networks-california-did