



“Protecting Patients from Surprise Medical Bills”

by

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Chairman Doggett, Ranking Member Nunes, and members of the subcommittee, I am Jeanette Thornton, Senior Vice President of Product, Employer, and Commercial Policy for America's Health Insurance Plans (AHIP). AHIP is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve the affordability, value, and access of the care our members receive, and enhance the well-being of our members and their families.

We appreciate this opportunity to offer our support for solutions to alleviate the financial burdens imposed on patients by surprise medical bills. Every American deserves affordable, high-quality coverage and care, as well as control over their own health care choices. Surprise medical bills stand in the way of this commitment, which is why health insurance providers have been advocating for federal legislation that will protect patients from these unexpected and unjustified costs.

Our members have come together with organizations representing American consumers, employers, brokers, and others to offer real solutions to this problem. We are calling for an end to arbitrary and inflated surprise medical bills foisted on to patients by specialty doctors and emergency medical services ("EMS") providers otherwise known as ground and air ambulance companies.

Our testimony focuses on the following:

- A review of how surprise medical bills occur;
- Data demonstrating the frequency and magnitude of surprise medical bills;
- Principles and recommendations we support to protect patients from surprise medical bills;
- Our concern that arbitration, if included in surprise medical billing legislation, would increase health care costs for everyone; and
- A comparison of two state laws—one enacted in California, another in Texas—that provide important lessons as we seek federal legislative solutions that will effectively protect the health and financial security of every American.

How Surprise Medical Bills Occur

Surprise medical bills occur when patients are treated by out-of-network providers under circumstances where consumers cannot reasonably plan for or avoid treatment from these providers. For example, they can occur following an emergency trip to the hospital, or when an ancillary out-of-network provider cares for a patient during a planned procedure at an in-network facility.

When patients have health care coverage and get care from doctors in their plan's network, the health insurance provider typically covers costs beyond the copayment, coinsurance, or deductible required under their health plan. However, when patients receive care from out-of-network providers—either voluntarily or involuntarily—the provider often will send patients a bill for charges for which they are responsible. Under current law and practice, most states allow a doctor to bill a patient for any balance that may be outstanding after the health insurance provider pays the costs for which it is responsible.

Patients often don't realize and have no way of knowing that many physicians are independent contractors who work *at* the hospital, but not *for* the hospital, and who independently choose whether or not to join a health plan network. That means that hospitals can have “in network” status, but the doctors delivering care to patients at that hospital might not. This is the type of scenario that leads to surprise medical bills and creates tremendous financial burdens for patients and their families.

The Frequency and Magnitude of Surprise Medical Bills

Surprise medical bills mean that patients and their families are often burdened with thousands of dollars of costs—or even tens of thousands of dollars—for the care they received in, or on their way to, an emergency room or at a hospital, often without even knowing the doctor who treated them. And, this burden often comes on top of the challenges faced by patients and their families to recover from a serious health condition.

In February 2019, the USC-Brookings Schaeffer Initiative for Health Policy published a white paper¹ which reported that:

- Approximately 1 in 5 emergency department visits involved care from an out-of-network provider that could result in a surprise out-of-network bill (if not prohibited by state law).
- Among people covered in the large group market, more than 50% of all ambulance cases involved an out-of-network ambulance in 2014.
- In 15% of hospitals, the researchers reported that a patient was seen by one or more out-of-network providers in at least 80% of emergency cases.

While emphasizing that surprise medical bills “often are very large,” the USC-Brookings paper explains that “out-of-network emergency physicians charged on average about eight times what Medicare pays for the same service, while in-network rates paid by commercial insurers averaged about three times what Medicare pays.”

Similarly, a blog post published last week by *Health Affairs* cited a study which found that mean reimbursement for the highest-level emergency physician service was 306% of Medicare’s payment for the same service, whereas median reimbursement was 257% of the Medicare rate.²

The problem of surprise medical bills tends to be concentrated among doctors from certain medical specialties. These providers are likely to charge substantially more than their peers in other specialties, not accept private insurance, and are not actively chosen by patients. Studies have found that surprise medical bills are most likely to come from emergency medicine physicians, anesthesiologists, radiologists, and pathologists.

For example, one study found that:

- Anesthesiologists charge, on average, 5.8 times the Medicare reimbursement rate;
- Radiologists charge, on average, 4.5 times the Medicare rate; and
- Emergency medicine physicians and pathologists charge, on average, 4 times the Medicare rate.³

¹ Loren Adler, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Christen Linke Young, Erin L. Duffy (February 2019). USC-Brookings Schaeffer Initiative for Health Policy. State Approaches to Mitigating Surprise Out-of-Network Billing. <https://www.brookings.edu/research/state-approaches-to-mitigating-surprise-out-of-network-billing>

² Loren Adler, Paul B. Ginsburg, Mark Hall, Erin Trish (May 14, 2019). Analyzing The House E&C Committee’s Bipartisan Surprise Out-Of-Network Billing Proposal. *Health Affairs*.

³ Bai, G., & Anderson, G. F. (2017). Variation in the Ratio of Physician Charges to Medicare Payments by Specialty and Region. *JAMA*, 317(3), 315

The likelihood of receiving a surprise medical bill varies greatly from state to state and county to county, largely because specialists and emergency rooms in some parts of the country are markedly less likely to accept private insurance. In some regions, hospitals are buying up more and more facilities and doctor practices, gaining monopolistic market power that makes it more challenging to agree to reasonable rates in order to deliver an affordable health plan network to patients and their families. We see this in places like McAllen, Texas and St. Petersburg, Florida, where patients had an 89% and 62% chance, respectively, of receiving surprise medical bills. Conversely, in more competitive health care markets like Boulder, Colorado and South Bend, Indiana, researchers found the rate of surprise bills to be nearly zero.⁴

Even for consumers who never receive one, surprise medical bills mean higher premiums. A 2015 analysis of out-of-network charges in New Jersey⁵ shows that for the largest health insurance provider in the state, out-of-network claims comprised 8% of their total commercial spending in 2013. If the plan had paid these out-of-network claims at 150% of Medicare rates, rather than the billed charges, the insurer would have paid 52% less for out-of-network services, amounting to savings of almost half a billion dollars (\$497 million), which could have resulted in a reduction of 4.3% in total commercial claims and consumers paying 9.5% less out-of-pocket.

The bottom line is that surprise medical bills create financial hardship for millions of Americans, and federal legislative action is needed to address this problem for everyone, regardless of the kind of coverage they have.

Solutions for Protecting Patients From Surprise Medical Bills

AHIP is advocating for federal legislation that would protect patients and consumers from surprise medical bills. Our recommendations build upon our collaboration with other leading organizations representing consumers, employers, and health insurance providers. Working with these partners, over the past six months we have endorsed a set of guiding principles for federal legislation and also addressed a letter to congressional leaders, calling for meaningful steps to address surprise medical bills.^{6,7}

⁴ Cooper and Morton (2016)

⁵ Avalere Health (2015). "An Analysis of Policy Options for Involuntary Out-of-Network Charges in New Jersey."

http://avalere-health-production.s3.amazonaws.com/uploads/pdfs/1427291367_AH_Analysis_of_Policy_Options_WP_v3b2.pdf

⁶ <https://www.ahip.org/wp-content/uploads/Surprise-Billing-Consensus-Statement-12.10.18.pdf>

⁷ <https://www.ahip.org/wp-content/uploads/Hill-Sign-on-Letter-Surprise-Medical-Bills-031819-2.pdf>

Our recommendations for federal legislation focus on four priorities:

First, balance billing should be banned in situations where patients are involuntarily treated by an out-of-network provider.

As a condition of participating in Medicare, hospitals and other health care providers should be prohibited from billing a patient the balance in excess of any health insurance provider reimbursement for: (a) emergency health care services provided at any hospital; (b) ambulatory transportation to any health care facility in an emergency; and (c) any health care services or treatment performed at an in-network facility by an out-of-network provider not selected by the patient.

In addition, the cost-sharing that may be imposed upon an insured patient should be limited to the amount for which the patient would be responsible for a participating network provider.

Second, health insurance providers should be required to reimburse non-participating providers an appropriate and reasonable amount in the above scenarios.

All health plans and health insurance issuers should be required to reimburse a non-contracted hospital or health care provider in the above scenarios an amount equal to the negotiated rate for the same service under the patient's health plan contract. If no such rate is ascertainable, then the plan should be obligated to pay the amount required for Medicare Parts A or B.

These requirements should be applied to all ERISA self-funded health plans, and non-ERISA and insured plans, with the option for states to establish similar standards for reimbursement through enacted legislation, so long as the state methodology would not increase patient cost-sharing amounts or premiums.

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

An independent dispute resolution process, established at the state level, should be available when there is a dispute as to whether a reimbursement was correctly determined according to the methodology we are recommending.

Under this process, the review of claims must be limited in its scope of review to whether the reimbursement payment was calculated in accordance with the law and any implementing regulations, excluding a determination as to the merits of the payment amount. Also, internal appeals processes must have been exhausted prior to initiating this dispute resolution process.

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

For non-emergency situations, hospitals should be required to notify patients at their first point of contact, including by a provider on a patient's behalf (e.g., scheduling surgeon), that some providers assigned to them may be out-of-network and inform them of their right to select in-network providers or decline care.

This notice should be for informational purposes only and not constitute a waiver of patient rights or a release of obligations imposed upon facilities or providers under this law. The notice should not act as a statement of consent by the patient to pay for services rendered.

We appreciate that Health Subcommittee Chairman Lloyd Doggett has introduced legislation, the "End Surprise Billing Act of 2019" (H.R. 861), which would provide a role for hospitals in providing such notices as well as ending balance billing in certain circumstances. We support this bill.

Arbitration Would Increase Health Care Costs for Everyone

We have serious concerns about any proposal that would use arbitration to determine payments to out-of-network providers. We appreciate that the Trump Administration and some Congressional proposals have rejected arbitration in favor of a market-based approach to protecting the American people from surprise medical bills.

Our major concern with arbitration is that this approach fails to address the root cause of surprise medical bills: exorbitant bills from certain specialty doctors and EMS providers. For some specialties (e.g., anesthesiologists, pathologists, radiologists, emergency medicine physicians, and certain surgeons), there is little need to participate in health plan networks because they will always have a steady flow of patients. Market forces do not apply to these providers, and their profit strategy can rely on charging highly inflated prices, knowing that patients and health insurance providers will not see the bills until after treatment and have no choice but to pay.

The fundamental problem with arbitration is that it gives equal weight to billed charges and negotiated rates. Billed charges from these specialists represent a form of price gouging. As long as the inputs into the process give weight to price gouging, the end result will be payments that are excessively high—which in turn will increase premiums. And if health plans must continue paying these exorbitant bills—even if slightly reduced—everyone who buys health insurance will shoulder the burdensome costs resulting from this price gouging. Arbitration will not succeed in correcting this market failure.

Lessons to be Learned From State Legislation

As Congress explores legislative options for eliminating the problem of surprise medical bills, it is important to look at state laws in this area. Two states in particular, California and Texas, have enacted laws that take starkly different approaches to this issue.

In California, a state law passed in 2018 provides surprise medical billing protections and establishes reimbursement requirements for *non-emergency* services received from non-contracting providers at contracting facilities. This law applies to both health care service plans and health insurance providers. The new California law is not based on provider charges. Instead, it requires health insurance providers to reimburse non-contracting providers the greater of the average contracted rate or 125% of Medicare fee-for-service reimbursement for the same or similar services in the general geographic area. The methodology for determining the average contracted rate went into effect January 1, 2019.

This approach determines the reimbursement methodology based on market rates defined as what similar providers routinely accept as payment in-full for their services. As a result, it does not increase health care spending. Instead, it encourages health insurance providers and health care providers to enter into mutually beneficial contracts. If the Congress chooses to implement this type of methodology to address the issue of surprise medical bills, it will allow health plans to continue to manage costs through contracting with health care providers while maintaining existing incentives for contracting providers and negotiating with new providers to join networks. By banning balance billing, protecting provider networks, and not adding new costs to the system, California represents the best current approach to protecting patients from surprise medical bills.

By contrast, a Texas state law ties reimbursement for non-contracting providers to the 80th percentile of provider charges. To understand the impact of this approach, we note that in Texas billed charges at the 80th percentile of FAIR Health data (usual and customary rates) for a high severity emergency department visit total \$1,902. This represents a payment of 3.94 times the average negotiated rate (allowed amounts by health plans) of \$483. This outcome demonstrates that linking payments for out-of-network services to provider charges will lead to inflated payments with higher costs for consumers—similar to the outcome we highlighted in our earlier discussion about arbitration.

The experience of Texas also shows how arbitration can slow down the claims process, increase administrative burden, exacerbate patient aggravation, and limit payment certainty. When Texas established an arbitration system to resolve surprise medical bill disputes, the number of complaints increased dramatically. In 2013, the Texas Department of Insurance received 43 requests for mediation. A year later that figure had increased to more than 600, with at least 8,000 complaints expected this year. By the fall of 2018, there was a backlog of more than 4,000 cases.⁸

Looking at the different approaches taken in these two states, we urge the committee to pursue a California-style solution that protects patients and consumers with common sense rules that prevent specialty doctors from receiving exorbitant payments.

Conclusion

Thank you for this opportunity to testify. AHIP and our members appreciate the committee's bipartisan commitment to finding solutions to surprise medical bills that will ensure quality care and lower costs for everyone. We stand ready to work with the Administration and Congress to alleviate the financial burdens imposed on the American people by surprise medical bills and make health care more affordable. By working together and putting the best interests of patients first, we can strengthen our health care system and reduce costs for all Americans.

⁸ Root & Najmabadi. *Thousands of Texans Were Shocked by Surprise Medical Bills – Their Requests for Help Overwhelmed the State*. The Texas Tribune. February 12, 2019.
<https://www.texastribune.org/2019/02/12/texas-mediation-balance-billing-faces-massive-backlog/>