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EXAMINING SURPRISE BILLING: PROTECTING PATIENTS FROM FINANCIAL PAIN

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS

COMMITTEE ON EDUCATION AND LABOR
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

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EXAMINING SURPRISE BILLING: PROTECTING PATIENTS FROM FINANCIAL PAIN

Tuesday, April 2, 2019

House of Representatives

Committee on Education and Labor

Subcommittee on Health, Employment, Labor, and Pensions

Washington, DC.

The subcommittee met, pursuant to notice, at 10:15 a.m., in room 2175, Rayburn House Office Building. Hon. Frederica S. Wilson [chairwoman of the committee] presiding.

Present: Representatives Wilson, Norcross, Morelle, Wild, McBath, Underwood, Stevens, Courtney, Shalala, Levin, Trahan, Walberg, Roe, Allen, Banks, Taylor, Watkins, Wright, Meuser, and Johnson.

Also present: Representatives Scott and Foxx.

Staff present: Nekea Brown, Deputy Clerk; Ilana Brunner, General Counsel Health and Labor; Emma Eatman, Press Aide; Daniel Foster, Health and Labor Counsel; Mishawn Freeman, Staff Assistant; Christian Haines, General Counsel Education; Stephanie Lalle, Deputy Communications Director; Andre Lindsay, Staff Assistant; Kota Mitzutani, Staff Writer; Max Moore, Office Aide; Merrick Nelson, Digital Manager; Veronique Pluviose, Staff Director; Banyon Vassar, Deputy Director of Information Technology; Marty Boughton, Minority Press Secretary; Courtney Butcher, Minority Coalitions and Members Services Coordinator; Rob Green, Minority Director of Workforce Policy; Sarah Martin, Minority Professional Staff Member; Hannah Matesic, Minority Director of Operations; Kelley McNabb, Minority Communications Director; Alexis Murray, Minority Professional Staff Member; Brandon Renz, Minority Staff Director; Ben Ridder, Minority Legislative Assistant; Meredith Schellin, Minority Deputy Press Secretary and Digital Advisor; and Heather Wadyka, Minority Staff Assistant.

Chairwoman WILSON. The Subcommittee on Health, Employment and Labor and Pensions will come to order. Welcome, everyone.

I note that a quorum is present so I ask unanimous consent that Ms. Schrier of Washington and Mrs. Davis of California be permitted to participate in today's hearing with the understanding that their questions will come only after all members of the Subcommittee on Health, Employment, Labor and Pension on both

sides of the aisle who are present have had an opportunity to question the witnesses. Without objection. So ordered.

The subcommittee is meeting today in a hearing to receive testimony on "Examining Surprise Billing: Protecting Patients from Financial Pain."

Pursuant to committee rule 7(c), opening statements are limited to the chair and the ranking member. This allows us to hear from our witnesses sooner and provides all members with adequate time to ask questions.

I recognize myself now for the purpose of making an opening statement. We are here this morning to examine surprise medical billing, a serious issue that can disrupt if not devastate the lives of individuals and families.

This is the first hearing the U.S. Congress has held on surprise billing, and I am proud that our subcommittee is taking the lead on this important issue. It is my hope that this will be the first of many productive, bipartisan conversations.

Surprise medical bills occur when patients covered by health insurance are subject to higher than expected out-of-pocket costs for care received from a provider who is outside of their plan's network. The victims of surprise medical billing often of have no control over whether their medical provider is in-or out-of-network.

With one infamous case, a young San Francisco woman named Nina Dang suffered a severe bike accident. She was barely lucid when a bystander called an ambulance and took her to an emergency room at a nearby hospital. Before she knew it, doctors had done X-rays and scans and put her broken arm in a splint, and then sent her on her way.

A few months later, Nina was hit with a $20,000 medical bill because the hospital, which she did not choose, was an out-of-network facility.

But even patients who are able to take precautions to avoid out-of-network costs during a medical emergency are not immune from surprise bills.

Scott Kohan suffered a violent attack one night in Austin, Texas. He woke up in an emergency room with a broken jaw, a throbbing headache, and staples in his head. Despite his shock and immense pain, Scott took out his phone and searched through his insurer's website to make sure he was laying in an in-network hospital bed. When he found out it was, he proceeded with a necessary jaw surgery.

Imagine Scott's frustration and devastation when he received a surprise medical bill for nearly $8,000. It turned out that the emergency room was in his insurance network, but the oral surgeon who worked in the ER was not.

These stories have been documented in detail by Vox reporter Sarah Kliff. These are not isolated incidents. According to a survey, 50 percent—57 percent of consumers report they have received an unexpected medical bill that they thought would be covered by their insurance.

A separate survey found that 7 in 10 patients who have received unaffordable out-of-network medical bills were unaware that their provider was out-of-network at the time they received the services.

This issue requires bold action to protect patients from the financial pain of surprise medical bills.

States have taken steps forward by enacting innovative, bipartisan billing laws. New York, New Hampshire, Connecticut, New Jersey, Maryland, Illinois, Oregon, California, and my home State of Florida have all adopted strong reforms that protect consumers.

Importantly, all of these solutions either hold patients harmless against charges or prohibit the practice of billing—of balance billing, where a patient is sent a bill for the difference between what insurance will pay and what the provider charges.

We have also seen many States pioneering new ways to resolve billing disputes between providers and insurers in ways that, most importantly, take consumers out-of-the middle. These State-level solutions are promising, and witnesses today will be able to provide this subcommittee with details on how such efforts are working in States where they may be falling short.

However, only Congress can fully close the gaps and loopholes that leave patients vulnerable to severe financial distress. Most Americans live in States that have not passed major reforms regarding surprise bills. And even in States that have enacted reforms, they are unable to regulate self-insured plans, which cover more than 60 percent of individuals in employer-sponsored coverage.

Health care has not recently been an area of bipartisan consensus. Unfortunately, that has only been re-affirmed by the administration's actions last week to not defend in court the Affordable Care Act and its protections for people with pre-existing conditions.

But I am hopeful that this is an opportunity for us to work together on behalf of our constituents. Surely, we can all agree that a patient should not have to spend the last few minutes before emergency surgery researching whether everyone in the operating room is in-network. And Dr. Roe came over to me this morning and said I am so glad that you are having this hearing.

I am grateful to the witnesses for their time and testimony here today and I look forward to working with my colleagues and with stakeholders as we develop a solution to the challenge of surprise medical billing.

Now I want to recognize Ranking Member Walberg for the purpose of an opening statement. The esteemed Representative Walberg.

[The statement of Chairwoman Wilson follows:]

Prepared Statement of Hon. Frederica S. Wilson, Chairwoman, Subcommittee on Health, Employment, Labor, and Pensions

We are here this morning to examine surprise medical billing a serious issue that can disrupt, if not devastate, the lives of individuals and families.

This is the first hearing the U.S. Congress has held on surprise billing, and I am proud that our subcommittee is taking the lead on this important issue. It is my hope that this will be the first of many productive, bipartisan conversations.

Surprise medical bills occur when patients covered by health insurance are subject to higher than expected out-of-pocket costs for care received from a provider who is outside their plan's network.

The victims of surprise medical billing often have no control over whether their medical provider is in-or out-of-network.

In one infamous case, a young San Francisco woman named Nina Dang suffered a severe bike accident. She was barely lucid when a bystander called her an ambulance that took her to an emergency room at a nearby hospital.

Before she knew it, doctors had done X-rays and scans and put her broken arm in a splint, and then sent her on her way. A few months later, Nina was hit with a $20,000 medical bill because the hospital which she did not choose was an out-of-network facility.

But even patients who are able to take precautions to avoid out-of-network costs during a medical emergency are not immune from surprise bills.

Scott Kohan suffered a violent attack one night in Austin, Texas. He woke up in an emergency room with a broken jaw, a throbbing headache, and staples in his head. Despite his shock and immense pain, Scott took out his phone and searched through his insurer's website to make sure he was laying in an in-network hospital bed.

When he found out it was, he proceeded with a necessary jaw surgery.

Imagine Scott's frustration when he received a surprise medical bill for nearly $8,000. It turned out the emergency room was in his insurance network, but the oral surgeon who worked in that ER was not.

These stories, which have been documented in detail by Vox reporter Sarah Kliff, are not isolated incidents.

According to a recent survey, 57 percent of consumers report they have received an unexpected medical bill that they thought would be covered by their insurance. A separate survey found that seven in 10 patients who have received unaffordable out-of-network medical bills were unaware that their provider was out-of-network at the time they received the services.

This issue requires bold action to protect patients from the financial pain of surprise medical bills.

States have taken steps forward by enacting innovative, bipartisan surprise billing laws. New York, New Hampshire, Connecticut, New Jersey, Maryland, Illinois, Oregon, California, and my home State of Florida have all adopted strong reforms that protect consumers.

Importantly, all of these solutions either hold patients harmless against charges or prohibit the practice of balance billing, where a patient is sent a bill for the difference between what insurance will pay and what the provider charges.

We have also seen many States pioneering new ways to resolve billing disputes between providers and insurers in ways that, most importantly, take consumers out of the middle.

These State-level solutions are promising, and witnesses today will be able to provide this subcommittee with details on how such efforts are working in States, or where they may be falling short.

However, only Congress can fully close the gaps and loopholes that leave patients vulnerable to severe financial distress.

Most Americans live in States that have not passed major reforms regarding surprise bills. And even in States that have enacted reforms, they are unable to regulate self-insured plans, which cover more than 60 percent of individuals in employer-sponsored coverage.

Health care has not recently been an area of bipartisan consensus. Unfortunately, that has only been re-affirmed by the administration's actions last week to not defend in court the Affordable Care Act and its protections for people with pre-existing conditions.

But I am hopeful that this is an opportunity for us to work together on behalf of our constituents.

Surely, we can all agree that a patient should not have to spend the last few minutes before emergency surgery researching whether everyone in the operating room is in-network.

I am grateful to the witnesses for their time and testimony here today, and I look forward to working with my colleagues and with stakeholders as we develop a solution to the challenge of surprise medical billing.

Mr. WALBERG. I could get used to that, Madame Chairperson. Thank you. And thank you for this hearing. I think along with Dr. Roe and the rest of my Subcommittee members, and I think we concur that this is an issue we ought to be dealing with.

And we shouldn't delay in considering options even as we stand on this side of the aisle also very strongly supportive of taking care of preexisting conditions as well. This certainly falls into that area.

The high and rising cost of health care is a significant worry for families, workers, and employers across the country. Concerns about high premiums, high deductibles, and drug prices are known and well documented. But the issue of surprise billing has rapidly risen to the forefront of people's worries when it comes to health care.

Surprise billing, sometimes called balance billing happens when a patient visits an—out-of-network care facility or even when they are at an—in-network care facility but are seen by a doctor who is not in their network.

The story of surprise billings may go something like this. A worker who is having trouble breathing visits an emergency room at a hospital in his or her health insurance network. While there, they receive an x-ray of their chest and is seen by a doctor who is, who prescribes medicine to ease the strain on the lungs.

Following the visit, he or she gets a bill—a high bill for the trip to the emergency room. Even though the hospital was technically in in-network, the doctor who saw him was not, leaving him to pay for the cost of treatment.

This understandably causes frustration for individuals who thought they did everything correct. It can also cause a high degree of uncertainty and stress for workers and families as they try to find the money to pay for the health care service they believed would be handled by their insurance. According to a 2018 poll from the Kaiser Family Foundation, surprise medical bills are the leading health care concern for Americans surpassing concerns about high premium, high deductibles, and rising drug costs.

39 percent of insured working age adults reported they had received a surprise medical bill in the past year from a doctor, hospital, or lab that they thought was covered by their insurance. Of the 39 percent of individuals who received surprise medical bills, 50 percent owed more than $500.

The fear of an unexpected medical bill can be paralyzing and we don't want Americans foregoing care they need for fear that they will end up responsible for medical expenses that they can't afford.

We need solutions that equip patients with the information they need to confidently seek treatment without the worry they will faced a huge surprise bill. About 60 percent of workers or 110 million individuals are insured through employer-sponsored health care plans under the Employee Retirement Income Security Act, ERISA.

Employer provided coverage is important to workers around the country. Employers can custom design a health care plan best suited to their workers needs which helps them retain their work force and also an important recruiting tool.

I just had a conversation with an employer this morning, a major employer in Detroit, who as a result of opportunities now has looked for additional benefits that they can supply for their employees.

A 2018 study from AHIP found that over 70 percent of workers are satisfied with their employer sponsored coverage.

22 States have laws addressing surprise billing. However, under ERISA, self-insured employer-sponsored plans are only subject to Federal rules and protections and State rules and regulations on health insurance do not apply.

Promoting public policy solutions that allow employers to continue offering high quality health coverage is good for employers and employees alike. That's why we are here today, to listen and learn from a variety of stakeholders about different proposals to address this serious issue.

With this in mind, we recognize that any potential Federal policy solution to end the practice of surprise billing must preserve important ERISA protections and ensure that self-insured plans remain subject to Federal law alone.

Committee Republicans are committed to pursuing policies that lower costs, expand choice, and end surprise billing for insured individuals. Workers and families deserve certainty about their health care coverage and I look forward to discussing how we can provide a better way forward for the American people. Thank you and I yield back.

[The statement of Mr. Walberg to follows:]

Prepared Statement of Hon. Tim Walberg, Ranking Member, Subcommittee on Health, Employment, Labor, and Pensions

Thank you for yielding.

The high and rising cost of health care is a significant worry for families, workers, and employers across the country. Concerns about high premiums, high deductibles, and drug prices are known and well-documented, but the issue of surprise billing has rapidly risen to the forefront of peoples' worries when it comes to health care.

Surprise billing, sometimes called balance billing, happens when a patient visits an out-of-network care facility, or even when they are at an in-network facility but are seen by a doctor who is not in their network. The story of surprise billing may go something like this: A worker who's having trouble breathing visits an emergency room at a hospital in his health insurance network. While there, he receives an X-ray of his chest and is seen by a doctor who prescribes medicine to ease the strain on his lungs. Following the visit, he gets a bill a high bill for the trip to the emergency room. Even though the hospital was technically in-network, the doctor who saw him was not, leaving him to pay for the cost of the treatment.

This understandably causes frustration for individuals who thought they did everything correct. It can also cause a high degree of uncertainty and stress for workers and families as they try to find the money to pay for the health care service they believed would be handled by their insurance.

According to a 2018 poll from the Kaiser Family Foundation, surprise medical bills are the leading health care concern for Americans, surpassing concerns about high premiums, high deductibles, and rising drug costs. Thirty-nine percent of insured working-age adults reported they had received a surprise medical bill in the past year from a doctor, hospital, or lab that they thought was covered by their insurance. Of the 39 percent of individuals who received surprise medical bills, 50 percent owed more than $500.

The fear of an unexpected medical bill can be paralyzing, and we don't want Americans forgoing care they need for fear that they'll end up responsible for a medical expense they can't afford. We need solutions that equip patients with the information they need to confidently seek treatment without the worry they'll face a huge surprise bill.

About 60 percent of workers, or 110 million individuals, are insured through employer-sponsored health care plans under the Employee Retirement Income Security Act (ERISA). Employer-provided coverage is important to workers around the country. Employers can custom design a health care plan best-suited to their workers' needs, which helps them retain their work force and is also an important recruiting tool. A 2018 study from AHIP found that over 70 percent of workers are satisfied with their employer-sponsored coverage.

Twenty-two States have laws addressing surprise billing; however, under ERISA, self-insured employer-sponsored plans are only subject to Federal rules and protections, and State rules and regulations on health insurance do not apply.

Promoting public policy solutions that allow employers to continue offering high-quality health coverage is good for employers and employees alike. That's why we're here today to listen and learn from a variety of stakeholders about different proposals to address this serious issue. With this in mind, we recognize that any potential Federal policy solutions to end the practice of surprise billing must preserve important ERISA protections and ensure that self-insured plans remain subject to Federal law alone.

Committee Republicans are committed to pursuing policies that lower costs, expand choice, and end surprise billing for insured individuals. Workers and families deserve certainty about their health care coverage, and I look forward to discussing how we can provide a better way forward for the American people.

Chairwoman WILSON. Without objection all other members who wish to insert written statements into the record may do so by submitting them to the committee electronically in Microsoft Word format by 5 o'clock p.m. on April 16, 2019. I will now introduce our witnesses.

Christen Linke Young is a fellow at USC-Brookings Schaeffer Initiative for Health Policy. Welcome.

Ilyse Schuman is a Senior Vice President for Health Policy at the American Benefits Council. Welcome.

Frederick Isasi is the Executive Director of Families USA, a leading voice of health care consumers. Thank you.

Dr. Jack Hoadley is a Research Professor Emeritus at the McCourt School of Public Policy at Georgetown University. Welcome.

We appreciate all of the witnesses for being here today and look forward to your testimony. Let me remind the witnesses that we have read your written statements and they will appear in full in the hearing record.

Pursuant to committee rule 7(d) and committee practice, each of you is asked to limit your oral presentation to 5 minutes as a summary of your written statement.

Let me also remind the witnesses that pursuant to Title 18 of the U.S. Code Section 1001 it is illegal to knowingly and willfully falsify any statement representation, writing, document or material fact presented to Congress or otherwise conceal or cover up a material fact.

Before you begin your testimony, please remember to press the button on the microphone in front of you so that it will turn on and the members can hear you. As you begin to speak, the light in front of you will turn green. After 4 minutes the light will turn yellow to signal that you have 1 minute remaining. When the light turns red, your 5 minutes have expired and we ask that you wrap it up.

We will let the entire panel make their presentations before we move to member questions. When answering a question please remember to once again turn your microphone on. I will first recognize Ms. Young.

STATEMENT OF CHRISTEN LINKE YOUNG, J.D., FELLOW, USC—BROOKINGS SCHAEFFER INITIATIVE ON HEALTH POLICY, THE BROOKINGS INSTITUTION

Ms. YOUNG. Thank you. Chairwoman Wilson, Ranking Member Walberg, members of the subcommittee, thank you for the opportunity to testify today. I am Christen Linke Young, a Fellow with the USC-Brookings Schaeffer Initiative for Health Policy. My testimony today is based on research conducted with a number of talented coauthors and reflects my personal views.

Surprise out-of-network bills arise when a consumer receives care from an out-of-network provider in situations that they cannot reasonably control. One common example is an out-of-network anesthesiologist at an in-network hospital. But these bills can arise for many services. Emergency department, pathology, and even neonatology.

Situations like these, where a patient is treated by an out-of-network provider that she did not choose are common. Studies suggest that about 20 percent of emergency department visits and 10 percent of elective inpatient care stays involve at least one out-of-network provider, and about half of ambulance rides are out-of-network.

The bills patients receive under these circumstances can be quite large. The existence of surprise bills and their large sizes reflect a market failure. For most types of physicians joining insurance company networks is standard because many patients are not willing to bear higher out-of-network costs. But for types of physicians that patients do not choose, this logic doesn't apply.

Emergency physicians and anesthesiologists receive a flow of patients based on individuals electing care at the hospital in which they practice. And that volume will be the same regardless of whether the physician is in-or out-of-network. Because volume does not depend on prices set by providers in these no choice specialties, going out-of-network frees them to bill patients at essentially any rate they choose. And, as would be expected, we see that physician specialties that are able to bill out-of-network have extraordinarily high charges compared to other doctors.

For example, for most physician types, median out-of-network charges are about double what Medicare pays for the same service. But for anesthesiologists and emergency medicine physicians, charges are about five times greater than the equivalent Medicare payment.

To be sure, many of these providers do still choose to join insurance networks. That may be because they find it distasteful to bill patients directly or they prefer the ease of collecting from insurers. But when they do go in-network, they appear to receive some of the highest in-network rates in the health care industry.

Whereas the in-network payment rate across many similar specialties averages about 125 percent of the Medicare rate for the service, the available data suggests that the average in-network rate for anesthesiologists and emergency medicine physicians is roughly three times the Medicare rate.

One way to understand these very high in-network rates is that these physician types exploit the fact that they could remain out-of-network to demand very high payment rates when they do go in-

network. Payment rates more than double what their peer physicians who cannot stay out-of-network receive.

And the impact is felt broadly by consumers of health care. Sometimes, out-of-network care generates an eye-popping surprise bill that ends up in the news. But in many other cases, the insurer agrees to pay the very high charge, and this, along with high in-network rates, drives up health care premiums for all of us.

Policymakers who want to solve this problem need to correct the market failure and create an environment where these providers face a more typical set of incentives. There are two basic ways to approach this solution.

The first is to establish an amount that these physicians will be paid when they deliver care out-of-network. Policymakers should establish the out-of-network price for the service, either directly or through arbitration, prohibit balance billing by the provider above this amount, and require that the insurer treat it as in-network.

The goal is not to establish the exactly correct payment rate for the service, but rather to establish conditions that diminish the attractiveness of the out-of-network option and lead these providers to go in-network or work with hospitals to get paid a fair rate for the service.

While there are a number of methods that can be used to establish the out-of-network price, it is critical that it not be set at a rate that is too high, either higher than now or that locks in the current distorted market, since that would drive up costs and frustrate the basic goal of restoring a market for these services.

The second approach is to get these providers out of the business of billing directly to patients or issuers at all. Instead, they would be paid by the hospital or the facility in which they practice.

Hospitals would negotiate with insurers for a rate that includes the services and hospitals would pay the anesthesiologists or other facility-based providers. An alternative version would require that facility-based providers establish contracts with all insurers that are in-network for the facility.

Before I close, I want to briefly highlight the work States are already doing. Many States have taken steps to correct the market failure by pursuing a diverse array of policies. But States are somewhat limited in their ability to act comprehensively by the threat of ERISA preemption and they face challenging border State issues. Thank you. I look forward to your questions.

[The statement of Ms. Young follows:]

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for Health Policy & Economics

B Center for Health Policy at BROOKINGS

Testimony of Christen Linke Young, J.D.
Fellow, USC-Brookings Schaeffer Initiative on Health Policy

U.S. House of Representatives
Committee on Education & Labor
Subcommittee on Health, Employment, Labor, and Pensions
Hearing on "Examining Surprise Billing: Protecting Patients from Financial Pain"

April 2, 2019

Chairwoman Wilson, Ranking Member Walberg, members of the subcommittee, thank you for the opportunity to testify today. I am Christen Linke Young, a Fellow with the USC-Brookings Schaeffer Initiative for Health Policy. My research focuses on private insurance, access to coverage, and the intersection between state and federal policy making. I am honored to have the opportunity to speak with you today about surprise out-of-network billing.

A group of scholars affiliated with the USC-Brookings Schaeffer Initiative for Health Policy – Loren Adler, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Erin L. Duffy, and me – recently published an analysis of out-of-network billing and associated policy solutions.[1] The material that follows is lightly adapted from that publication, which reflects the work of this diverse and thoughtful group of coauthors. Further, this testimony reflects my personal views and should not be attributed to the staff, officers, or trustees of the Brookings Institution.

Executive Summary

Surprise out-of-network bills arise when a consumer receives care from an out-of-network provider in situations they cannot reasonably control. One common example is when a patient sees out-of-network anesthesiologist for a procedure at an in-network hospital, but these sorts of bills can arise with respect to many types of services – emergency department, radiology, pathology, and even neonatology and hospitalist care.

Situations like these – where a patient is receiving care from an out-of-network provider that she did not choose – are fairly common. Studies suggest that about 20 percent of emergency department visits and 10 percent of elective inpatient care stays involve at least one out-of-network provider, and about half of ground ambulance rides are out-of-network. The bills patients receive under these circumstances can be quite large.

The existence of these surprise out-of-network bills and their large sizes reflect a market failure. For most types of physicians in most geographic areas, joining insurance company networks is standard because many patients are not willing to bear higher out-of-network costs. But for

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

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types of physicians that patients do not choose, this logic does not apply. Emergency physicians, anesthesiologists, and other ancillary physicians receive a flow of patients based on individuals receiving care at the hospital in which they practice, and that volume will be largely the same regardless of whether they join an insurance company network.

Because volume does not depend on the prices set by providers in these kinds of specialties, going out-of-network frees them to bill patients at essentially any rate they choose. And, as would be expected, we see that physician specialties that are able to bill out-of-network have high charges compared to other doctors. For example, for most physician types, median charges are about double what Medicare pays for the same service. But for anesthesiologists and emergency medicine physicians, charges are about five times greater than the equivalent Medicare payment.

To be sure, many of these providers do still choose to join insurance company networks. That may be because they find it distasteful to bill patients directly or because they prefer the ease of collecting from insurers rather than patients. But when they do go in network, they appear to receive some of the highest in-network payment rates in the health care industry. Whereas the in-network payment rate across many similar specialties averages around 125 percent of the Medicare rate for the service, the available data suggest that the average in-network rate for anesthesiologists is roughly 350 percent the Medicare rate. For emergency medicine physicians it is roughly 300 percent the Medicare rate.

One way to understand these very high in-network rates is that these physician types exploit the fact that they could remain out-of-network to demand very high payment rates when they do go in-network – payment rates more than double what their peer physicians who cannot realistically plan to stay out-of-network receive.

Further, the impact is felt broadly by consumers of health care. Sometimes, an out-of-network care episode generates an eye-popping surprise balance bill that ends up in the news, but in many other cases, the insurer agrees to pay the very high charge, and this, along with high in-network rates, drives up premiums for everyone.

Policymakers who want to solve this problem need to correct the market failure and create an environment where these providers face a more typical set of incentives. There are two basic ways to approach the solution.

The first is to establish an amount that these physicians will be paid when they deliver care out-of-network. Policymakers should establish the out-of-network price for the relevant service, either directly or through arbitration; prohibit balance billing above this amount; and require the insurer treat this amount as in-network. The goal is not to establish the exactly "correct" commercial payment rate, but rather to establish conditions that diminish the attractiveness of the out-of-network option and lead these providers to go in-network or work with hospitals to get paid a normal rate. While there are a number of methodologies that can be used to establish this out-of-network price, it is critical that it not be set at a rate that is "too high" (either higher

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than now or that locks in the current distorted rate), since that would drive up costs and frustrate the basic goal of restoring a market for these services.

The second approach is to get these types of providers out of the business of billing directly to patients or insurers, at all. Instead, they would be paid by the hospital or other facility in which they practice. Hospitals would negotiate with insurance companies for a rate that includes the services, and the hospitals would pay the anesthesiologists and other-facility based providers. An alternative version would require that facility-based providers establish contracts with all insurers that are in-network for the facility at which they practice.

Introduction

Surprise out-of-network medical bills occur when patients are treated by providers outside their health plan's contracted network under circumstances that cannot reasonably be avoided. Usually, surprise bills happen when patients are treated by an out-of-network provider that they did not choose. For example, patients undergoing surgery at an in-network hospital performed by an in-network surgeon (of their choosing) may be surprised to learn after the fact that their anesthesiologist (who they did not choose) was out-of-network. This analysis focuses on out-of-network bills that arise either from emergency care – including emergency ambulance transport – or from services delivered to patients at in-network facilities[2] by out-of-network specialty physicians or other providers that patients typically have no role in choosing, which commonly include ancillary physicians (anesthesiologists, radiologists, pathologists, assistant surgeons), hospitalists, and neonatologists.

The financial consequences of surprise out-of-network bills can be substantial. Contracted, in-network providers agree to accept health plan payment rates that are substantially discounted from their "list price," and health plans typically require much lower cost-sharing amounts from their enrollees for in-network services. Patients treated on an out-of-network basis, however, usually are liable for typically higher cost-sharing amounts through their health plan and the difference between the provider's full charges and the insurer-paid amount – a provider practice known as balance billing – which can be extremely large. Patients enrolled in closed-network health plans, such as health maintenance organizations (HMOs), potentially are liable for the full provider charges for out-of-network care.

Prevalence and Magnitude of Surprise Out-of-Network Bills

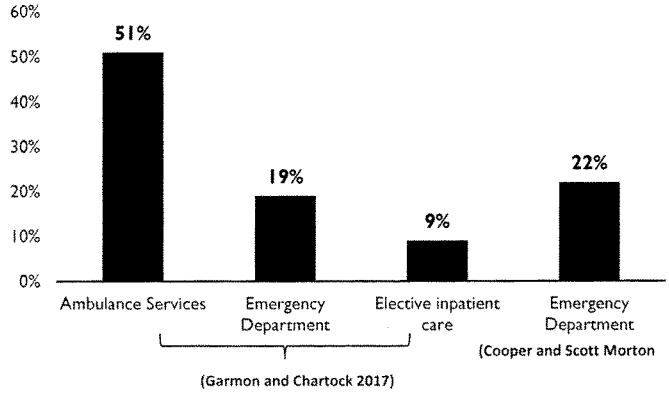
Health care services resulting in a potential surprise out-of-network bill are quite common. Three national studies all found that roughly 1 in 5 emergency department (ED) visits involved care from an out-of-network provider that could result in a surprise out-of-network bill if not

[2] The term "facility" encompasses hospitals, ambulatory surgical centers, and freestanding emergency departments.

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prohibited by state law.[3,4,5] Further, among people with large employer-sponsored health plans, more than 50 percent of all ambulance cases involved an out-of-network ambulance in 2014, and even for elective inpatient admissions, 9 percent of scheduled hospital stays at in-network facilities led to a potential surprise out-of-network bill.[6,7] Surprise billing is prevalent in almost all areas of the country, for enrollees in both employer and individual market health plans, and across plan types.[8,9]

Figure 1. Percentage of Visits Leading to a Potential Surprise Out-of-Network Bill



Source: Garmon and Chartock 2017; Cooper and Scott Morton 2016

Note: For the Garmon/Chartock figures, 19% represents the % of outpaitent ED cases, including those to an OON ED, that could result in a potential surprise balance bill.

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[3] Cooper, Zack, Fiona Scott Morton. 2016. "Out-of-network emergency-physician bills—an unwelcome surprise." *N Engl J Med* 2016; 375:1915-1918. https://www.nejm.org/doi/full/10.1056/NEJMp1608571.

[4] Garmon, Christopher, Benjamin Chartock. 2017. "One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills." *Health Affairs*. Vol 36. No. 1 https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0970.

[5] Claxton, Gary, Matthew Rae, Cynthia Cox, Lary Levitt. 2018. "An Analysis of Out-of-Network Claims in Large Employer Health Plans." *Peterson-Kaiser Health System Tracker*. https://www.healthsystemtracker.org/brief/an-analysis-of-out-of-network-claims-in-large-employer-health-plans/#item-start.

[6] Garmon and Chartock, 2017.

[7] Cooper, Zack, Fiona Scott Morton, Nathan Shekita. 2019. "Surprise! Out-of-Network Billing for Emergency Care in the United States." *NBER* Working Paper 23623. https://www.nber.org/papers/w23623.pdf.

[8] Garmon and Chartock, 2017.

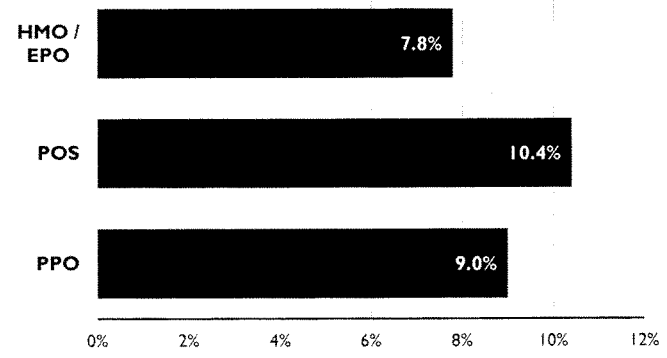
[9] Gunja, Munira Z., Sara R. Collins, Michelle M. Doty, Sophie Buetel. 2016. "Americans' Experiences with ACA Marketplace Coverage: Affordability and Provider Network Satisfaction." https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2016_jul_1883_gunja_americans_experience_aca_marketplace_affordability_v2.pdf.

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Figure 2. Prevalence of Potential Surprise Out-of-Network Bills from Elective Inpatient Care at In-Network Facilities Across Plan Types



Source: Garmon and Chartock 2017

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When they occur, surprise out-of-network bills often are very large. According to a study examining data from a large national insurer, 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. Thus, even if insurers were to pay out-of-network emergency physicians at their average in-network contracted rates, patients could still be liable for a balance bill reflecting substantially higher charges. For an emergency physician visit in this study, the average balance – or the difference between charges and average contracted rates – was $623.[10] However, many patients face much higher balance bills in the thousands or tens of thousands of dollars, sometimes from claims for multiple services or multiple physicians working in the ED charging many times what Medicare would pay.[11] For perspective, roughly one-quarter of multi-person, non-elderly households are estimated to be unable to pay $1,000 from currently liquid assets.[12]

Why Surprise Out-Of-Network Bills Happen

Normally, negotiations between health plans and physicians are driven by a price-volume trade-off, in which a physician is willing to accept a lower per service price in exchange for the health

[10] Cooper and Scott Morton, 2016.
[11] Rosenthal, Elisabeth. 2014. "After Surgery, Surprise $117,000 Medical Bill From Doctor He Didn't Know." *The New York Times*. http://www.nytimes.com/2014/09/21/us/drive-by-doctoring-surprise-medical-bills.html.
[12] Rae, Matthew. Gary Claxton, Larry Levitt. 2017. "Do Health Plan Enrollees have Enough Money to Pay Cost Sharing?" *The Kaiser Family Foundation*. https://www.kff.org/report-section/do-health-plan-enrollees-have-enough-money-to-pay-cost-sharing-issue-brief/.

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plan effectively steering more enrollees to that physician by including the physician in its network. Indeed, for most physicians in most geographic areas, it is not possible to maintain a practice without entering some insurer networks because few patients are willing to bear the higher costs associated with seeing an out-of-network physician. However, for some types of physicians, that basic dynamic does not apply.

For ED physicians,[13] patient volume is driven by patients' choice of hospital[14] and is unlikely to be affected by the whether the physician is in-network or not. While patients seeking emergency care usually go to a facility in their insurer's network,[15] once at the ED, they typically have no choice over the specific physicians treating them. Yet, there is no guarantee that these physicians will be in the same insurer networks as the facility because these physicians generally contract independently with health plans (unless they are salaried by the facility).[16] Since patients have no option to choose an alternative in-network physician in this situation, the physicians' incentive to accept a lower in-network rate is reduced compared to scenarios where patients do have a choice. Volume is likely to be similarly insensitive to network status for facility-based ancillary physicians such as radiologists, anesthesiologists, pathologists, and assistant surgeons. For elective care, insured patients regularly seek a network facility and primary physician, such as a surgeon, but then have no choice of these ancillary physicians, who similarly contract independently with health plans.[17] A similar dynamic applies for emergency ambulance transport since ambulances tend to be centrally dispatched and patients almost never have a choice of which ambulance company transports them in an emergency.

These providers, therefore, have a potentially lucrative out-of-network billing option that is unavailable to others. The amount charged to out-of-network patients faces few market constraints, so it is unsurprising that emergency medicine and ancillary physicians have much higher charges than other specialists relative to Medicare payment levels on average.[18] For example, emergency medicine physicians who billed out-of-network for one large insurer averaged charges of nearly 800 percent of Medicare rates[19] and the top 25 percent of anesthesiology claims billed to Medicare patients had billed charges more than 9 and a half times the Medicare rate (See Figure 3).[20]

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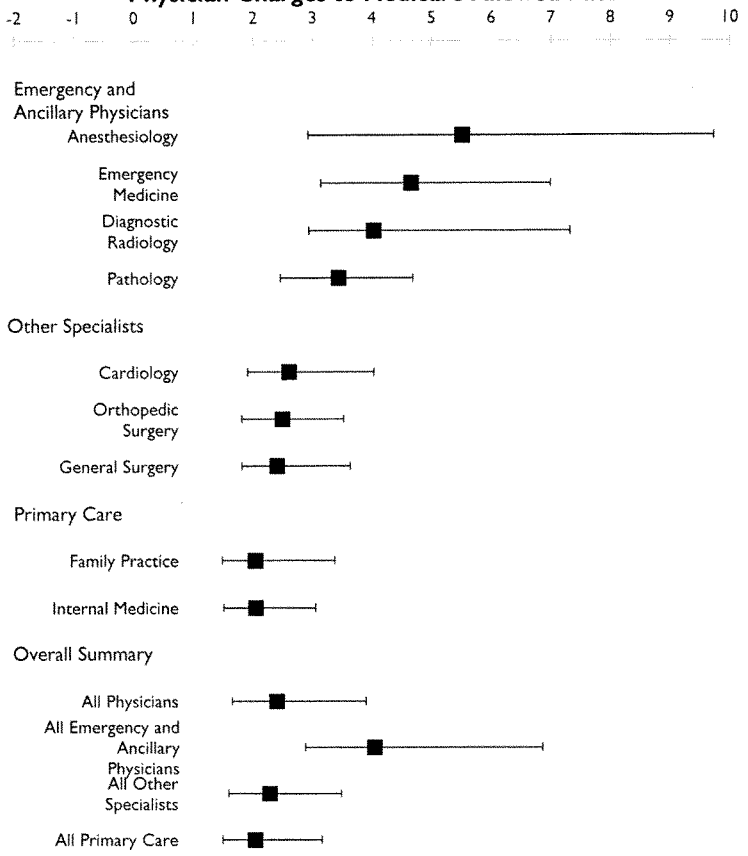
[13] In this paper, we use the term "emergency physician" or "emergency medicine physician" to refer to those specializing in emergency medicine, while the term ED physician is used to refer to all physicians that deliver services in the emergency department, which will include emergency medicine physicians as well as many other specialties who consult on ED cases.
[14] There are also infrequent instances where patients have no choice of hospital (e.g., when unconscious or in urgent need of the closest facility) and may end up at an out-of-network facility.
[15] Cooper and Scott Morton, 2016.
[16] Some hospitals directly employ certain hospital-based physicians or utilize faculty at an academic medical center.
[17] Indeed, in conversations with Schaeffer Initiative researchers, stakeholders indicated that surgeons sometimes contract with health plans separately for their primary and assistant surgery services, or for their ED coverage, so it is possible for a surgeon to be in-network when acting as the primary surgeon but out-of-network when assisting in elective surgery or on call in the ED, all at the same facility.
[18] Bai, Ge, Gerard F. Anderson. 2017. "Variation in the Ratio of Physician Charges to Medicare Payments by Specialty and Region. *JAMA*. 2017;317(3):315-318. https://jamanetwork.com/journals/jama/fullarticle/2598253.
[19] Cooper and Scott Morton, 2016.
[20] Schaeffer Initiative researchers analysis of *Medicare Provider Utilization and Payment Data: Physician and Other Supplier* Public Use Files, calendar year 2016. Median and inter-quartile range (IQR) computed across physicians and services, weighting by the number of services rendered.

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Figure 3. Median and Interquartile Range (IQR) Ratios of Physician Charges to Medicare Allowed Rate



Source: Authors' analysis of Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use Files, calendar year 2016.. Provider specialties are included in the data. The primary care specialty includes family practice and internal medicine physicians. Median (IQR) computed across physicians and services, weighting by the number of services rendered.

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While these charges are high, there also are costs for physicians who rely on out-of-network billing. Collecting from individual patients is more difficult than from an insurer. Out-of-network physicians often settle with patients and/or health plans for payment below their full billed charges and some patient charges are eventually sent to collections, where providers typically receive pennies on the dollar. Collecting out-of-network bills also entails administrative and hassle costs, and even the timeliness of the insurer-owed portion of the bill tends to vary by provider network status, with payments often more prompt to in-network providers. The physicians involved also may find sending patients a surprise bill distasteful and be willing to accept less total compensation to avoid doing it. These factors help explain why many ED and ancillary physicians opt to be in health plan networks despite the lack of patient choice.

Physicians are not the only actors whose decisions determine the prevalence of out-of-network billing; decisions by health plans and hospitals play a role as well. Notably, patients *do* generally choose their health plans and hospitals, so both health plans and hospitals have economic – and other – incentives to protect patients from surprise out-of-network billing by persuading ED and ancillary physicians to be in network. However, the availability of the lucrative out-of-network billing option can make it costly for health plans and hospitals to achieve this outcome.

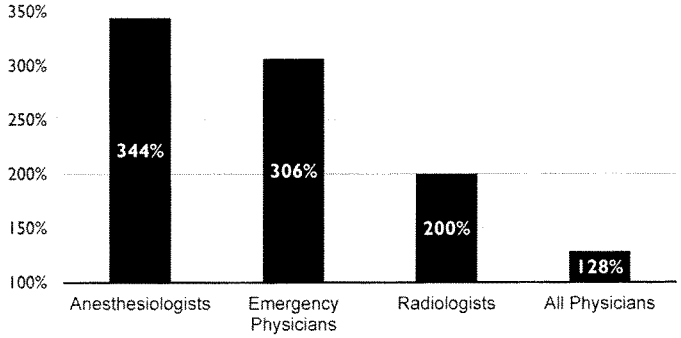
Most directly, ED and ancillary physicians' ability to engage in out-of-network billing enables these physicians to demand high in-network rates, which makes contracting with these physicians quite costly, and in turn increases insurance premiums. While comprehensive data on commercial payment rates by specialty are not widely available, evidence strongly suggests that the specialties with the highest rates of surprise out-of-network billing typically get paid significantly higher contracted payment rates – relative to Medicare reimbursement for the same service – than other specialists. Emergency physicians[21] appear to receive average contracted payment from commercial health plans at roughly 250 to 300 percent of Medicare rates,[22,23,24] radiologists receive about 200 percent of Medicare rates,[25,26] and in a large survey conducted by the American Society of Anesthesiologists, commercial contracted payments to anesthesiologists averaged nearly 350 percent of Medicare rates in 2018.[27] In contrast, studies using claims data show that, across an array of non-emergency services provided by non-ancillary specialists, average mark-ups over Medicare range from approximately 115 percent to near 200 percent.[28,29] Another study using nationally representative survey data on medical expenditures found that employer-sponsored insurance payments for office visits provided by

[21] It is worth noting that ED physicians also must treat any patient who presents at the ED until stabilized regardless of ability to pay as a result of the Emergency Medical Treatment and Labor Act (EMTALA), but their uncompensated care burden does not appear to be large enough to justify pricing disparities this great.
[22] Trish, Erin, Paul Ginsburg, Laura Gascue, and Jeffrey Joyce. 2017. "Physician Reimbursement in Medicare Advantage Compared with Traditional Medicare and Commercial Health Insurance." *JAMA Internal Medicine*. 2017;177(9):1287-1295. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2643349.
[23] Cooper and Scott Morton 2016.
[24] Cooper, Scott Morton, and Shekita, 2019.
[25] Trish, Ginsburg, Gascue, and Joyce, 2017.
[26] Pelech, Daria. 2018. "An Analysis of Private-Sector Prices for Physicians' Services." *Congressional Budget Office* Working Paper 2018-01. https://www.cbo.gov/system/files/115th-congress-2017-2018/workingpaper/53441-workingpaper.pdf.
[27] Stead, Stanley W., Sharon K. Merrick. 2018. "ASA Survey Results for Commercial Fees Paid for Anesthesia Services—2018." *ASA Monitor* 10 2018, Vol. 82, 72-79. http://monitor.pubs.asahq.org/article.aspx?articleid=2705479.
[28] Trish, Ginsburg, Gascue, and Joyce, 2017.
[29] Pelech, 2018.

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specialists averaged about 117 percent of Medicare,[30] and a Medicare Payment Advisory Commission (MedPAC) analysis of commercial PPO claims from one large national insurer found that contracted payment rates nationwide for all physicians averaged 128 percent of Medicare rates.[31] While Medicare rates are not necessarily a perfect measure of the relative cost of delivering different services, discrepancies this large and consistent across the specialists most commonly involved in surprise out-of-network billing appear difficult to justify.

Figure 4. Average Contracted Payment Relative to Medicare Rates for Selected Specialties



Note: Anesthesiologist comparison based on relative mean conversion factors in 2018. Emergency physician comparison based on relative mean payment rates for CPT code 99285 in 2012. For radiologists, 200% represents mean commerical payment for CT Head/Brain scans relative to the Medicare rate (CPT code 70450). All physicians comparison based on data from commercial PPO claims for one large national insurer.

Source: Stead and Merrick 2018; Trish, Ginsburg, Gascue, and Joyce 2017; MedPAC 2017

Hospitals could seek to limit surprise out-of-network billing by requiring the emergency and ancillary physician groups they contract with to participate in the same health plan networks as the hospital. Unlike health plans, hospitals have leverage over these physicians because they rely on the hospital for patient volume. And, in practice, many hospitals do apply pressure on their emergency and ancillary physicians to sign contracts with the health plans they accept. However, they may lack the market leverage necessary to insist on compliance.

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[30] Biener, Adam I., Thomas M. Selden. 2017. "Public and Private Payments for Physician Office Visits." *Health Affairs*. Vol 36 No. 12. https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0749.

[31] MedPAC. 2017. "Report to the Congress: Medicare Payment Policy." March 2017. http://medpac.gov/docs/default-source/reports/mar17_entirereport.pdf.

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Indeed, taking such a stance on surprise out-of-network billing would often have costs for the hospital. Economic theory predicts that a hospital that wishes to bar an ED or ancillary physician from billing hospital patients on an out-of-network basis would need to compensate physicians to forgo this lucrative option, particularly since physicians barred from going out-of-network are likely to have limited leverage when negotiating in-network rates.[32] For instance, a hospital that wanted to prohibit out-of-network billing by its contracted physicians might have to offer higher stipends, medical director fees, or other forms of direct payment.[33] Equivalently, an emergency or ancillary physician group who wanted to bill hospital patients out-of-network – or is able to better leverage the out-of-network billing threat to extract especially high in-network health plan payments – might be willing to accept less in these payment streams.[34]

The fact that it is costly for a hospital to require its ED and ancillary physicians to go in network also makes it costly for insurers to encourage hospitals to take such an approach. In principle, the insurer could offer the hospital higher facility payment rates in exchange for guaranteeing that the hospital's ED and ancillary physicians accept network rate offers. However, because this would create such significant costs for the hospital, the increase in payment rates would likely need to be relatively large.

Since, as previously noted, patients generally do choose their insurers and hospitals, hospitals or insurers might be willing to pay what would be required to get physicians to forgo surprise out-of-network billing if patients demanded it. In practice, however, consumer demand is unlikely to be strong enough. Few patients even know that network status can differ between the facility and emergency and ancillary clinicians. Additionally, health events that would make this protection valuable are relatively uncommon and hard to anticipate. As a result, exposure to surprise out-of-network billing may not be a particularly salient consideration when consumers are choosing hospitals or insurers, in which case hospitals or insurers that offer this protection may not be able to attract enough additional customers – or raise their premiums enough – to cover the significant costs they would certainly incur to compensate ED and ancillary physicians for forgoing their lucrative out-of-network billing option. Furthermore, even if consumer pressure were strong enough to squelch surprise out-of-network billing, emergency and ancillary physicians would continue to be able to extract very high levels of in-network payment, which consumers and their employers would bear through higher premiums.

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[32] When deciding whether to contract with a health plan, physicians consider the payoff to remaining out of network, which is the amount of money they can collect when billing on an out-of-network basis minus the costs, including both the time and money to collect from patients and any distaste for surprise billing patients. Additionally, physicians must consider the cost of compensating the hospital for the reputational harm stemming from surprise out-of-network billing occurring at their facility and any distaste the hospital has for surprise billing patients. A similar model is detailed by Cooper, Scott Morton, and Shekita 2019.

[33] Stipends, medical director fees, and other forms of direct payment from hospital to physician group are often related to the payer mix of the hospital, services performed that are not reimbursed by insurers, and other factors.

[34] For a discussion of this phenomenon occurring, see Bank of America Merrill Lynch. "Physician Staffing: Out-of-network concerns are blown out-of-proportion. EVHC Top Pick." April 2016.
Excerpt: "*According to Envision, hospitals are aware of their contracting strategy, and oftentimes it is expressly done to reduce the subsidy that the hospital would otherwise have to pay. Essentially, EVHC [Envision] might say to the hospital, 'I can staff your hospital with a $300,000 subsidy, or I can go out-of-network with United and the subsidy would be $0.*'"

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Principles for Designing a Solution

Before discussing specific policies, it is useful to lay out what features a solution to the surprise out-of-network billing problem should have. In this section, we describe four principles for a solution to surprise out-of-network billing.

1. Take the patient out of the middle

A key first step is removing the patient from the middle of disputes over surprise out-of-network billing and requiring insurers, providers, and/or regulators to resolve problems. Any solution, therefore, should prevent patients from receiving a surprise out-of-network bill in the first place, making discordant network status between facility and ED or ancillary clinicians invisible to patients. This is in contrast to some current state laws that require patients proactively to file a complaint about surprise out-of-network bills. Patients may be unaware of legal protections and end up paying an out-of-network bill unnecessarily. Additionally, navigating the complaint process is likely to create significant barriers and costs for patients.

2. Apply protections comprehensively

Protections from surprise out-of-network billing should apply comprehensively across settings – at hospitals, ambulatory surgical centers (ASCs), and freestanding EDs – and not merely in emergency situations. Specifically, protections should apply to services where patients lack meaningful choice of provider. A comprehensive approach would include:

- All out-of-network emergency care,[35] whether the facility is in- or out-of-network (including out-of-network facility fees);
- Post-stabilization services at an out-of-network facility (including facility and professional fees);[36]
- All out-of-network emergency ambulance transport;
- All out-of-network ancillary and hospitalist services delivered through an in-network facility. Ancillary services should be defined as all anesthesiology, radiology, pathology, assistant surgery, and other consulting services, encompassing any tests or imaging performed in addition to the physician professional services.
- Out-of-network neonatology services at an in-network facility immediately following birth until a reasonable option is provided for transfer to an in-network facility with access to an in-network physician.

It may also be appropriate to include some or all out-of-network laboratory services (including pathology) ordered by in-network physicians in the physician office setting. Further, for out-of-network treatment at an in-network facility other than the services described above, protections

[35] Emergency services should be defined by the "prudent layperson" standard, which is broader than the "stabilization" standard under EMTALA. It covers situations beyond true life-and-limb emergencies, to include circumstances where patients reasonably believe they might have an emergency condition, even if it turns out they do not. See 29 CFR 2590.715-2719A.

[36] Such a protection could apply for the first 24 hours after stabilization, and thereafter if no reasonable option is provided for transfer to an in-network facility.

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should apply if the provider does not provide notice of their network status and associated costs and obtain patient consent at least 48 hours before treatment.

3. Minimize reliance on notice and consent exceptions

In an attempt to balance protecting patients and allowing legitimate elective uses of out-of-network care, many proposals create and exception from prohibitions on balance billing if the medical provider gives notice. Such an exception, however, may allow some providers to thwart surprise billing protections if patients do not fully understand what they are signing or do not realistically have the option to withhold consent, and therefore should be limited if allowed at all. Given the amount of paperwork patients typically must fill out when obtaining medical care and the worry and pain involved with their illness, the notice of potentially high out-of-network billing charges may not be salient enough for patients to take notice. Additionally, the notice might be provided at a point where patients lack realistic alternatives.

Moreover, a notice and consent exception should be unnecessary for many settings, as there is no reason to think that patients would ever opt for out-of-network care when they are not otherwise choosing their provider. A notice and consent exception should be reserved for out-of-network billing protections applied to non-ancillary out-of-network services at an in-network facility, such as a preferred surgeon.

4. Include means of enforcement

An effective policy needs to alter the behavior of health care payers, hospitals, physician groups, and individual clinicians. Regulatory efforts can be frustrated by lack of an efficient enforcement mechanism binding all relevant parties. Attention should be paid to how any new standards will be enforced.

Analyzing Potential Policy Approaches

There are two broad policy approaches that can address surprise out-of-network billing in a comprehensive manner. The first, termed "billing regulation," relies on capping or setting what out-of-network providers can charge patients and health plans in surprise situations, either by explicitly choosing a rate or determining it through an arbitration process. Additionally, plans would be required to treat such services as in-network for purposes of enrollee cost-sharing. The second approach, termed "contracting regulation," effectively makes it impossible for facility-based emergency, ancillary, and similar services to be out-of-network with a health plan when the facility itself is in-network. This second approach can be achieved either through a requirement on ED and ancillary clinicians, hospitalists, and neonatologists to contract with the same health plans as the facility or facilities they practice in, or through a prohibition on these physicians contracting with health plans or billing patients directly.

Billing Regulation

Billing regulation combines two key elements:

- Limit the amount that a provider can receive for delivering a given out-of-network service; and
- Require health plans to hold patients harmless beyond their normal in-network cost-sharing amounts – this means that plans must pay the difference between the capped provider charges and the patient's in-network cost-sharing, and must apply the patient's cost-sharing amounts to their in-network deductible and out-of-pocket maximum.[37]

The first step – limiting provider payment for out-of-network services – can be accomplished as either a limit on the amount the provider can charge when care is delivered out-of-network (a maximum amount charged or charge limit), or as a requirement that the health plan pay a minimum amount combined with a prohibition on provider balance billing (a minimum payment owed or payment standard) These approaches are functionally equivalent; this analysis will refer to charge limits.

A key decision in designing such a policy is determining how to set a reasonable cap on what an out-of-network provider can charge, which is described in some detail below.

General Considerations in Setting a Charge Limit or Payment Standard

Charge limits can be established in one of two ways: directly specifying a limit or specifying an arbitration process. The first approach is simpler and more transparent, although arbitration may provide more flexibility in payment rates across circumstances. Before discussing each of the specific approaches to setting a charge limit in more detail, however, it is useful to consider the policy implications of setting a limit that is "too high" versus one that is "too low."

A charge limit for out-of-network ED, ancillary, and similar clinicians that is "too high" would lead to excessive health care spending. Because fully-insured health plans would be required to pay ED, ancillary, and similar physicians the difference between their capped charges and the patient's in-network cost-sharing, physicians would effectively be guaranteed payment equal to the charge limit. As a result, any charge limit set above current average contracted rates in a market would place upward pressure on those contracted rates, and, above a certain level, those increases could more than offset any reduction in payments to physicians currently billing out of network.

Even setting a charge limit close to the average amounts currently collected by these physicians would likely lead to excessive spending because it would bake in today's inflated costs for ED

[37] Under this approach, policymakers would have to decide whether insurers would be required to pay out-of-network providers directly or whether they would instead be permitted to pay the mandated amount to the patient, who would in turn pay the provider. Requiring insurers to pay providers directly would minimize hassle costs for patients. On the other hand, because requiring insurers to pay providers directly would make it easier for out-of-network providers to collect payment (or allow them to do so more quickly), it might reduce these providers' incentive to join insurers' networks. In circumstances where the charge limit has been set "too high" (discussed in more detail in the following section), retaining some incentive for providers to join networks at rates below the charge limit would be desirable. Requiring insurers to directly pay providers with whom they lack contractual relationships may also create some operational complexities, although at least some of the states that have taken steps to limit surprise billing appear to have surmounted those problems in practice.

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and ancillary services. As detailed earlier, it appears that emergency and ancillary physicians currently are paid more than they would earn absent the ability to routinely treat and bill patients out-of-network. This analysis will refer to the payment rate that would prevail without the ability to routinely treat and bill patients out-of-network as the "normal market" rate (although to the extent that physician markets are concentrated, even this rate still may be excessive).

On the other hand, setting a charge limit "too low" may be perceived as unfair. It could also raise concerns about physician shortages or reduced access to care if compensation is insufficient to incentivize physicians to train for affected specialties. However, for these particular facility-based clinicians, there are countervailing pressures that would mitigate the impact of a payment standard lower than "normal market" rates. Specifically, these providers by definition practice in facilities, and there are a variety of ways that facilities can compensate for rates that are, in some sense, "too low." Today, facilities make a variety of payments directly to these clinicians (separate from health plan payments for actual services rendered) such as stipends or medical director fees.[38] Further, hospitals can become involved in the negotiations between clinician groups and health plans. If facility-based ED or ancillary clinician out-of-network payment rates were capped at too low a level, facilities would be expected to compete to attract ED and ancillary clinicians by using one of these channels to offer additional payment.[39] Indeed, the facilities are the drivers of these physicians' practice volume, so the more natural negotiation is between the facility and facility-based clinician, rather than between the health plan and clinicians.

There are legal constraints on how much and in what ways facilities can direct funds to clinicians, and there may be some short-term disruption, but these mechanisms should ultimately help augment any rate set "too low" toward the "normal market" rate.[40] Importantly, there is evidence that the payments from facilities to clinicians for contracted services are today often related to the payer mix of the facility – for example, offering a higher subsidy if a relatively high percentage of a facility's patients are uninsured or have public insurance with relatively lower reimbursement.[41] That a mechanism already exists through which facilities can provide compensation to ED and ancillary clinicians who expect to earn lower revenue for contracted services provides strong evidence that a similar response could ensue if a payment standard was set below a "normal market" rate. However, the legal considerations are significant and facilities and clinicians will need to take care to document that these fund flows represent

[38] American Academy of Emergency Medicine. 2005. "The Business of Emergency Medicine—Made Easy!" https://www.aaem.org/UserFiles/file/thebusinessofem.pdf.
[39] However, in most cases, we would not expect facilities to typically compensate emergency and ancillary clinicians for the entire difference between their current contracted rates and the new charge limit because they no longer need to be compensated to forego the now-outlawed lucrative out-of-network billing option.
[40] While these payment arrangements with facilities would mitigate concerns about setting a rate that is "too low" for ED and ancillary physicians, as well as hospitalists and neonatologists, the same mechanism does not exist for out-of-network emergency facilities (i.e., the facility rather than the physician fee) nor for out-of-network ambulances. Thus, the consequences of setting a payment rate that is "too low" may be more problematic for these particular services, although we do not think there is much risk that a rate in the range of 125 percent of Medicare (our recommendation) would be too low to cover the costs of delivering these services.
[41] American Academy of Emergency Medicine. 2005. "The Business of Emergency Medicine—Made Easy!" https://www.aaem.org/UserFiles/file/thebusinessofem.pdf.

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fair market transactions to avoid running afoul of state and federal self-referral and anti-kickback laws.

In principle, one might be concerned that the need to subsidize these physicians could make delivering these services unprofitable for hospitals and thereby jeopardize access to hospital services. In practice, however, this is unlikely to be a concern. Under standard economic models of hospital-insurer bargaining, hospitals should be able to pass increases in their (marginal) cost of delivering services along to insurers.

Ultimately, the existence of other mechanisms for compensating these clinicians has important implications for weighing the relative risks of setting a charge limit too low rather than too high. In particular, whereas setting a charge limit that is too high can have harmful outcomes, the concerns related to setting a charge limit too low can be largely mitigated through compensating payments from hospitals to physicians, although referral fee laws could be an obstacle to some extent. Despite this legal/contractual complication, where there is uncertainty about the appropriate charge limit, the availability of hospital "topping off" payments or negotiating on behalf of physician groups in establishing in-network contracts gives policymakers reason to lean toward setting a lower limit rather than a higher limit.

Specific Options for Directly Setting a Charge Limit

It is now useful to consider three different prices that are commonly considered as the basis for directly setting a charge limit: Medicare rates, billed charges, and contracted rates.

Medicare rates

Medicare rates are reasonable, if imperfect, estimates of the relative cost of providing various services, and are frequently used by commercial health plans to guide rate negotiations with providers.[42] The Medicare fee schedule for physician services is publicly available, making Medicare rates a transparent and accessible benchmark to operationalize a charge limit. Medicare payments are adjusted by geographic area on the basis of input prices and are accepted as payment-in-full for Medicare patients by nearly all physicians in the United States. However, Medicare rates are generally lower than negotiated commercial rates for many physician services.[43,44] Medicare rates are not tied to any market negotiation and can be affected by political and budgetary considerations, so some might fear that these rates will be too low or not vary enough across geographies to reflect market conditions. The first concern can be ameliorated by setting the out-of-network charge limit as a multiple of Medicare rates. For example, Missouri and California have incorporated Medicare rates as a part of their state policies scaled to 120 and 125 percent of Medicare allowed rates, respectively. Commercial rates as a percentage of Medicare do vary by market, and state policymakers could further address

[42] Clemens, Jeffrey, Joshua D. Gottlieb. 2017. "In the Shadow of a Giant: Medicare's Influence on Private Physician Payments." *Journal of Political Economy*, 2017 Vol 125, No. 11. https://users.nber.org/~jdgottl/ShadowOfAGiant.pdf.
[43] Trish, Ginsburg, Gascue, and Joyce, 2017.
[44] Pelech, 2018.

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geographic variation by scaling the multiple of Medicare rates used for a charge limit based on commercial rates in their state (or in some geographic markets within the state). Another approach, discussed below, would draw on the ratio of contracted rates to Medicare rates for specialists other than emergency medicine and ancillary clinicians.

Billed charges

Physicians' billed charges are another measure available to policymakers, but basing an out-of-network charge limit on billed charges would likely lead to too high a limit and drive up health costs and insurance premiums. Charges (or list prices) face little constraint from market forces and tend to be extremely high relative to objectively reasonable prices. This is particularly true for the specialties most commonly involved in surprise out-of-network billing since, as discussed earlier, physicians in these specialties have particularly strong incentives to set high charges.

Emergency medicine physicians and anesthesiologists, the two specialties with the highest prevalence of out-of-network treatment at in-network facilities,[45] had median charges of 465 percent and 551 percent of Medicare payment rates, respectively, in 2016, based on a USC-Brookings Schaeffer Initiative analysis of Medicare claims data, compared to an average across all non-emergency medicine or ancillary specialists of 227 percent (See Table 1).

The ratio of charges to Medicare payments is especially large at percentiles of the distribution above the median. Table 1 shows the median, 20th, and 80th percentiles of physician charges for different specialties. Across all provider types, the distribution of charges is skewed such that the distance between the median and 80th percentile is greater than the distance between the median and 20th percentile. And for anesthesiologists, radiologists, and emergency medicine physicians, in particular, the 80th percentile of charges tends to be extremely high. Operationally, this means that even a small shift in the percentile used to set a payment standard can result in a large leap in absolute payment.

Because charges are not meaningfully market-determined, they often do not vary in logical ways with the underlying cost of delivering different services. At any moment in time, an out-of-network charge limit based on billed charges is likely to overvalue some services relative to others. The absence of market discipline means that billed charges are also likely to change in unpredictable ways over time, potentially causing unexpected and undesirable changes in the level of the out-of-network charge limit. The latter problem could, in principle, be addressed by benchmarking the charge limit to billed charges at a point in time and then updating the charge limit based on some inflator unrelated to future charges, but it would be preferable to simply take a more sensible approach to setting the charge limit at the outset.

[45] Garmon and Chartock, 2017.

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Table 1. Ratio of Charges to Medicare Rates by Physician Type, CY 2016

	Median	20th Percentile	80th Percentile
Emergency and Ancillary Physicians			
Anesthesiology	5.51	2.52	11.08
Emergency Medicine	4.65	2.79	7.50
Diagnostic Radiology	4.02	2.64	8.03
Pathology	3.43	2.25	5.10
Other Specialists			
Cardiology	2.59	1.73	4.57
Orthopedic Surgery	2.48	1.68	3.91
General Surgery	2.39	1.68	4.13
Primary Care			
Family Practice	2.03	1.38	3.82
Internal Medicine	2.03	1.39	3.45
Summary			
All Physicians	2.39	1.49	4.60
All Emergency and Ancillary Physicians	4.03	2.57	8.00
All Other Specialists (Not Emergency and Ancillary Physicians)	2.27	1.46	4.01
All Primary Care	2.03	1.39	3.54

Source: Authors' analysis of Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use Files, calendar year 2016. All Other Specialists includes all other specialist physicians included in the data, i.e., it is not restricted to only those examples listed under other specialists in the table.

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Average contracted rates

At first blush, in-network rates appear to have the benefit of being market-driven and thus more accurately reflecting the relative costs of different services. However, as detailed earlier, contracted rates as a percentage of Medicare rates are considerably higher for emergency and ancillary physicians compared to other specialties because of the lucrative out-of-network billing

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option available to these physicians. (Unusually high levels of market concentration in these specialties may also play a role.)

Therefore, tying provider payment in cases of surprise out-of-network bills to average contracted rates for that service would cement the currently inflated rates reaped by ancillary and emergency physicians. However, average commercial payment rates (as a percentage of Medicare) for *non-ancillary* specialists with similar training may provide useful insight regarding what reasonable, market-determined payment rates might be.

One promising approach, then, would be to employ the average mark-up over Medicare rates among contracted network rates for a group of *non-ancillary* specialists with similar training. In other words, policymakers would determine by what percentage the weighted-average in-network payment rate for non-ancillary specialist services exceeds Medicare rates, and then set the charge limit for the surprise out-of-network services in relation to that percentage of the relevant Medicare rate in the same region. For instance, if average in-network rates for cardiologists or surgeons (or a blend of appropriate specialties) are 150 percent of Medicare rates, then out-of-network charges for ED, ancillary, and similar services could be capped at 150 percent of Medicare rates for the same services. This method has the potential advantage of adjusting the payment standard to local or state-specific conditions in the commercial market. Alternatively, a charge limit could be based on *nationwide* or regional average contracted rates for non-ancillary specialists as a percentage of Medicare rates.

While a suboptimal solution (though still preferable to the status quo) that cements today's inflated payment rates, if policymakers instead prefer to tie an out-of-network charge limit to the higher average network rates for emergency medicine and ancillary specialists, policymakers should seek to minimize unintended consequences on future contract negotiations that might lead to lower network participation rates. Specifically, if payment is tied to average contracted rates in the previous year or years, then health plans have an incentive to cancel contracts with higher-than-average rates and physicians may have an incentive to cancel contracts with lower-than-average rates, in order to make the prescribed payment rate more favorable in the future.[46] Insurer-specific or provider-specific averages are particularly vulnerable – more so than market or regional averages – to these adverse effects since there is a direct mechanism for individual insurers or providers to influence their own future payment rates. This risk can be avoided by tying the payment rate to an average at a moment in time *prior to* passage of legislation, and then either indexing that amount forward by a measure of inflation or converting it to an equivalent percentage of the Medicare rate and using that ratio thereafter.

Using Arbitration to Determine Payment

Another option to determine provider payment for surprise out-of-network services is to create an arbitration process, which states such as Illinois, New Hampshire, New Jersey, and New York

[46] See California Regulatory Notice Register. 2018, No. 31-Z. https://oal.ca.gov/wp-content/uploads/sites/166/2018/08/31z-2018.pdf for a discussion of this concern in relation to California's recent surprise billing law, AB 72.

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have pursued and has been proposed federally by Sen. Maggie Hassan and Rep. Michelle Lujan Grisham.[47] Arbitration offers the potential advantage of allowing payment rates to vary more for specific circumstances and potentially adjust more easily over time. The uncertainty in outcome from arbitration might also increase the incentive to contract for both the health plan and provider. Arbitration might also be more politically palatable because it allows lawmakers to avoid explicitly prescribing payment rates. However, it is unclear why an outside arbiter would be better at picking the "appropriate" rate than lawmakers. Nor does this approach completely avoid the need to set rates, as policymakers typically must provide some sort of criteria or guidance to the arbiter about what the appropriate rate is.

An arbitration approach also comes with administrative costs. If those administrative costs are high enough, they could undermine the effectiveness of the policy by leading insurers to simply accede to providers' demands rather than pursue arbitration.

If policymakers choose an arbitration process, they may wish to consider a "baseball-style" or "final offer" structure. In this approach, if the provider and health plan are unable to settle on a payment rate, each submits their best and final offer, and an independent arbiter (typically a neutral party chosen by an agency such as the state's insurance department) chooses which offer they think better represents an appropriate rate. Baseball-style arbitration offers a few potential advantages over other forms of dispute resolution.[48,49] First, it may prove more efficient to review two competing bids than for an arbiter to directly determine the "correct" number.

Second, the possibility of the other party's bid being chosen creates an incentive to negotiate and settle rather than risk losing outright. And third, because the arbiter must choose either the plan or provider offer, there is an incentive to make a reasonable final offer, which both increases the chances of settlement and potentially provides important information to the arbiter in deciding which offer to choose. Making the arbitration decisions public, as New Jersey's law does, may additionally make settlement before arbitration more likely as both sides would then know roughly what rate arbiters tend to select. Providing clear guidance to the arbiter about how to select the winning rate offer could have a similar effect.

Rather than providing specific rate guidance, policymakers may wish to specify a floor and ceiling rate to avoid the risk of the arbiter choosing an outlier payment amount. If guidance is provided for the arbitration process, the same discussion applies as above for choosing an appropriate payment standard. Similarly, policymakers are better off "erring" on the low side given that facilities would be expected to compensate facility-based clinicians if the rate chosen is lower than the "normal market" rate. And most importantly, policymakers should exclude any reference to billed charges in their guidance to arbiters because such a reference would likely lead to an excessive payment standard.

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[47] Adler, Loren, Paul B. Ginsburg, Mark Hall, Erin Trish, Benjamin Chartock. 2018. "Analyzing Senator Hassan's Binding Arbitration Approach to Preventing Surprise Medical Bills." *Health Affairs Blog*, October 18, 2018. https://www.healthaffairs.org/do/10.1377/hblog20181017.792315/full/.

[48] Shorter, J. B. 2009. "Final-Offer Arbitration for Health Care Billing Disputes: Analyzing One State's Proposed Dispute Resolution Process.". *Appalachian Journal of Law*, 9:191-215.

[49] Monhait, J. 2013. "Baseball Arbitration: An ADR Success." *Harvard Journal of Sports & Entertainment Law*, 4:105- 43.

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Contracting Regulation

The material above described "billing regulation" approaches that can be used to address surprise out-of-network billing. It is useful to consider to a different set of solutions, which eliminate the possibility for patients to be seen by an out-of-network ED, ancillary, or similar clinician at an in-network facility, termed "contracting regulation" approaches.

There are two main "contracting regulation" approaches, both of which would likely have relatively similar effects on both provider payment and patients' experiences. Notably, though, neither of these contracting regulation approaches would address surprise bills for patients brought to the emergency department at an out-of-network hospital or transported in an out-of-network ambulance, so billing regulation would still be necessary to address these instances.

Requiring Clinicians to Contract with All Health Plans Accepted by the Facility

The first approach is to require that any ED, ancillary, or similar clinician who contracts to practice at a facility also contract with all health plans accepted by the facility. This would straightforwardly eliminate the possibility of patients being treated by an out-of-network ED, ancillary, or similar clinician at an in-network facility. However, this approach may prove administratively costly in practice. Requiring a facility-based clinician to join every single health plan network that the facility is in, especially for clinicians practicing in multiple facilities, could prove time-consuming and administratively burdensome.

Some might also object that this requirement shifts too much leverage to insurers in negotiations with facility-based ED and ancillary clinicians, as insurers would know that these clinicians have to accept whatever payment rate they offer to practice at all. However, this concern is not as serious as it might appear for the same reasons that we generally do not worry about setting a charge limit too low. If insurers do indeed use this leverage to pay ED and ancillary clinicians very low rates, then facilities will have good reason to step in to provide additional compensation – or insist that health plans offer reasonable rates as a condition of their contract with the facility – in order to ensure adequate staffing.

Another possible complication, which also applies to a lesser degree to the second contracting regulation approach discussed below, is how to apply this regulation to clinicians who provide some but not all of their facility-based services in the ED or as an ancillary provider. Many different specialists (e.g., various types of surgeons) provide treatment in EDs and separately see other patients as the primary provider in the same facility for nonemergency services. And assistant surgeons who act as ancillary providers almost always also see patients as the primary surgeon in the same facility. To protect consumers broadly against surprise out-of-network bills, this approach would have to require that such specialists contract with all the facility's payers specifically for at least the ED and ancillary services they provide, which might require contracting and billing under two different national provider identifiers (NPIs).

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A weaker form of this approach might simply require facility-based ED, ancillary, and similar clinicians to "negotiate in good faith" to join the networks of all the health plans that the facility accepts. In this case, a dispute resolution mechanism would have to be included, such as arbitration, to resolve any disputes over what constitutes reasonable versus unreasonable rate negotiation.

Prohibiting Independent Facility-Based ED and Ancillary Clinician Billing

The second contracting regulation approach would prohibit facility-based ED and ancillary clinician services from being billed individually to health plans or patients at all.[50] Under this approach, facilities would incorporate all ED and ancillary clinician services into the facility fees they negotiate with health plans and these facility-based clinicians would have to obtain their full payment from the facility for the services they provide. This approach can alternatively be thought of as requiring facilities to contract with health plans over a "bundled" package of services that includes any associated ED or ancillary clinician services. This bundling approach may appear radical, but it is not dramatically different than how nursing services are billed and nurses are paid today. Note that it may make it more attractive for these clinicians to become facility staff in some cases, but would not require that outcome as these providers could continue to deliver services as independent physician groups and contract with the facility for payment.

Facility-based physicians who both provide services in the ED or as an ancillary provider and separately as the primary physician in nonemergency situations would still be allowed to contract with health plans or bill patients for this latter set of services, but not the former. Neonatology services provided in the 24 hours after a new birth up until a reasonable option for transfer is provided and those provided by hospitalists would also be incorporated in the services that cannot be billed to health plans or patients, in line with their incorporation under billing regulation approaches.

Requiring physician compensation for facility-based ED and ancillary services to come entirely from facilities would mark a significant change, but this solution has the benefit of maintaining price competition for ED and ancillary providers while simultaneously protecting patients. As detailed earlier, the more natural market negotiation exists between ED and ancillary clinicians and the facility they practice at, rather than with the health plan where no price-volume tradeoff exists. Facilities would need to offer sufficient compensation to attract ED and ancillary clinicians and those clinicians would compete to contract with facilities based on price, quality, and the services they provide. Facilities would then negotiate with health plans on reimbursement for this bundled service including these related physician services.

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[50] Yale University professors Zack Cooper and Fiona Scott Morton have proposed an approach along these lines specific to emergency services. See "Out of Network Emergency-Physician Bills—An Unwelcome Surprise." *N Engl J Med* 2016;1915-1918.

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Physicians may view becoming reliant on a facility (typically a hospital) for payment – and the associated loss of independence – as a drawback of this approach. However, they need not become hospital employees. Instead, they could still maintain an independent contractual arrangement similar to what typically exists today. Still, the level of contractual disruption this policy approach would entail may present a practical challenge.

Note that the ultimate outcomes under this contracting regulation approach would be similar in most relevant respects to the outcomes under a billing regulation approach with a relatively low level out-of-network charge limit. (Indeed, this contracting option can be thought of as a billing regulation approach with an out-of-network charge limit set to zero.) In either case, facilities would now play the primary role in compensating ED and ancillary physicians for their services.

Stark and Anti-Kickback Laws

Some of the policy solutions described above may expand or create new fund flows from hospitals to other clinicians, and so providers may raise concerns about their obligations under state and federal "referral fee" laws that govern financial arrangements between physicians and hospitals or other providers. In general, these laws, known federally as the Stark Law and the Anti-Kickback Statute, limit what payments can flow between physicians and facilities that refer patients to one another. If new legislation were to require certain specific forms of billing or contracting (like requiring all billing be conducted by the hospital), that should clearly override any conflicting implication from a more general law designed to proscribe inappropriate financial arrangements.

However, as noted previously, there could be legitimate concern about how these referral laws would apply to more indirect changes in contracting and payments between facilities and providers. Thus, if a low payment rate for emergency and ancillary physicians were to induce hospitals to compensate these physicians directly through stipends or other fund flows, careful legal counsel and documentation would be needed to ensure that the additional payments were legally structured. In particular, documenting that transactions are based on fair market value for the relevant services and avoiding payments that are based on the volume or value of services would be important. Policymakers may also wish to consider whether modifications to these federal laws are necessary.

Surprise Ambulance Bill Protections

Ambulance services are frequently overlooked in laws that address surprise billing, but increasingly they are a source of concern for out-of-network billing. Not too long ago, most ambulance service was provided either by local government or by hospitals for amounts close to what Medicare pays. Recent years, however, have seen a proliferation of for-profit ambulance companies that charge a good deal more than Medicare. Prices for government and hospital-

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based ambulance services also have increased substantially, to help cover cost deficits and to make up for volume lost to newer competitors.[51]

Because much ambulance transport is done on a scheduled basis (e.g., transferring patients), health plans usually include ambulance service in their contracted networks, but some ambulance companies, especially for-profit ones, are unwilling to agree to rates offered by insurers, preferring instead to remain out of network by relying on their ability to balance bill for emergency transport (mainly by responding to 911 dispatchers).

As described earlier, one analysis of 2014 commercial claims from primarily large employers reported that more than half of all ambulance cases involved an out-of-network ambulance.[52] Anecdotal reports suggest that ambulance balance-billed amounts may be increasing.[53] Most egregious are air ambulance bills, which often amount to several tens of thousands of dollars. For ground ambulance service, balance bills in the past typically had been several hundred dollars, but the market developments just described have, more recently, resulted in balance bills of $1,000 or substantially more, which is several times higher than amounts Medicare pays.[54,55]

Out-of-network ambulance bills should be addressed in the same manner as out-of-network emergency services, through a limit on out-of-network billed charges based on a multiple of Medicare rates combined with a hold harmless requirement on health plans to limit enrollee costs to in-network cost-sharing amounts.

Considerations for States

A number of states have enacted legislation that targets surprise out-of-network billing, generally using some version of the billing regulation approaches described above. Several specific considerations apply to state policymaking in this area.

First, preemption under ERISA—which bars states from regulating self-insured employer health plans—will be a major consideration for any state considering regulation of surprise out-of-network billing. Since the mid-1990s, the Supreme Court has been clear that states can engage in "general health care regulation" – even if the rules affect ERISA plans.[56] Thus, states are permitted to regulate the conduct of health care providers even when they treat patients covered

[51] U.S. Government Accountability Office. 2012. "Ambulance Providers: Costs and Medicare Margins Varied Widely." GAO-13-6, Oct 1, 2012. https://www.gao.gov/products/GAO-13-6.
[52] Garmon and Chartock, 2017. See Supplemental Appendix Exhibit A1.
[53] Nation, George. 2017. "Taking Advantage of Patients in an Emergency: Addressing Exorbitant and Unexpected Ambulance Bills." *Villanova Law Rev.* 62(4): 747-85 (2017).
https://digitalcommons.law.villanova.edu/cgi/viewcontent.cgi?article=3357&context=vlr.
[54] James, Sha'Ron. 2018. "Emergency Medical Transportation Costs in Florida." *Florida Insurance Consumer Advocate.*
https://www.myfloridacfo.com/Division/ICA/EMTWhitePaper.pdf.
[55] Consumer Reports. 2016. "$164 Per Mile: Surprise Ambulance Bills Are A Growing Problem & Difficult To Avoid." Feb. 22, 2016. https://www.consumerreports.org/consumerist/164-per-mile-surprise-ambulance-bills-are-a-growing-problem-difficult-to-avoid/.
[56] New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995).

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by self-funded employer plans. For example, the Court has upheld a state law that directed hospitals to bill payers in a very specific way, including imposing a significant surcharge on most ERISA plans; the Court concluded that the state was regulating hospitals, not employer health plans, and that this was permissible "general health care regulation."

Some regulations of surprise out-of-network billing can be constructed in ways that are clearly regulation of health care providers rather than payers. While regulation will certainly have effects on payers, including self-insured employer plans, rules about the practice of medicine and how providers interact with one another and bill for their services are the kinds of general health care regulations that the Court has allowed. However, to the extent a state wants to regulate what payers pay to providers or how payers treat consumer cost-sharing amounts, it must be careful to apply those standards only to fully-insured rather than self-insured plans.

State can take steps to limit the extent to which their regulation targets plans, rather than providers, and can thereby extend some meaningful protections to residents in self-insured plans. Specifically, billing regulation approaches that limit the amount a provider can charge (rather than establishing a minimum amount a plan must pay) are a particularly promising way for a state to design around ERISA preemption. To date states have not explored this option. State can also consider approaches that allow self-insured plans to opt in to a state regulatory scheme, and some enacted state laws contain this feature. That said, ERISA does still constrain state flexibility to enact comprehensive solutions.

A second consideration is the state's own accumulated body of insurance law and standards regarding the practice of medicine. State limitations regarding the corporate practice of medicine and insurance "provider protections" that govern the relationship between health plans and physicians could frustrate the state's surprise billing policy if not addressed. Finally, an evolving challenge for states is how to address situations where their residents receive care at an out-of-state facility, which can occur frequently in some regions.

Recommendations for Action

Solutions to surprise out-of-network billing should protect patients in a comprehensive manner and restore more normal market dynamics to contracting for emergency department and ancillary clinicians, which should in turn reduce health care spending. Below, are two approaches to achieving these objectives, which are likely to have similar effects in practice.

Option #1: Billing Regulation Only

The first option is a pure billing regulation approach. Under this approach, policymakers would:

- Set a limit on out-of-network charges equal to a multiple of the relevant Medicare rate in line with what non-emergency or ancillary specialists with similar training are paid by commercial payers. Given existing national data and the limited risks to setting the charge limit below "normal market" rates, 125 percent of the relevant Medicare rate could

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constitute a reasonable limit. Policymakers could modify the multiple, either nationwide or by state or market area, to reflect local market conditions.

- Require health plans to hold enrollees harmless for any cost-sharing beyond normal in-network cost-sharing amounts for these out-of-network services (and count such cost-sharing toward in-network deductibles and out-of-pocket limits).
- Apply these requirements to: (1) out-of-network emergency services (including ambulance transport but excluding services delivered after transfer to an in-network facility is offered); and (2) out-of-network ancillary clinician, hospitalist, and neonatology services delivered at an in-network facility (where a facility is defined as a hospital, ambulatory surgical center, or freestanding emergency department).

Option #2: Hybrid of Billing and Contracting Regulation

The second option is a hybrid billing regulation/contracting regulation approach. For out-of-network ambulance services and emergency services delivered at an out-of-network facility, policymakers would implement the billing regulation approach described under option #1. For the other services enumerated in the third bullet above—emergency, ancillary clinician, hospitalist, and neonatology services delivered at an in-network facility—the policy would bar independent billing, thereby implicitly requiring that insurers pay for these services entirely through payments to the facility at which they practice. (Facilities would then compensate clinicians delivering these services directly.)

By eliminating the lucrative out-of-network billing option for ED and ancillary physicians, these approaches could also reduce health care spending and insurance premiums (although for option #1, this reduction would likely only occur if policymakers set a charge limit sufficiently far below the inflated amounts currently paid for these services).

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Chairwoman WILSON. Thank you, Ms. Young. We will now recognize Ms. Schuman.

STATEMENT OF ILYSE SCHUMAN, SENIOR VICE PRESIDENT, HEALTH POLICY, AMERICAN BENEFITS COUNCIL

Ms. SCHUMAN. Chairwoman Wilson, Ranking Member Walberg, and distinguished Subcommittee members, thank you for the opportunity to testify on behalf of the American Benefits Council about the growing problem of surprise medical billing. The Council applauds your willingness to examine and consider Federal solutions to protect patients from the financial pain of these surprise medical bills.

Collectively our members directly sponsor or administer health benefits for virtually all Americans covered by employer-sponsored plans. Employers are deeply concerned about the burden that unexpected medical bills from out-of-network providers place on employers and their families.

While a number of States have sought to address this problem, ERISA exempts self-insured plans from State insurance regulations to ensure that national employers can offer uniform health benefits to employees residing in different States.

Accordingly, the problem of surprise billing cannot be left to the States to solve. Indeed, we view the effort to protect patients from surprise bills within the broader context of efforts to lower health care costs.

A lack of meaningful patient choice between providers who participate in a plans network and those who don't is the key component of surprise balance billing.

In the case of emergency services provided at out-of-network facilities and air ambulance service, the patient simply needs the most expeditious stabilizing care.

Even when patients seek care at an in-network hospital from in-network providers, patients generally lack a role in choosing ancillary but necessary physician like an anesthesiologist. On the day of surgery, is the patient really going to question the network status of the anesthesiologist?

A study comparing physician charge to Medicare payment ratios across specialty sheds light on the drivers of surprise billing. Physician excess charge was higher for specialties in which patients have fewer opportunities to choose a physician or be informed of the physician's network status. For example, anesthesiologists were charging more than five times as high as the Medicare rate.

The ability of such specialities to set billing rates in this environment serves as a powerful incentive to remain out-of-network which in turn generates surprise balance bills. Clearly this constitutes market failure which necessitates legislative or regulatory intervention.

Health plan networks play a critical role in employer efforts to lower the costs and improve the quality of health care for employees and their families. They are the best tool employers have to drive better health care value.

Despite the efforts of employers to prevent unexpected balance billing or help employees faced with such a bill, the underlying problem continues. We urge Congress to develop legislation ad-

dressing surprise balance billing that protects patients without undermining access to high quality, high value networks.

One council member company with 130,000 covered lives estimates that without networks premiums would increase by approximately $8,000, a 45 percent increase.

The council is also concerned that a requirement for payment by employer sponsored plans to providers in excess of in-network rates or by reference to build charges would discourage network participation and drive health care costs higher. Shifting the cost to payers merely masks the underlying problem of a distorted market.

We also have concerns with Federal legislation mandating finding arbitration. It would be costly, complex, and time consuming for nationwide employers. If Federal legislation does require the use of binding arbitration, policymakers should include sufficient protections to guard against increasing health care costs.

We offer the following recommendations for Federal legislation addressing the problem of surprise billing. At its root and at a nationally uniform manner. The message I'm delivering is reflected in a letter sent to you from over 30 trade associations.

No. 1, protect patient from surprise medical bills. No. 2, hospitals and physicians must provide up front information about out-of-network care and costs. No. 3, require certain reimbursement.

To ensure equitable payment for services provided without discouraging network participation, Federal legislation should establish a cap for emergency services at an out-of-network facility at 125 percent of the Medicare rate which would be clear and facilitate competition.

Legislation should also require all in-network providers, all at an—in-network facility to accept in-network rates. When a plan contracts with a hospital, it stands to reason that all essential service performed at the hospital would be included in the network.

Requiring in-network facilities to bundle medical services for covered procedures into a single payment could also help the problem if structured properly. Legislation must also address ambulance services. The council looks forward to working together on a solution that cures this problem not merely masks its symptoms.

[The statement of Ms. Schuman follows:]



TESTIMONY OF

ILYSE SCHUMAN
SENIOR VICE PRESIDENT, HEALTH POLICY
AMERICAN BENEFITS COUNCIL

BEFORE THE

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON EDUCATION AND LABOR,
SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR,
AND PENSIONS

HEARING ON "EXAMINING SURPRISE BILLING: PROTECTING PATIENTS FROM FINANCIAL PAIN"

APRIL 2, 2019

Chairwoman Wilson, Ranking Member Walberg and distinguished subcommittee members:

Thank you for the opportunity to testify on behalf of the American Benefits Council about the growing problem of "surprise" medical billing. I am Ilyse Schuman, the Council's senior vice president, health policy. The Council applauds your willingness to examine and consider federal solutions to protect patients from the financial pain of these surprise medical bills.

The American Benefits Council is a Washington D.C.-based employee benefits public policy organization. The Council advocates for employers dedicated to the achievement of best-in-class solutions that protect and encourage the health and financial well-being of their workers, retirees and families. Council members include over 220 of the world's largest corporations organizations serving employers of all sizes. Collectively our members directly sponsor or administer health and retirement benefits for virtually all Americans covered by employer-sponsored plans.

Employers are deeply concerned about the burden that unexpected medical bills from out-of-network providers place on employees and their families. Surprise balance bills arise in three scenarios:

(1) emergency treatment at out-of-network facilities,
(2) ambulance and air ambulance services provided by out-of-network providers and
(3) treatments provided by out-of-network providers working at an in-network facility.

Importantly, in all cases, the patient lacks a meaningful choice between receiving treatment from a provider who is in their health plan's network, and thereby subject to contracted cost and quality requirements, or one who is outside of the network.

Surprise medical bills bring financial stress to patients and families already dealing with the challenges of a medical emergency or serious health condition. A patient receiving treatment at an in-network hospital should justifiably expect that ancillary, but necessary, services performed by facility-based physicians such as anesthesiologists, radiologists, emergency medicine physicians, and pathologists, would be covered by their health plans as in-network charges. However, when these facility-based physicians choose not to participate in a plan's network, an unexpected balance bill to a patient can threaten the financial security of working families.

Our member companies recognize the toll that surprise balance billing can take on working families. Although employers are not obligated to pick up the balance billing charges, many large employers currently do so in order to provide additional financial protection to their employees and families beyond the substantial cost the employers

already bear as sponsors of the health plan. As a result, the surprise balance billing practice is a financial burden on employer plan sponsors as well as individuals.

While a number of states have sought to address this problem through regulation of health insurance sold in the state, over 60 percent of employer-sponsored coverage is offered to employees through self-funded group health plans. ERISA exempts self-insured plans from state insurance regulations to ensure that national employers can offer uniform health benefits to employees residing in different states. Accordingly, the problem of surprise billing cannot be left to the states to solve. Adequately addressing this problem in a way that limits the financial burden on all consumers necessitates a federal solution.

It is important to recognize that, while the magnitude of the surprise billing problem may not be great relative to the plan's overall spend, for a patient receiving a surprise medical bill it could impose substantial financial hardship. Beyond the individual patients and families financially burdened with these unexpected balance bills from out-of-network providers, this issue has significant implications for the health care system as a whole. We view the effort to protect patients from surprise bills within the broader context of efforts to lower health care costs. As such, we urge the subcommittee to consider addressing surprise balance billing in a manner that protects patients without undermining access to high-quality, high-value networks or increasing health care costs for individuals and employers.

A Lack of Meaningful Patient Choice

A key component of surprise balance billing is the "surprise" – that is, the lack of information necessary for patients to make informed decisions about the health care services they receive and from whom. In all three of the situations mentioned above, this lack of information and subsequent lack of informed choice arise, albeit in slightly different ways. In the case of emergency services provided by out-of-network facilities and air ambulance services, the patient – simply put – has no choice. Assuming that the patient is conscious, the emergent nature of the condition requiring the medical treatment presents the dilemma of identifying an in-network facility or provider in lieu of receiving the most expeditious stabilizing care. Such a choice is, in fact, no choice at all.

In the third scenario, where patients seek care at in-network facilities from in-network providers, patients generally lack the information necessary at the time of scheduling to receive care from an in-network ancillary (but necessary) service provider like an anesthesiologist, radiologist, or pathologist. On the day of surgery, is the patient really going to question the network status of the anesthesiologist? Again, the patient is left with effectively no choice at all. While different solutions may be more aptly suited to these different issues, the common theme of all three is that patients lack the true

ability to avail themselves of a network provider, leaving the patient without knowledge or choice with respect to out-of-network providers.

A Kaiser Family Foundation analysis[1] of medical bills from large employer plans found that a significant share of inpatient hospital admissions includes bills from providers not in the health plans' networks. Nearly one in five inpatient admissions includes a claim from an out-of-network provider. The analysis found that almost 18% of inpatient admissions result in non-network claims for patients with large employer plan coverage.

Even when enrollees choose in-network facilities, 15% of admissions include a bill from an out-of-network provider, such as from a surgeon or an anesthesiologist. For inpatient admissions, those that include an emergency room claim are much more likely to include a claim from an out-of-network provider than admissions without an emergency room claim. This is the case whether or not enrollees use in-network facilities.

As with inpatient admissions, outpatient service days with a facility claim that include a visit to the emergency room are much more likely to include a claim from an out-of-network provider, whether or not enrollees use in-network facilities. The analysis also found that enrollees with anesthesia or pathology claims are more likely to have an out-of-network provider claim, even when using in-network facilities.

For out-of-network emergency services, Congress and the U.S. departments of Labor, Health and Human Services, and the Treasury ("the Departments") have recognized the need for robust out-of-network coverage of emergency services. Section 2719A of the Public Health Service Act, which applies to all insured plans and to self-funded plans through Section 715 of ERISA, limits the plan's ability to impose cost shares on these services that are not applicable to in-network emergency services. The Departments adopted a "Greater-of-Three" rule, which imposes a minimum reimbursement amount on plans but does nothing to prevent the provider from balance billing patients.

A lack of choice also defines the massive costs associated with non-participating ambulance and air ambulance services. According to GAO's analysis of the most complete data identified for air ambulance transports of privately-insured patients, 69 percent of about 20,700 transports in the data set were out-of-network in 2017.[2] This imbalance reflects the incentives that balance billing creates for providers to remain out-of-network. As with emergency services, ambulance and air ambulance services are essential to ensure that patients receive the care they need in the most urgent of

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[1] https://www.healthsystemtracker.org/brief/an-analysis-of-out-of-network-claims-in-large-employer-%20health-plans/

[2] https://www.gao.gov/assets/700/697684.pdf

situations. By subjecting patients in these most dire of circumstances to balance billing, it exposes patients to material liabilities in order to receive the care they need.

Even in the case of the non-emergent surprise balance billing scenario at inpatient facilities, the patient often lacks a role in choosing an out-of-network provider and the necessary information to make an informed decision about provider network status. Despite the patient's efforts to select an in-network facility and in-network surgeon, patients are exposed to the threat of balance billing because necessary, but ancillary, providers who are engaged by the hospital without disclosure to the patient do not participate in the same networks as the patient. This is so because the out-of-network providers of ancillary services receive all the benefits of in-network status, *i.e.*, increased utilization, but are able to exact much larger reimbursements by remaining out-of-network.

A study by Ge Bai and Gerard F. Anderson, published in the Journal of the American Medical Association in 2017 comparing physician charge-to-Medicare payment ratio across specialties, sheds light on the drivers of surprise billing. Data from 429,273 individual physicians across 54 medical specialties were included. The physician charge-to-Medicare payment ratio ranged between 1.0 and 101.1 across individual physicians, with a median of 2.5. Among the 54 specialties studied, anesthesiology had the highest median (5.8), followed by interventional radiology (4.5), emergency medicine (4.0), and pathology (4.0). The ratio also varied across states. The study concluded that: "Physician excess charge was higher for specialties in which patients have fewer opportunities to choose a physician or be informed of the physician's network status (e.g. anesthesiology)."[3]

A study by Zack Cooper, Fiona Scott Morton and Nathan Shekita (the "Cooper study")[4] similarly explains that a "fundamental problem" in emergency medicine in the United States is that emergency department physicians face inelastic demand from patients when they are practicing inside in-network hospital emergency departments. As a result, these hospital-based physicians need not set their prices in response to market forces, as noted in the study:

> Because they are part of a wider bundle of hospital care and cannot be avoided once the hospital choice is made, emergency physicians (and other specialist physicians like radiologists, pathologists, and radiologists) face inelastic demand from patients and will not see a reduction in their patient volume if they fail to negotiate contracts with insurers.

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[3] https://jamanetwork.com/journals/jama/fullarticle/2598253

[4] https://www.nber.org/papers/w23623.pdf

A recent report by the USC-Brookings Schaeffer Initiative for Health Policy drew a similar conclusion about why surprise out-of-network bills happen, stating that:

> For most physicians in most geographic areas, it is not possible to maintain a practice without entering some insurer networks because few patients are willing to bear the higher costs associated with seeing an out-of-network physician. However, for some types of physicians, that basic dynamic does not apply. For ED physicians, patient volume is driven by patients' choice of hospital and is unlikely to be affected by whether the physician is in-network or not; hospitalists and neonatologists face a similar dynamic.[5]

The ability of such specialties to set billing rates in this environment serves as a powerful incentive to remain out-of-network, which, in turn, generates surprise balance bills. Clearly, this constitutes a market failure which necessitates legislative or regulatory intervention. In these situations where the consumer does not have a role in choosing their providers, the consumer is not the problem. The problem is that the consumer does not have a choice.

THE CHANGING LANDSCAPE FOR OUT-OF-NETWORK REIMBURSEMENT

The landscape for out-of-network reimbursement is changing. This is the message of a 2018 Milliman white paper (the "Milliman Report")[6] and the experience of Council member companies. The paper reports that billed charge trends have consistently outpaced in-network reimbursement trends, and that "most billed charge trends are considered out of sync with costs and well above typical in-network reimbursement." The paper further notes that for some markets, it is common to see hospital billed charge levels many times those of typical commercial in-network reimbursement rates with Medicare and other government payer charge levels usually much lower.

Historically, many plans have reimbursed out-of-network providers as a percentage of billed charges. This reflected an economic assumption that billed charges would correlate with the financial cost to the provider with a premium imposed because the provider is not reaping the benefit of in-network status with the plan. The changing dynamics in the amounts billed by out-of-network providers, however, no longer accurately reflect that economic assumption.

The Cooper study, focusing on out-of-network billing for emergency care, found that physicians charge, on average, 637 percent of what the Medicare program would pay for identical services, which is 2.4 times higher than in-network payment rates.

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[5] https://www.brookings.edu/wp-content/uploads/2019/02/Adler_et-al_State-Approaches-to-Mitigating-Surprise-Billing-2019.pdf

[6] http://us.milliman.com/uploadedFiles/insight/2018/changing-landscape-oon-reimbursement.pdf

As the gulf between billed charges and in-network rates grows, the Milliman Report observes that many payers – including some Council member companies – are redefining out-of-network reimbursement as a multiple of Medicare rather than based on a percent of billed charges. The Milliman Report also describes another approach payers are taking to address out-of-network reimbursement – paying the in-network level for the market, determined as an average for providers in the market, or the standard base schedule, or even below the network level for non-emergency care.

Council members see the increasing disconnect between billed and network charges and the pressure it places on both patients and the benefit plans their employers sponsor. Reimbursing out-of-network providers by reference to billed charges is unsustainable and will result in even higher health care costs and fewer in-network providers. **As Congress seeks to address surprise balance billing as part of a broader goal of lowering health care costs and improving price transparency, the finding that most billed charge trends are "out of sync" with costs and "well above" typical in-network rates is alarming. We urge you to consider an approach that would narrow this gap, lower costs and enhance transparency – not widen this gap even further by creating incentives for providers to be out-of-network and increase billed charges in an effort to increase the final reimbursement they receive.**

THE IMPORTANCE OF HIGH-QUALITY, HIGH-VALUE NETWORKS

Health plan networks play a critical role in employer efforts to lower the cost and improve the quality of health care for employees and their families. Understanding the importance of networks in driving better health care value is at the foundation of understanding the surprise billing problem and developing an effective solution.

As plan sponsors, employers take great care to provide their employees and their families access to networks of providers that: (1) provide high quality health care services, (2) provide those services at reasonable and predictable costs to both plans and patients, and (3) control the aggregate cost of health care services. Patients generally face higher out-of-pocket costs under the terms of the health plan when using an out-of-network provider as an incentive to utilize network providers. However, because there is no contractual agreement in place between the out-of-network provider and the plan (or its third-party administrator), there is no ability for the plan to either predict patient costs or prevent any liability owed to the provider outside of the plan. The implications of this lack of a contractual agreement – and, critically, the reasons for it – are under examination by the subcommittee today.

It is essential that any legislative solution protects patients without undermining access to high-quality, high-value networks. The ability of certain specialists to set billing rates in an environment in which a patient chooses an in-network facility and the

ancillary provider receives the automatic referral serves as a powerful incentive to remain out-of-network and fuels the surprise medical bills patients are facing. Clearly, this constitutes a market failure that limits the benefit of networks in controlling costs for patients and plans.

A federal solution to surprise billing should serve to lower, not increase, premiums and lower costs for consumers and employer plan sponsors. Undermining high-quality, high-value networks removes the greatest leverage plans have to lower health care costs. Setting a federal requirement in a way that discourages network participation would result in higher costs for consumers. The resulting premium increase also makes plans more likely to trigger the looming "Cadillac Tax," the 40 percent excise tax on employer-sponsored health plans that cost above a certain level.

Employer Response to Surprise Medical Bills

Council member companies are taking steps to limit the incidence of surprise billing in the first place through, for example, enhanced communications to employees about the potential for balance bills from out-of-network providers. Our members recognize the stress and financial devastation surprise medical bills can bring to working families and provide assistance to their employees in multiple ways. This assistance may take the form of contracting with other entities to negotiate the bill with the provider on the employee's behalf. Some employers provide balance bill legal defense services for employees to contest balance bills themselves.

Despite the efforts of plans to prevent unexpected balance billing or help employees faced with such a bill, the underlying problem continues. We are concerned that federal legislation enshrining a reimbursement rate for out-of-network providers in excess of in-network rates will eliminate what remains of plans' negotiating leverage to avoid or reduce the incidence and amount of surprise billing.

Need for Federal Solution: Evaluating Policy Approaches

Understanding the problem is the key to finding a solution. Congress should develop legislation addressing surprise balance billing that protects patients without undermining access to high-quality, high-value networks or increasing health care costs for individuals and employer providers of health coverage. We urge Congress not to widen this gap even further by guaranteeing out-of-network providers a reimbursement rate that discourages network participation.

The Council is concerned that a requirement for payment by employer-sponsored plans to providers in excess of in-network rates would discourage network participation and drive health care costs higher. We are also concerned that using any

reference to billed charges, such as the 80th percentile of charges, as a payment benchmark would undermine participation in high-value networks and drastically increase costs for all consumers. Any attempt to characterize billed charges by facility-based physicians as reflective of market value is belied by the fact that the "market" itself is distorted. When patients have fewer opportunities to choose a physician or to be informed of the physician's network status, the marketplace for these services is not functioning.

Shifting the cost of surprise balance billing from patients to payers merely masks the underlying drivers of charges from out-of-network providers for emergency treatment or at an in-network facility. Health plan networks promote better quality and lower cost for consumers. Moreover shifting the burden of balance billing from the patient to the plan or employer will no doubt result in higher premiums and increased costs for all consumers, and will do little to eliminate the underlying source of the issue. A federal solution to surprise balance billing should serve to lower, not increase, premiums and costs for consumers and employer plan sponsors, and the entire health economy as a whole.

Binding arbitration is an inefficient and ineffective approach to addressing surprise billing. We have serious procedural and substantive concerns with federal legislation mandating binding arbitration. For large companies with nationwide operations, a binding arbitration model would be administratively complex, costly and time-consuming. The experience of the mediation process in Texas is instructive. According to a recent report,[7] the Texas Department of Insurance received just 43 requests from consumers for mediation in 2013. In 2014, the number of requests grew to more than 600 and have climbed steeply ever since. There were 4,519 requests in 2018, creating a significant backlog, and regulators expect 8,000 during the current fiscal year. The Texas experience is illustrative of the administrative challenges of a nationwide mandated dispute resolution process. If federal legislation requires the use of binding arbitration to resolve disputes between payers and providers, at a minimum, policymakers should include sufficient protections to guard against increasing health care costs and undermining value-based networks. For example, arbitrators should not be allowed to take billed charges into consideration.

POLICY RECOMMENDATIONS

We offer policy recommendations for federal legislation directed at addressing the problem of surprise balance billing at its root and in a nationally uniform manner.

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[7] https://www.texastribune.org/2019/02/12/texas-mediation-balance-billing-faces-massive-backlog/

1. Protect patients from surprise medical bills.

Federal legislation to protect patients from surprise medical bills must begin with capping patient cost-sharing at in-network amounts. To protect consumers and families, federal legislation should prohibit balance billing of patients for emergency services provided at an out-of-network facility, for treatment by an out-of-network provider at an in-network facility, and out-of-network ambulance and air ambulance providers. Federal legislation should ensure patient cost-sharing is limited to in-network amounts for emergency services performed at an out-of-network facility, for treatment by out-of-network facility-based physicians performed at in-network facilities or for out-of-network ambulance or air ambulance providers.

2. Ensure disclosure and transparency.

Take the "surprise" out of surprise billing by requiring hospitals and other providers to disclose upfront information to patients about pricing and out-of-network care. Patients should be informed about out-of-network care and cost at the time of scheduling non-emergency care at an in-network facility and follow-up care from emergency treatment at an out-of-network facility.

3. Require certain reimbursement.

To ensure equitable payment for the services provided without discouraging network participation or resulting in higher costs for all consumers, federal legislation must set a reasonable federal reimbursement structure that:

a. Establishes a federal cap for emergency services at an out-of-network facility at 125 percent of the Medicare rate. Using a Medicare rate eliminates problems inherent in relying upon a method based on billed charges. This approach is clear and would facilitate competitive, balanced negotiation.

b. Requires all providers at an in-network facility to accept in-network rates. Federal legislation should require in-network facilities to accept in-network reimbursement rates for all care performed at the facility by all providers associated with the facility. When a plan contracts with a hospital, it stands to reason that essential services performed at the facility – emergency, anesthesiology, radiology and pathology – would be included in the network. No one would purchase a car without a steering wheel or tires. Yet, these are the very specialties that – by virtue of their necessity – are unhampered by competitive market forces in setting their rates or electing not to participate in a network. Requiring in-network facilities to bundle medical services for covered procedures into a single payment also could help address this problem if structured properly. In the case of bundled services performed by out-of-network providers, the costs of those services within the bundle cannot

exceed either the allowable in-network rate or 125% of Medicare. But, care must be taken to ensure that the contracted bundled payment is final and not merely a progress point toward further negotiation.

4. Address ambulance services.

Any legislative solution for surprise balance billing should also specify that ambulances and air ambulance services are considered emergency services for purposes of the statutory limitations on balance billing and reimbursement rates.

* * * * *

The Council shares your concern with surprise medical bills and the financial pain they inflict on patients. We look forward to working together on a solution that cures this problem, not merely masks its symptoms. With this goal in mind, relief can come to patients burdened by surprise medical bills and all consumers seeking lower cost and better quality health care.

I appreciate the opportunity to testify, and the Council looks forward to working with this subcommittee, and all the members of the Education and the Labor Committee, to advance these proposals.

Truth in Testimony Disclosure Form

In accordance with Rule XI, clause 2(g)(5)*, of the *Rules of the House of Representatives*, witnesses are asked to disclose the following information. Please complete this form electronically by filling in the provided blanks.

Committee: Education and Labor

Subcommittee: Health, Employment, Labor, and Pensions

Hearing Date: April 2, 2019

Hearing Title :

Examining Surprise Billing: Protecting Patients from Financial Pain

Witness Name: Ilyse Schuman

Position/Title: Senior Vice President, Health Policy

Witness Type: ○ Governmental ● Non-governmental

Are you representing yourself or an organization? ○ Self ● Organization

If you are representing an organization, please list what entity or entities you are representing:

American Benefits Council

If you are a non-governmental witness, please list any federal grants or contracts (including subgrants or subcontracts) related to the hearing's subject matter that you or the organization(s) you represent at this hearing received in the current calendar year and previous two calendar years. Include the source and amount of each grant or contract. *If necessary, attach additional sheet(s) to provide more information.*

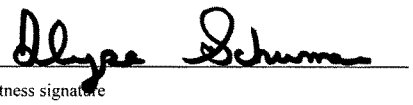
N/A

If you are a non-governmental witness, please list any contracts or payments originating with a foreign government and related to the hearing's subject matter that you or the organization(s) you represent at this hearing received in the current year and previous two calendar years. Include the amount and country of origin of each contract or payment. *If necessary, attach additional sheet(s) to provide more information.*

N/A

False Statements Certification

Knowingly providing material false information to this committee/subcommittee, or knowingly concealing material information from this committee/subcommittee, is a crime (18 U.S.C. § 1001). This form will be made part of the hearing record.



Witness signature

3/28/19

Date

If you are a non-governmental witness, please ensure that you attach the following documents to this disclosure. Check both boxes to acknowledge that you have done so.

☑ Written statement of proposed testimony

☑ Curriculum vitae

*Rule XI, clause 2(g)(5), of the U.S. House of Representatives provides:

(5)(A) Each committee shall, to the greatest extent practicable, require witnesses who appear before it to submit in advance written statements of proposed testimony and to limit their initial presentations to the committee to brief summaries thereof.

(B) In the case of a witness appearing in a nongovernmental capacity, a written statement of proposed testimony shall include a curriculum vitae and a disclosure of any Federal grants or contracts, or contracts or payments originating with a foreign government, received during the current calendar year or either of the two previous calendar years by the witness or by an entity represented by the witness and related to the subject matter of the hearing.

(C) The disclosure referred to in subdivision (B) shall include—

(i) the amount and source of each Federal grant (or subgrant thereof) or contract (or subcontract thereof) related to the subject matter of the hearing; and

(ii) the amount and country of origin of any payment or contract related to the subject matter of the hearing originating with a foreign government.

(D) Such statements, with appropriate redactions to protect the privacy or security of the witness, shall be made publicly available in electronic form not later than one day after the witness appears.

Ilyse Schuman

Senior Vice President, Health Policy

Ilyse Schuman is senior vice president, health policy, for the American Benefits Council. In this role, Ilyse directs the development and advocacy of the Council's health policy priorities. Before joining the Council staff, Ilyse was the Council's Policy Board of Directors Advisory Council representative from Littler Mendelson, P.C., where she was co-chair of the Workplace Policy Institute. In this role, Ilyse provided strategic counsel and representation to clients on a broad array of workplace issues and developments in Congress and executive branch federal agencies. She was also a member of the firm's ERISA/Employee Benefits practice and co-led the firm's Legislative and Regulatory practice.

A former top congressional staff member and policy advisor, Ilyse worked on the Senate Committee on Health, Education, Labor and Pensions from 2001 to 2008, culminating in her role as minority staff director and chief counsel. She began her work in the Senate as chief labor counsel for Senator Mike Enzi (R-WY) on the Subcommittee on Employment, Safety and Training. After leaving the Senate, Ilyse served as managing director of the Medical Imaging and Technology Alliance. Ilyse also has served as in-house counsel at a manufacturer and market and technology leader. She holds a bachelor's degree from Tufts University Jackson College and a law degree from Georgetown University.



Chairwoman WILSON. Thank you, Ms. Schuman.

Ms. SCHUMAN. I am happy to answer any questions.

Chairwoman WILSON. Thank you. We will now recognize Mr. Isasi.

STATEMENT OF FREDERICK ISASI, J.D., MPH, EXECUTIVE DIRECTOR, FAMILIES USA

Mr. ISASI. Thank you very much, Chairwoman Wilson and Ranking Member Walberg and members of the subcommittee. Thank you for the opportunity to speak with you today. I am Frederick Isasi, the Executive Director of Families USA. For nearly 40 years, we have served as one of the leading national voices for health care consumers both in Washington, DC. and on the State level.

Our mission is to ensure that every individual live to their greatest potential by ensuring that the best health care is equally accessible and affordable to all.

Surprise out-of-network medical bills are a truly egregious and all too frequent example of how distorted economic incentives in the health care sector are overwhelming the interests of patients and families.

A whopping 1 in 5 emergency department visits results in surprise medical bills. These bills can account—can amount to hundreds, thousands, and even tens-of-thousands of dollars. This is an utterly nonpartisan issue affecting people across the country in both rural and urban areas.

Given this committee's jurisdiction, it is critical to note that self-insured as we have heard today self-insured ERISA health plans are as likely to experience surprise billing as fully insured and individual plans.

So, what is most important to remember about this issue? We are talking about situations in which families despite enrolling in health insurance, paying their premiums, doing their homework, and trying to work within the system are being left with completely unanticipated and sometimes financially devastating health care bills.

And this is happening in part and I want to say this really clearly because hospitals, doctors, and insurers are washing their hands of their patients' interest.

Take for example one significant driver of this problem. The movement of hospitals to offload staffing requirements for their emergency departments to third party management companies. These hospitals very often make no requirements of these companies to ensure the staffing of the ED fit within the insurance networks that the hospitals have agreed to.

As a result, a patient who does their homework ahead of time and rightly thinks they're going to an in-network hospital receives services from an out-of-network physician and a surprise medical bill follows.

Let me give you one real world example. Nicole Briggs from Morrison, Colorado outside of Denver. Nicole woke up in the middle of the night with intense stomach pain. She went to a free-standing ER. She was told she needed an emergency appendectomy. She went to her local hospital.

She did her due diligence. Confirmed repeatedly that the hospital and its providers were in-network. However, months later she received a surprise bill from the surgeon who ended up was out-of-network. The bill to Nicole was $5,000.

Nicole tried to work it out with her insurance company but within 2 years a collection agency representing the surgeon took her to court and won the full amount, including interest. As a result, a lien was placed on her home and the collection agency garnished her wages each month.

This came right before Nicole was about to deliver a baby and go on maternity leave.

And by the way, this investigation found that there were over 170 liens placed on people's homes in the Denver area by emergency department physicians. And this is just one example.

Consumers are exposed to surprise medical bills in other ways. Often as we have heard ground and air ambulances are out-of-network and many ancillary services like anesthesiology, laboratory services, imaging services can be out-of-network despite the fact the facility and the physician that is supervising are all in-network.

This is inexcusable behavior on the part of hospitals, doctors, and health insurers. They each know or should know that patients have no real way of understanding the financial trap they have just walked into.

In these surprise bill instances, it is the providers and insurers, not the patients who should bear the burden of settling on a fair payment.

Nicole and millions of families around this Nation need you to act. There are—they are paying their premiums trying to do their due diligence and to operate within the system, but the current system is leaving them financially vulnerable and destabilized.

To put the needs of families first, we built a coalition and developed 5 key principles for legislative action by Congress to address surprise medical bills.

The first, and we have heard this from, I think from the whole panel so far. Providers should be prohibited from billing for surprise out-of-network services and these protections should trigger automatically without consumers having to jump over hurdles.

Second, it should prevent surprise out-of-network payments from increasing health insurance premiums. That's really important. Consumers care about their premiums too.

Third, legislation should apply protections to all commercial health insurance plans, including ERISA plans that this committee has jurisdiction over.

Fourth, protection should apply to all care settings and care types where families can receive out-of-network bills due to no fault of their own.

And finally, we are very supportive of increased transparency in the health care sector. We fight for it all the time. But we underscore in this instance increased transparency cannot be the only or main strategy to deal with this problem.

So we are grateful for being able to testify to the subcommittee. I would be very happy to talk about these principles more or answer any questions.

[The statement of Mr. Isasi follows:]

FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

Testimony of Frederick Isasi, JD, MPH
Executive Director
Families USA

The Impact of Surprise Out-of-Network Medical Bills on Consumers

Before the House Education and Labor Committee
Subcommittee on Health, Employment, Labor, and Pensions

April 2, 2019

Families USA
1225 New York Avenue, NW
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Washington, DC 20005

Chairwoman Wilson, Ranking Member Walberg, and Members of the House Education and Labor Committee's Subcommittee on Health, Employment, Labor, and Pensions – thank you for the opportunity to speak with you today. I am Frederick Isasi, the Executive Director of Families USA. For nearly 40 years, we have served as one of the leading national voices for health care consumers both in Washington, D.C. and on the state-level. Our mission is to allow every individual to live to their greatest potential by ensuring that the best health care is equally accessible and affordable to all.

The Larger Context of Health Care Costs for Families

Unfortunately, while our country has made substantial progress in health care coverage over the last several decades,[1] health care costs continue to rise much faster than paychecks and erode the financial security of our nation.[2] The consequences of rapidly growing health care costs are real. Approximately 40 percent of our nation's families report not receiving needed medical care[3] because the costs are unaffordable and 44 percent say they didn't go to a doctor when they were sick or injured in the past year because of cost.[4] Additionally, a startling 30 percent of people in our nation report that health care costs are interfering with their ability to meet the most basic necessities of their life, like securing food, heating, or housing.[5]

We are one of the wealthiest nations in the world and we spend twice as much as other high-income nations to provide health care.[6] People across this nation should not have to live in fear of getting sick and facing a sudden, crippling financial burden. And, yet, this what so many American families experience every day.[7] In fact, a larger percentage of the population actually fear medical bills from a serious illness than the serious illness itself (40 percent vs. 33 percent).[8] What's more, according to the American Psychological Association, the stress associated with medical bill anxiety can actually make them sicker.[9]

The Consequences of Surprise Medical Bills

Surprise out-of-network medical bills truly are an egregious example of how our health care system is allowing consumers' costs to spin out of control. Surprise bills can undermine and even destroy the financial security that families are attempting to build and maintain by purchasing comprehensive health insurance.[10] Surprise medical bills are incredibly common. In fact, one-in-five emergency department visits that families make result in surprise medical bills.[11] These bills can result in hundreds, thousands, and even tens-of-thousands of completely unanticipated out-of-pocket costs.[12] They occur most often when families receive emergency care or, when families do their very best to go to an in-network provider and suddenly, after-the-fact, discover ancillary services like anesthesiology, radiology, lab,[13] or ambulance[14] fall outside of their provider network. Surprise out-of-network billing is an utterly non-partisan issue. It is occurring across the nation and in both rural and urban settings.[15]

Allow me to highlight the experience of Nicole Briggs, from Morrison, Colorado. Nicole woke up in the middle of the night with intense stomach pain. After first visiting a free-standing ER, she was told she needed an emergency appendectomy, and she went to

the local hospital. She did her due diligence to confirm repeatedly that the hospital and its providers accepted her insurance. However, months later, she received a surprise bill from the surgeon for $4,727. While the hospital was in-network, the surgeon was an independent, out-of-network provider.

Nicole explained the situation to the insurer, but they continued to demand payment. She declined to pay the bill, and within two years, a credit agency representing the surgeon took her to court, and won the full amount, including interest. As a result, a lien was placed on her home, and the collection agency garnished her wages by 25 percent each month. This came right as she was pregnant and about to go on maternity leave.[16]

The Cause of Surprise Bills

Surprise out-of-network bills are a terrible example of how distorted economic incentives in the health care sector are overwhelming the interests of patients. They're an example of how easily providers and payers have washed their hands of caring for their patients and are sacrificing the financial security of our nation's families to generate revenue or turn a profit. Surprise out-of-network bills are the result of a systemic problem in our health care system that places consumers directly in the middle of a tug-of-war between health care providers and insurers over the price of services.[17]

Central to the business model of providers and insurers is the rate negotiated between them for services. Larger hospital systems have significant leverage, allowing them to command top dollar for in-network rates. Insurers are often forced to pay their high charges for in-network status, or insurers may simply walk away from the negotiation.[18] On the other hand, when hospitals are smaller, insurers hold the leverage. Those hospitals must choose between accepting lower negotiated rates than they desire, or walking away from the negotiation and providing care out-of-network. [19] These distorted market incentives lead to out-of-network provider status and ultimately, harmful surprise bills for families. In general, compared to in-network providers, out-of-network providers charge nearly three times as much for care.[20] This leaves families with balance bills that average over $600, but can exceed $20,000.[21]

One significant driver of this problem is the movement by hospitals to off-load staffing requirements for their emergency departments to third-party management companies that have no responsibility to ensure staffing fit with the provider networks otherwise agreed to by the hospital.[22] In fact, two-thirds of hospitals in the US outsource the staffing of their emergency departments to third-party physician management firms.[23] Research shows that out-of-network claims are higher in hospitals that contract with common staffing companies. [24] All too often, these firms use a business model that leverages the higher prices that can be charged with an out-of-network status.[25] As a result, a patient with a medical emergency, who rightly thinks they are going to an in-network hospital, often receives professional services from an out-of-network physician. This is inexcusable behavior on the part of the hospital, doctor, and health insurer. They each know or should know that patients have no real way of understanding the financial

trap they have walked into. In these surprise bill instances, we and many believe it is the providers and payers who should bear the burden of settling on a fair payment. [26]

The Intersection of Hospital Non-profit Status and Surprise Billing

Recent research has found that surprise billing, while widespread, is not evenly distributed among hospitals.[27] Specifically, nonprofit hospitals, teaching hospitals, and government-owned hospital have lower than average rates of out-of-network bills. For-profit hospitals have higher rates of surprise bills and higher out-of-network billing rates.[28] Finally, hospitals in areas with higher rates of economic inequality are more likely to have surprise bills.[29]

However, there are countless exceptions to this overall trend. Sadly, many nonprofit and public hospitals with billions of dollars in favorable tax status and charitable donations are engaging in this egregious balance billing.[30] These hospitals receive a non-profit tax status because of the "community benefit" they purport to provide. In total this nonprofit tax status is worth at least $25 billion to hospitals on an annual basis.[31] What could be a more basic and fundamental community benefit than ensuring that patients who come to these nonprofit hospitals in need of critical care do not end-up experiencing a surprise, financial catastrophe?

For example, in January of this year, news reports revealed that Zuckerberg San Francisco General Hospital, the largest public hospital and only Level 1 trauma center in San Francisco, does not contract with any providers who are in-network whatsoever.[32] While more than 90 percent of the hospital's patients are either uninsured or covered by Medicare or Medicaid, for the thousands of people with private insurance who seek emergency care at San Francisco General, or who *must* visit the hospital due to the severity of their medical need, there is no way to avoid surprise medical billing. Only after being exposed by Vox Media did the hospital decide to change its predatory billing practices.[33] It is unforgiveable that facilities that are exempt from paying taxes and receive large sums of charitable contributions are saddling consumers with thousands of dollars of unexpected medical bills for the provision of critical care. And it its unacceptable that it takes an exposé by a national media outlet to shame hospitals to change their behavior.

Surprise Billing in Self-Insured, ERISA Plans

Given this committee's jurisdiction, it is critical to note that surprise medical bills are caused by systemic issues that pervade the health care system and can be found across health insurance plans. Consumers who receive coverage through self-insured, ERISA health insurance plans are *no less likely* to receive a surprise bill than those in fully insured group or individual plans.[34]

As you know, ERISA pre-empts state law, and thus, only Congress can enact protections that comprehensively reach into ERISA plans.[35] A large majority of working families across the nation— 61 percent-- are enrolled in ERISA health insurance products and are looking to this Committee and Congress for action.[36] Among people with large

employer coverage, nearly one in five (17.6 percent) inpatient admissions includes a claim from an out-of-network provider. And 15.4 percent of inpatient admissions with only in-network facility claims include a claim from a non-network provider. When the inpatient admission includes an emergency room claim, the share of claims that include non-network providers jumps to 24.7 percent (for in-network facilities).[37]

Take, for example, the experience of Stacey Shapiro, a first-grade teacher in the public school system in Austin, Texas. Stacey woke up one morning not feeling well. A short while later, she passed out on the bathroom floor and her boyfriend took her to the nearest hospital. After a few hours of tests, IV fluids, and anti-nausea medications, doctors diagnosed her with hypoglycemia, or low blood sugar. For this relatively simple visit, Stacey received a surprise bill of $6,720. Stacey says she received instruction from her Austin Independent School District insurer to just pay the deductible of $1,275. However, the hospital continued to send her bills for the remaining $5,000. Stacy eventually contacted a local press outlet to tell her story. Only after the local outlet contacted the hospital did the hospital tell Stacy that she had fulfilled her financial obligations.[38]

While it is reasonable to expect consumers to "shop around" for in-network providers when they have the luxury of time, in an emergency situation, no one should have to worry about the financial consequence of taking a loved one to the nearest emergency room.

The Range of Care that Results in Surprise Bills

Although the frequency of surprise bills is high in emergency departments and among select physician providers that are involved in facility-based care, consumers are exposed to surprise medical bills in other care settings and from other provider types.[39] Often, ground[40] or air ambulance providers that transport patients for emergency care are out of network.[41] Moreover, new research shows laboratory services also can be a common source of surprise medical bills.[42] For example, the Health Care Cost Institute examined how often a professional claim for various specialties and care types was out-of-network when associated with an in-network admission. Their research found that more than one out five lab claims (22.1 percent) for inpatient hospital care in an in-network hospital were billed as out-of-network.[43] State regulators also report consumer complaints of surprise bills from out-of-network lab work. For example, Pennsylvania Insurance Commissioner Jessica Altman has described multiple consumers in her state receiving surprise bills after visiting their in-network OB/GYN's office because their mammograms were sent to out-of-network labs for review.[44]

Addressing the Problem of Surprise Bills

The ubiquity of surprise medical bills in all types of health plans and in all states warrants immediate federal action. Current federal law enacted as part of the Affordable Care Act (ACA) provides limited protections that apply to families who receive out-of-network care in emergency situations.[45] Specifically, the ACA limits copayments and coinsurance charged *by the insurer* to in-network rates, when families receive services

from an out-of-network emergency provider.[46] Despite these protections, however, *providers* may still balance bill families for additional out-of-network costs. Furthermore, insurers are not required to count copayments or coinsurance paid by a family toward in-network deductibles and out-of-pocket caps.[47] Thus, current federal law leaves families with considerable financial exposure for surprise out-of-network bills for emergency services and no protections for other categories of surprise, out-of-network bills.

Principles for Surprise Bill Legislation

To ensure that surprise bill protections truly put the needs of families first, Families USA and our consumer partners recommend that Congress consider the following principles in crafting legislation:

- **Hold Consumers Harmless:** Most importantly, legislation must ensure that families are held harmless from surprise out-of-network balance bills, which they receive due to no fault of their own. Importantly, families should not have to take any action to trigger such protections and providers should be prohibited from sending such bills. Furthermore, in a surprise billing situation, insured families should never have to pay more than their standard, in-network cost-sharing requirements. Legislation also should be explicit that these capped cost-sharing payments accrue to in-network deductibles and out-of-pocket caps.

- **Protect against surprise bills increasing health insurance premiums:** It is critical that Congress not only consider the immediate impact of surprise bills on families' out-of-pocket costs, but also the impact of these bills on the overall health insurance premiums paid by families, employers, and the government. Thus, some reasonable standard should be established for what insurers must pay providers for surprise out-of-network care. Such safeguards should take into account the importance of protecting the ability of the health insurance market to operate and for healthy negotiations between providers and payers. This payment cap should be limited to instances of true, surprise billing that occur by no fault of the consumer and is out of families' control. Families USA is open to various mechanisms to determine payment limits, including benchmark rates based on Medicare payment or a binding arbitration process with appropriate guardrails. Other approaches could require hospitals to negotiate a bundled payment for all services rendered, including the costs of providers and/or ancillary care.[48]

- **Protect consumers in all health plans:** Legislation should apply protections to all commercial health insurance plans. This includes self-insured plans, as well as fully insured individual, small group, and large group plans. This is important because consumers receive surprise bills indiscriminately across all plan types.[49]

- **Protect consumers in all care settings and from all providers:** While surprise medical bills occur at high frequency in emergency situations and from a specific set of provider types involved in facility-based care, consumers are also exposed to surprise medical bills in other care settings and from other providers.[50]

Surprise bill protections should apply to all care settings and care types from which a consumer could receive an out-of-network bill due to no fault of their own. This will ensure, for example, that if a consumer visits an in-network doctor who sends their labs out-of-network to be read, the consumer will not be responsible for a surprise balance bill from the lab.

- **Transparency alone does not solve this problem**: In discussions of surprise billing, often the question arises of whether increased transparency for families could be a sufficient way for Congress to address the problem. We and many experts believe that transparency is not enough.[51] For example, in many surprise billing cases, the affected patient has little-to-no ability to seek an alternative in-network provider due to the medical urgency of their situation, even if more information were provided. Furthermore, there is strong evidence that the health care sector does not have the ability to provide to consumers actionable, real-time information about provider networks or the true cost of services, including ancillary services.[52] While we support greater transparency requirements for plans and providers, proposing transparency as the solution to surprise medical bills is insufficient and would continue to leave families helpless against this pervasive problem.

A Call to Action

Families USA is grateful to the committee for holding this important hearing today. Families have been trapped for too long in the tug-of-war between providers and payers that leads to surprise medical billing, and without your action it will only get worse.[53] The public has identified health care costs as a top priority for action this Congress,[54] and addressing surprise billing is a chance to demonstrate real leadership to our nation. Families USA urges Congress to swiftly take advantage of this opportunity and to pass legislation to protect consumers from surprise medical bills this year.

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Chairwoman WILSON. Thank you, Mr. Isasi. We will now recognize Dr. Hoadley.

PROFESSOR JACK HOADLEY, PH.D., RESEARCH PROFESSOR EMERITUS, GEORGETOWN UNIVERSITY, HEALTH POLICY INSTITUTE, MCCOURT SCHOOL OF PUBLIC POLICY

Dr. HOADLEY. Thank you, Chairwoman Wilson, Ranking Member Walberg, and members of the subcommittee. I do appreciate the opportunity to share my perspectives about surprise medical bills.

I'm Jack Hoadley on the research faculty at Georgetown University and I'm going to draw today on a 50-State study of State laws and regulatory activity that I have conducted along with my colleagues at Georgetown. We have also taken a more in-depth look at some of these particular State protections. As you have heard already today, patients often receive surprise medical bills when they have reason to assume they are being treated by network providers or when they have no real ability to select a network provider.

Many Americans are worried that they may confront a surprise bill of this type and it happens all too often. And you have heard the examples already.

Our research shows that to date, 25 States have acted to protect consumers from surprise bills in at least some circumstances. Nine of these 25 meet our standards as offering what we consider to be comprehensive protection.

For protections to be comprehensive, we look to No. 1, whether they apply in both emergency situations, and in-network hospital settings such as electing an in-network surgeon but being treated by another clinician who is out-of-network. Second, that these laws apply to both HMOs, PPOs and all other types of insurance.

Third, that the laws address both insurers by requiring them to hold consumers harmless from balance bills and providers by barring them from sending balance bills.

And fourth, that the laws adopt some kind of a payment standard, either a rule to determine payment from insurer to provider or an arbitration process to resolve payment disputes.

Although these four conditions don't guarantee complete protection for consumers, they combine to protect consumers in most emergency in-network hospital settings that the States can address. But as you have already heard, State protections are limited by Federal law and ERISA which exempts State from State regulations, self-insured employers sponsored plans. Although many of the State laws have been in effect only a short time, we can learn some key lesson from the State experiences.

First, it is critical to consider whether consumers are protected regardless of the type of provider. Some State laws limit their protections to hospital-based physicians such as anesthesiologists or emergency department physicians. But consumers may also face surprise bills when treated by other specialists who are called in for their particular health needs such as a neonatologist, a cardiologist or a gastroenterologist.

And some State laws do not offer protections when services are delivered in out-of-network hospitals but only cover situations

where you're in the in-network hospital but are treated by an out-of-network provider.

In addition, most State laws have not addressed ground ambulance transportation and States are prevented by the Federal Airline Deregulation Act from addressing air ambulance providers. So those are also gaps.

Second, some State laws apply only to HMO enrollees and not to PPO enrollees and this limits the scope of consumers protected, but of course the larger gap as I have already mentioned is the ERISA plans.

New Jersey and New York have explored voluntary approaches for ERISA plans but it is too early to tell if these will have any impact and they are only voluntary steps.

Third, some States have considered making protections contingent on whether consumers receive a disclosure about the possibility of surprise bills, and although disclosure is helpful for consumers, making protection contingent on those disclosures seems inadequate given the challenge that consumers already face in understanding the many disclosures they see in a medical encounter.

In going to the medical system, you get a whole clipboard full of pieces of paper you are supposed to read and sign and this is just one more of those it doesn't really help.

Fourth, determining how to set a payment rate for the services delivered by a non-network provider may be the most challenging issue as we have already heard some comments on. Some States set a payment standard for what the insurer must pay, but States differ in whether to base a standard on Medicare rates, on average network rates, or on provider charges. And there are advantages and disadvantages to each of these. For example, basing payment on provider changes will tend to dive up costs.

Other States have elected an arbitration process to determine the reasonable reimbursement for a particular case. Arbitration is typically designed in a way that encourages providers and insurers to reach a voluntary agreement and leave the arbitration as a last resort.

And the last lesson is the challenge of enforcement. States have more ability to regulate insurers than providers and that can be an issue. But the key is to avoid placing the onus on the consumer to protest a surprise bill.

Although States are making progress in protecting consumers from surprise medical bills, they are looking to the Federal Government to address the self-insured ERISA arrangements they cannot regulate. Federal legislation would also help consumers in the many State that have not yet acted.

In addition, State officials have noted that a Federal law could help when a State resident receives care across the board or in another State.

But questions remain on what role States should continue to play if there is a Federal law. For example, does that Federal law defer to existing State laws or leave a role for States to adapt rules to local market environments?

The key unifying principle for States has been that consumers should not be liable for surprise medical bills in these circumstances we are talking about. Protecting consumers in these

situations will offer them some relief from worry about health costs. Thank you.

[The statement of Dr. Hoadley follows:]

State Approaches to Protecting Consumers from Surprise Medical Bills

Statement of
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Before the
House Committee on Education on Labor
Subcommittee on Health, Education, Labor, and Pensions
Examining Surprise Billing: Protecting Patients from Financial Pain

April 2, 2019

Good morning, Madam Chairwoman, Ranking Member, and Members of the Subcommittee. My name is Jack Hoadley, and I am a Research Professor Emeritus at Georgetown University's McCourt School of Public Policy. Together with Kevin Lucia and other Georgetown colleagues, I have been studying for ten years the ways states address surprise medical bills. Our most recent analysis of state legislation was conducted with the support of the Commonwealth Fund, resulting in a June 2017 report[1] and an update published in the "To the Point" blog in January of this year.[2] I am pleased to have the opportunity to share the findings of this research and my perspectives on this policy issue with the Subcommittee.

What Are Surprise Medical Bills?

A surprise medical bill is any bill sent by a medical provider to a patient for an amount larger than expected. A surprise bill can happen when you did not expect that a medical procedure would be so expensive or when you did not understand the consequences of a cost-sharing requirement, such as a deductible, included in your insurance policy. These are unfortunate circumstances, but they are not the type of surprise billing that are the current focus for your Committee. Our concern today is about those surprise medical bills that result from interactions with the medical system in situations where patients reasonably assumed that they were being treated by providers in their health plan's insurance network or where patients had no real ability to select their medical provider.

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[1] K. Lucia, J. Hoadley, and A. Williams, Balance Billing by Health Care Providers: Assessing Consumer Protections Across States, Issue Brief, The Commonwealth Fund, June 2017. https://www.commonwealthfund.org/publications/issue-briefs/2017/jun/balance-billing-health-care-providers-assessing-consumer.

[2] J. Hoadley, K. Lucia, and M. Kona, State Efforts to Protect Consumers from Balance Billing, To the Point, The Commonwealth Fund, January 18, 2019. https://www.commonwealthfund.org/blog/2019/state-efforts-protect-consumers-balance-billing.

In these situations, surprise bills arise when insurance makes a payment for out-of-network care based on in-network rates, but the provider bills the consumer for the balance of their charges beyond what the insurer pays and beyond the consumer's cost sharing.

These surprise bills, sometimes referred to as balance bills, may occur in emergency situations where a consumer has no effective way to choose their provider. The bill may come from an air or ground ambulance service, from an emergency department physician, or from any physician or other clinician who provides treatment in the case of this emergency. It may also be a bill from the facility in cases where the closest emergency facility is out of network.

Surprise bills also occur for consumers who do their due diligence by selecting an in-network facility and an in-network surgeon for an elective procedure such as a joint replacement. But on the day of surgery, the anesthesiologist assigned by the hospital to provide care or the radiologist who reads an MRI or CT scan is out of network. This is another situation where consumers typically assume these health care professionals are in network or have no forewarning that an out-of-network clinician will be providing care. The balance bill is therefore unexpected. Unexpected bills may also occur when a consumer relies in good faith on an inaccurate provider directory or misinformation from a doctor's office.

All these situations are different from those where consumers make an informed and voluntary choice to receive services from an out-of-network obstetrician or oncologist and understands and accepts that their costs will be greater than if they chose an in-network physician.

We lack good data on how often unanticipated surprise medical bills from out-of-network providers occur, but insurance claims data suggest that about 20 percent of inpatient emergency department encounters have the potential for a surprise out-of-network bill. This is twice the rate of out-of-network encounters for elective inpatient care.[3]

These unexpected medical bills are a major concern for Americans, with two-thirds saying they are "very worried" or "somewhat worried" that they or a family member will receive a surprise bill. In fact, these bills are the most-cited concern related to health care costs and other household expenses.[4]

Most public-sector insurance programs—including Medicare, Medicaid, Tricare, and VA care—protect their beneficiaries fully or in large part from balance bills. But the same protections do not exist for most private insurance. The Affordable Care Act requires that insurers under its jurisdiction make payments for emergency services that are out of network comparable to what they would pay for those services when they are in network. But the ACA does not restrict health care providers from asking patients to pay the balance of the bill.[5]

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[3] C. Garman and B. Chartock, One in Five Inpatient Emergency Department Cases May Lead to Surprise Billing, Health Affairs 36(1); 177-181, January 2017

[4] A. Kirzinger, B. Wu, C. Muñana, and M. Brodie, Kaiser Health Tracking Poll – Late Summer 2018: The Election, Pre-Existing Conditions, and Surprises on Medical Bills, Kaiser Family Foundation, September 5, 2018. https://www.kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-late-summer-2018-the-election-pre-existing-conditions-and-surprises-on-medical-bills/

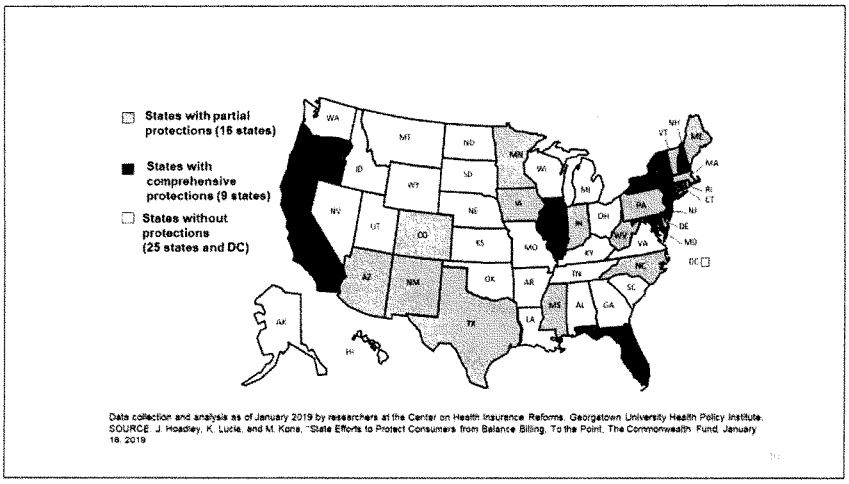
[5] K. Keith, New Regulation Justifies Previous Position On Emergency Room Balance Billing, Health Affairs Blog, May 9, 2018. https://www.healthaffairs.org/do/10.1377/hblog20180509.247998/full/.

Employers and insurers may voluntarily protect their employees or enrollees from these balance bills in some situations. And as I will describe here, some states have acted to protect consumers from surprise bills in some circumstances. However, state protections are limited by federal law (ERISA), which exempts self-insured employer-sponsored plans, covering 61 percent of privately insured employees, from state regulation.[6] As a result, state laws do not apply to the majority of Americans covered under employer-sponsored health plans.

The Scope of State Protections

At Georgetown, we conducted a study, most recently updated in January 2019, that found that 25 states today have laws offering consumers at least some protections in a balance billing situation (Figure).[7] The key element in all these state laws is that they take the consumer out of the equation and make sure that they are only obligated to pay normal cost sharing.

Figure. State Laws Protecting Consumers Against Balance Billing



Data collection and analysis as of January 2019 by researchers at the Center on Health Insurance Reforms, Georgetown University Health Policy Institute. SOURCE: J. Hoadley, K. Lucia, and M. Kona, "State Efforts to Protect Consumers from Balance Billing," To the Point, The Commonwealth Fund, January 16, 2019.

Although 25 states have created some protections, only nine—California, Connecticut, Florida, Illinois, Maryland, and New Hampshire, New Jersey, New York, and Oregon—have laws meeting our standard for "comprehensive" protections.

To qualify as offering comprehensive protection for consumers, we look for a state to meet four conditions:

- Extend protections to both emergency department and in-network hospital settings;

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[6] 2018 Employer Health Benefits Survey (Section 10), Kaiser Family Foundation, October 3, 2018. https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-10-plan-funding/.

[7] J. Hoadley, K. Lucia, and M. Kona, State Efforts to Protect Consumers from Balance Billing.

- Apply balance billing laws to all types of insurance that are subject to state regulation, including both HMOs and PPOs;
- Protect consumers both by requiring that insurers hold them harmless from extra provider charges—meaning they are not responsible for the charges—and by prohibiting providers from balance billing; and
- Adopt an adequate payment standard—a rule to determine how much the insurer pays the provider—or an arbitration process to resolve payment disputes between providers and insurers.

Collectively, these conditions do not necessarily constitute total protection for consumers with no gaps. But they combine to protect consumers in most emergency room and network hospital settings.

We have seen considerable state activity in recent years. In 2017 and 2018, four states—Arizona, Maine, Minnesota, and Oregon—created balance-billing consumer protections for the first time, and two—New Hampshire and New Jersey—substantially expanded existing protections. Many states in their current legislative sessions are considering new bills. Several states—Colorado, Georgia, New Mexico, Oklahoma and Washington—have seen action in at least one chamber of their legislatures. It remains to be seen what new laws will be enacted or which ones will meet our standard for comprehensive protections.

The approaches taken by states in recent years has varied. For example, New Jersey has met our criteria for comprehensive protection by creating a dispute-resolution process to establish a payment amount for the out-of-network service. Other states have recently acted to protect consumers from balance billing in a more limited way. For example, Missouri's new protections apply only if the provider and insurer voluntarily agree to participate in the process. Such laws mark a starting point; many states have built up their protections over several years.

Lessons from the States

In many cases, state laws have been in effect only a short time so it is premature to understand fully how effective they may be. But we can still take away some key lessons from the state experiences.

Scope of State Protections

One issue has been the scope of laws passed in different states. Some states apply protections only to bills coming from certain types of providers. For example, a state may otherwise have a comprehensive approach to balance billing, but only applies the protection to certain hospital-based physicians—radiologists, anesthesiologists, pathologists, neonatologists, or emergency department physicians when those services are provided in a network hospital or ambulatory surgical treatment center. Thus, the law would not apply to surprise bills for services by a consulting cardiologist or orthopedist called in to treat the patient. This law also fails to protect patients who are taken in an emergency to a non-network hospital.

In addition, most state laws do not apply to ground ambulance services. Furthermore, states are prohibited by federal law from addressing bills arising from air ambulance services.[8]

Types of Insurance to Which Laws Apply

A second issue is the range of insurance products to which state laws apply. Laws in several states apply balance billing protections only apply to HMO enrollees and not to PPO enrollees.

Furthermore, as I pointed out earlier, states are prohibited by ERISA from applying protections to self-funded arrangements. New Jersey has included in its law a provision allowing self-funded plans to participate in the state protections on a voluntary basis. Because this law was just enacted in 2018, it is too early to know whether any ERISA plans will opt to participate.

Gaps in State Protections

A third issue is whether there are gaps in how well consumers are protected. Some states have made protections contingent on disclosure to the consumer that they may be subject to balance bills if they are treated by out-of-network providers. Protections, at least in nonemergency situations, only apply if the required disclosure does not occur. Disclosure can be helpful to consumers but making protection contingent on this disclosure seems inadequate given the challenges that consumers face in understanding the many disclosures handed to them when receiving medical services.

California's law goes a step beyond most other states in one regard. It explicitly forbids providers from sending their patients balance bills. It further requires providers to refund any amounts consumers pay that should not have been paid.

Determining a Payment Amount for Non-Network Services

A fourth issue is how to set a payment amount for the services delivered by a non-network provider. For in-network services, insurers pay based on the contracts established for network participation. In the absence of a contract, it is important to have a mechanism to establish a payment amount. Without any such mechanism, insurers and providers may be at odds over the payment, and payment disputes can leave the patient at risk.

Some states—for example, California, Maryland, and Oregon—have opted to set a payment standard in law to determine what the insurer must pay, while also requiring that the provider accept this amount as payment in full. Payments vary in how they are structured and in the level of payment. Standards can be structured as a percentage of Medicare rates, or they can be based on a percentage of average network payments or based on a percentage of provider charges. The different approaches matter; for example, a charge-based standard is more likely to be inflationary. Political and market considerations in a state have led to setting standards in different ways and at different levels.

Other states—for example, Florida, New Jersey, and New York—have opted instead for an arbitration process to determine a reasonable reimbursement rate for a particular case. The expectation is that in most cases, providers and insurers will agree on an appropriate amount

[8] S. Corlette and M. Kona, Lawmakers had a Chance to Provide Relief from Surprise Medical Bills – and Whiffed It, CHIRBlog, September 27, 2018. http://chirblog.org/lawmakers-blow-chance-to-curb-surprise-medical-billing/.

voluntarily. But where no agreement can be reached within a reasonable time, the parties go to binding arbitration. New Jersey and New York use "final offer" or "baseball-style" arbitration, where each party elects a payment amount. The arbitrator then selects one amount or the other but cannot select any other amount. This system is designed to create an incentive for the sides to submit reasonable amounts, thus making it easier to reach a voluntary settlement. One consideration is whether to provide the arbitrator any sort of guidance; if this is done, it raises similar considerations to those in setting a payment standard.

States have typically found designing a payment standard or arbitration process to be the most challenging issue in gaining consensus among all stakeholders. When all stakeholders come to the table, it often proves possible to reach agreement on a solution that fits the particular needs and market conditions of that state.

Enforcement

A final consideration raised by the states that have acted on balance billing is how to enforce the protections they write into their laws. State insurance departments have jurisdiction over insurers, so enforcing rules on their insurers is a normal part of doing business. But they generally have no jurisdiction over providers. Prohibitions against balance billing by providers are sometimes defined as an unfair business practice, an established area for state regulation. But enforcement remains a challenge. A critical consideration is to avoid placing the onus on the consumer to protest a surprise bill.

The Role for Federal Legislation

Although states continue to make considerable progress in protecting consumers from surprise medical bills, they are looking to the federal government to address the self-insured ERISA arrangements they have no jurisdiction to regulate. In addition, protections are still lacking in half the states, meaning that federal legislation could make these consumer protections universal.

Federal policymakers also face decisions on the degree to which they allow a continuing state role in these protections. Federal policy could defer to state laws that meet a standard for adequate consumer protection. Federal policy could also leave a role for states in adapting payment standards or arbitration processes to their market environments.

Throughout the state actions to date, the unifying principle has been that consumers should not be liable for surprise medical bills in circumstances where they have little or no control over whether their medical providers are in network. Protecting consumers in these situations will offer some relief from worry about their health costs.

Chairwoman WILSON. Thank you. Thank you, Dr. Hoadley. We will now proceed to member questions. Under committee rule 8(a) we will now question witnesses under the 5-minute rule. I will now yield myself 5 minutes. First of all, let me thank you for the very interesting testimony.

When we talk about surprise billing, it seems that a fundamental problem facing consumers is that they often have no way of knowing whether their provider is in the plan's network. And it is unclear to me who has the burden of making sure that the consumers have the information they need in order to make an informed decision.

So I'm going to ask Mr. Isasi under current law, who is responsible for making sure that a doctor or hospital is in-network? Is it the doctor, the insurance company, or the patient themselves?

Mr. ISASI. Chairwoman Wilson, thank you for the question. To be very clear, it is the patient themselves that has a responsibility and these negotiations are very complex. These are some of the most important and intense negotiations in the health care sector between a payer and a provider. There is absolutely no visibility for a consumer to understand what is going on there.

And so the notion that a consumer wouldn't walk into an emergency department and know for example that their doctor was out-of-network, because that hospital could not reach agreement on an in-network provider for the ED, is absurd. Right. There is no way they would ever know that.

And similarly, if you walk in and you receive surgery and it turns out your anesthesiologist isn't in-network, there is no way for the consumer to know that.

And I would, I would like to say there is some discussion about transparency and creating, you know, sort of provider directories. We have tried to do that in many instances and what we know is that right now the health care sector has no real way to provide real actual insight to consumers about who is in-network, who is out-of-network.

I would posit probably everybody in this room has tried at some point to figure out if a doctor is in-network or out-of-network and as we know that system doesn't work.

So this idea that consumers can do research and find out what has happened behind the scenes in these very intensive negotiations is absurd and it doesn't work.

Chairwoman WILSON. Okay. Let me followup. The burden in non-emergency situations is also significant. Would any of the witnesses like to comment on this issue and elective procedures?

Do patients always know the name of all of the doctors who could potentially be sending them a bill later? Anyone.

Ms. SCHUMAN. I would be happy to talk about that. And the answer again is no. And there is no obligation on the part of those providers to provide that kind of notice to a patient about the kind of care they are going to be getting, whose it from and whether they are in-network or out-of-network and what the cost associated with that is.

Therefore I do think that rules requiring some disclosure up front at the time of scheduling when you can actually make a dif-

ference would be helpful. But as the other witnesses pointed out here, increased notice and transparency is only part of the problem.

Chairwoman WILSON. But even if a patient is able to determine the name of every doctor that will see them, I worry that not all of the information they are given about the network is accurate.

Dr. Hoadley, or Mr. Isasi, would you comment on the accuracy of provider directories? What happens if a consumer relies in good faith on accurate, on inaccurate information about their plan's network. The changes.

Dr. HOADLEY. Yes, that's a really good point. You know, directory, provider directories can be notoriously inaccurate. One of the things that even if they are accurate, that I have seen in my own family is you may be enrolled in Blue Cross. You ask your physician are they in the—participating in Blue Cross? They say yes. But it turns out Blue Cross has a variety of different networks. This would be true of any insurance company.

And so, you know, you may be in this one particular flavor of the Blue Cross plan and your provider may not participate in that particular network. So it's a very complex issue and some of the States have tried to link protections for balance billing with some of the issues around adequate networks and adequate provider directors.

Chairwoman WILSON. Okay. Ms. Young, why is it important for providing an appropriate Federal payment standard, whether by establishing a benchmark or creating a dispute resolution process? Why is that necessary to address this problem of surprise billing?

Ms. YOUNG. Absolutely. So as my co-panelists have talked about, notice isn't enough here. Even if a consumer had perfect information which is not a reasonable expectation, but even if they did have perfect information, they can't do anything with that information. They can't go across town to get their anesthesia and then come back to the hospital.

There, even with perfect information, they may be treated by out-of-network providers and so we need to set a standard that limits how much providers can be paid in these out-of-network scenarios that makes it sort of less attractive for providers to remain out-of-network. And so instead, they are subject to more normal market conditions.

Chairwoman WILSON. Thank you so much. I now recognize Ranking Member Walberg for his round of questions.

Mr. WALBERG. Thank you, Madame Chairwoman, and thank you to the panel for being here. Ms. Schuman, we have had this hearing specifically because of the rise, at least the ability to see the number of surprise billings that have taken place, the balance billings that are going on and the escalation there and the problems.

What factors could you suggest that have led to the rise in occurrence of these surprise billings and do you think the trend will continue if action isn't taken?

Ms. SCHUMAN. Well, thank you for the question. And all of these cases of surprise billing have a common theme. The patient lacks a meaningful role in choosing between a provider who is in the network or outside of the network. And the provider is not bound by competitive market forces to join or not join that network.

So the real problem fueling surprise billing is that for example hospital-based specialists like anesthesiologists, or radiologists, or emergency physicians don't have to lower their prices to draw patients. They can charge higher rates and the patients will still come.

So with these automatic referral of patients, the typical price-volume tradeoff for joining a network does not apply. Again, this is a fundamental market failure that I believe will only worsen if action is not taken to restore competition and choice.

Mr. WALBERG. We have talked about already in the initial questioning about transparency, adequacy of information just isn't there. Even if it were, are patients and their loved ones capable of navigating these types of decisions about their health care under difficult circumstances.

Ms. SCHUMAN. Well, I think any one of us who have been in this situation either ourselves or with our family members know how challenging that is. And patients and loved ones should not be put in the position or expected in a stressful emergency circumstance to be able to understand and navigate all the complexities of our health care system.

In these instances, our laws should go beyond just the mere notice of a provider's network status to protect individuals against costly surprises when they are in no position to direct their care themselves.

Mr. WALBERG. List a few mechanisms or approaches for patients, I guess we could say rate payers, insurance rate payers as well to protect themselves against that surprise billing experience.

Ms. SCHUMAN. Well, I laid out some of the recommendations. And to reiterate, I think it has to start again with protection of the patients and a ban on the practice.

But beyond that, we really do need to address this in a uniform way to make sure that we capture the 60 percent of ERISA self-funded plans and also one that is directed at the root of the problem which I just described.

And so therefore we need to remove those incentives that encourage these—out-of-network providers to stay out-of-network while at the same time ensure that they are equitably compensated for our services.

So in the case of an out-of-network hospital or facility, performing emergency services, I suggest that a Medicare rate of 125 percent it's clear and a way to restore competition and negotiation with respect to that out-of-network facility for emergency services.

For—in-network hospitals, when a plan has contracted with that in-network hospital, all of the providers practicing at that hospital should be paid no more than an in-network rate.

When you buy a car, you assume that the steering wheel and the tires are going to be attached. And I think it is somewhat similar to that.

I think there has also been a discussion about a bundled payment model whereby the hospital submits one single bill. And that might have some merit. Again but if there is appropriate safeguards on there to prevent against price escalation or undermining employer plan networks which are the greatest tool that employers

have to both reduce the cost of health care and increase the quality.

Mr. WALBERG. Just for the—I'm going to run out of time so I won't do this to you.

Chairwoman WILSON. Go ahead.

Mr. WALBERG. If you could just briefly discuss the price difference between—in-network rates and—out-of-network rates.

Ms. SCHUMAN. Sure. Happy to. And I think what we have seen is—in-network rates or—out-of-network rates more than two or three times—in-network rates depending upon again certain specialties.

And I think we have also seen a trend, a recent report about the fact that gap is growing and that it's alarming. It's not a comparison to cost and it's not in comparison to networks.

And I think as that trend continues and that gap continues to grow, we want to address the situation in a way that narrows that gap, not only makes it wider.

Mr. WALBERG. Thank you. And thanks for the grace period.

Chairwoman WILSON. Thank you.

Mr. WALBERG. I yield back.

Chairwoman WILSON. We will now hear from the distinguished chairman of the Education and Labor Committee, Mr. Scott. Welcome.

Mr. SCOTT. Thank you. Thank you, Madam Chair. Ms. Young, Section 1311(e)(3) of the Affordable Care Act helped improve transparency by requiring plans to provide public and timely disclosure of certain information. Why is this section important and what is the status of the implementation?

Ms. YOUNG. Thank you for the question. I think as we have talked about transparency, it is important, it is not a comprehensive solution to this problem. But it is important to give consumers information about their health care services.

The Federal Department of Health and Human Services has taken some steps to require disclosure of basic information about health plan information for qualified health plans under 1311(e) of the Affordable Care Act so those rules have been in place for a couple of years and I think we have those sort of first year data has become publicly available just over the last 6 months or so.

Mr. SCOTT. How useful is that information and is the Department of Labor doing its job under the provisions of the act?

Ms. YOUNG. So we don't think the information in—under section 1311(e) is particularly useful for consumers that are trying to navigate the out-of-network situation, though it does provide us some insight about what is going on in health plan networks and I think researchers would certainly welcome that transparency.

For the Department of Labor, so there is a parallel requirement on that group health plans make information available. My understanding is that the Department of Labor proposed some standards about updating sort of the tax form that ERISA plans file to include better information about health plans but that those policies have not been implemented and are not in effect.

Mr. SCOTT. And we have had a lot of back and forth about what doctors can charge. Why doesn't normal contract law apply? That a doctor can't charge what he or she wants? When you go into the

hospital and receive the services, you have under contract law agreed to pay a reasonable fee, not whatever the doctor thinks he can get out of you.

Why isn't what they accept under Medicare, what other physicians similarly situated accept? Why isn't there some more reasonable calculation of what a physician is owed? Not just what he wants, two, three, four five times what Medicare pays? I mean, it's a contract law.

Ms. YOUNG. Yes, so this is a, I think an interesting area of the law. Right now when patients are seen out-of-network, the providers are sending them balance bills at a rate that as you suggest, the provider has sort of largely made up. It's not determined by market forces.

There are some legal scholars who have been advancing this idea that there is no contract between the patient and the anesthesiologists in this circumstance and so as a result, the—there hasn't been a meeting of the minds and so we fall back on background contract law principles that would limit how much the anesthesiologist gets paid.

And there have been a couple of cases across the country that try to test this theory. I'm not an expert in these cases. I don't think any of them have been successful yet, but it is an interesting area of legal inquiry.

Mr. SCOTT. I don't know who this should be aimed at, but there is another surprise bill when you go in for a screening and which is supposed to be free under the Affordable Care Act and they do some little procedure in the middle of it.

It converts the whole thing into a treatment which is not free under the Affordable Care Act. Is that not a surprise in addition to the other surprises we are getting?

Ms. YOUNG. So I can talk a little bit about that issue. As you noted, it's not the same problem as the surprise balance billing that we have been talking about but consumers who are receiving free preventive care under the Affordable Care Act may—an example is a colonoscopy where the individual sort of starts with a screening colonoscopy and ends up getting a biopsy or a polyp removal.

Mr. SCOTT. And then you have to pay for the whole thing.

Ms. YOUNG. And that can generate charges. My understanding—

Mr. SCOTT. What about what kind of charge are we talking about?

Ms. YOUNG. It will depend on the procedure, but it can be fairly expensive or, I mean, it's an invasive outpatient procedure so it can be expensive.

The Department of Labor, HHS and Treasury have issued guidance that tries to limit that practice for colonoscopies performed in employer coverage, but my understanding is this is still a problem in the Medicare context.

Mr. SCOTT. Anybody else want to comment on that?

Dr. HOADLEY. I would simply note that, you know, it's an example of a broader issue that is what we are talking about here which is a lot of situations you go in for one particular procedure, you are doing an elective procedure but something else arises.

So you might be going in for your knee replacement but something happens while you are in the middle of that surgery. And your heart is not doing the right thing so they bring in a consulting cardiologist. And that could turn out to be one of these out-of-network situations.

So, you know, health care is not so predictable. We can't assume that simply because you went in to do X, a screening colonoscopy, a knee replacement, that isn't going to trigger some other problem and then that's part of what we are I think trying to address in these issues.

Chairwoman WILSON. Thank you, Mr. Scott. Dr. Roe.

Mr. ROE. I thank the Chair and I want to thank the Chair for having this very important hearing and all the members for being here.

And, Dr. Hoadley, I note, I was reading your what is a surprise medical bill that is any bill sent by a medical provider to a patient for an amount larger than expected.

I think all the bills I ever sent to patients thought they were larger than they expected. So probably applies to everything.

I really appreciate you being here and, Ms. Schuman, you make a point about a car. The difference in health care though is you go down to your car dealer and you buy a car. He doesn't have you sent you out without a car unless you pay for it. There is a law passed and as it should have been in 1986 called MTALA. You are very familiar with it and we have to cover anyone who comes into an emergency room and sees a Medicare patient as we should.

I'm an obstetrician by training and I have done that many, many times before. And so what happens to us in, on the provider side is that we have to provide those services as we should, regardless of your ability to pay. So we have that restriction on us as we should in the hospital.

I have been negotiated out of health care networks. Our group which was a large group so there are no innocents in this when you look at the insurers, the hospitals, the providers. Everybody is culpable here.

And I could not agree more about transparency. I have had a surprise bill after a surgery I had a year and a half ago so I'm very much aware of that and I could negotiate it because I knew the nuances of this. Many people cannot. It is complicated.

And even, Dr. Hoadley, as you said, even having—I have been—had my name in-networks that I wasn't in. That you use and many of those unscrupulous networks will use that to get people to sign up because this doctor, my doctor is in there when you are really not. And you get surprised bills.

So another couple things I want to mention is that we have to look at when you look at Medicare for instance as a benchmark, and most of us don't have a problem with that except if you look at the Medicare Wage Index.

Where I live in rural Tennessee, we have the lowest—second lowest Medicare Wage Index in the United States. We get .73 cents for what someone else gets $1 for. Now in California for instance they have a very, very generous Medicare Wage Index.

So we have to, we pay our providers less and we can keep less than 10 percent of the nurses that we actually train in our area

because we can't pay them enough. So when you benchmark off Medicare, you are just again where we live you're discriminating against us. And so we need to work that out and it is a very unfair system that needs to be fixed.

And one other buzz I have got up my—a burr up my saddle is in Medicare if I saw an elderly patient that had a very limited income and I wanted to waive her copay, it is illegal for me to do that. And yet in California it is illegal for a doctor to balance bill. You have got two very—it's a dichotomy.

So how do we do all this and put this together where it is fair to the patients and it is also fair to the providers? And one other thing and anybody can comment on this. We have one hospital system where I live now. They've merged so there is no competition. There is one.

And when you have a bundle payment where that goes just to the hospital what leverage does a provider have to be treated fairly?

Ms. SCHUMAN. Can I just comment on that and thank you so much for saying that. I think that we all stakeholders have to be part of this solution without a doubt. And you know, and I think that, you know, to that point, I think it is very important that all stakeholders again are part of the solution. And we are looking at this in the broader context of the effort to increase transparency and lower health care costs.

And I think one of the big drivers behind rising health care costs is that lack of competition that you talked about. So we really do have a unique opportunity to try to address the root of this problem and the lack of competition that is driving it more.

Mr. ROE. And to the Chairman's point a minute ago, let me tell you how frustrating it is as a provider. I am doing a procedure, let's say a colonoscopy on a patient. And you're doing a Medicare patient and you see the polyp that is there. If you take it out that's a second bill. I mean, are you going to stop and bring that patient back? I think that's awful to have a patient go through all of that again.

And so as I said there are no innocents here. I really appreciate just the start of having this discussion. We need to stop surprise billing, no question about that and do it fairly for everyone. I yield back.

Chairwoman WILSON. Thank you, Dr. Roe. And now Ms. Wild from Pennsylvania.

Ms. WILD. Thank you, Madam Chairwoman. Thank you all for being here. I am somewhat gratified by the fact that it seems that we have bipartisan consensus that surprise billing really is a genuine problem and that patients are the ones who really are the losers in this system.

I am, you know, I am struck by the fact that we all seem to be wanting a solution to this problem. But the solutions that I'm hearing don't really sound very workable in the context of our present medical system. And that's, you know, that's where I really struggle to understand how we are going to fix this.

Ms. Schuman made the comment that all stakeholders have to be a part of this and I agree with you. The problem is the ultimate stakeholder is the patient. And the patient has no part in this in

terms of negotiation or even understanding the complexity of the insurance market and who may be in-network or out-of-network.

I will tell you as somebody with a post-graduate degree who has worked in as a lawyer in the insurance field for many, many years, I never understand a hospital bill without calling and seeking answers. And that's somebody—coming from somebody who's educated, literate, and knows the field and I still have a tremendous problem with it.

Ms. Schuman, you also used the phrase and I think what you said was that we need more competition in choice. Was that your statement?

Ms. SCHUMAN. Yes, that was.

Ms. WILD. And what does that mean?

Ms. SCHUMAN. What that means I think that what Dr. Roe was talking about the fact that there was only one hospital in town and when you only have one hospital in town its sort of difficult to negotiate.

And I think that again was what I was getting to both specifically with respect to having more than one hospital in an area but also more specifically when we are talking about surprise billing and the fact that some of these specialties have this free flow of patients that are coming to them without having to compete on prices and quality to attract them.

Ms. WILD. I'm sorry, I have just never found that competition causes any sort of clarity when it comes to medical charges. If I develop a relationship with a physician, I continue to go see that physician because I have a level of comfort with him or her, if I—it—I happen to be in a district with two excellent regional medical centers. There is plenty of competition in my district but that hasn't done anything to drive the prices down.

And I guess my question to you is isn't the real problem that we have turned over our medical system to private market forces?

Ms. SCHUMAN. Well, I think that indeed those private market forces are the best lever to drive health care value, drive down costs and increase quality. And that's why I cited an example of an employer member of ours, one of our member companies who networks because of networks basically they're saving their employees and their families 45 percent than without networks.

So I think that networks and the high-value, high-quality lower-cost networks are the key to innovation and to be able to get better value, better cost, and better quality.

Ms. WILD. But using your reasoning, a patient in New York City which has a wealth of hospitals and physicians and insurance plans, should result in no patients having surprise billing.

And yet I am quite certain that there are plenty of New Yorkers who have surprise billing every single day. So, I come back to my question of, you know, I am really not convinced that private market forces and competition in choice is the solution here.

Ms. SCHUMAN. Well, I think I also said that there is a fundamental market failure right now. And I think that that's what we are looking for, some sort of national response to this that restores those fundamental—so the market can work because when the market can work it works best. But there needs to be assistance and intervention to make that market work.

Ms. WILD. Well, I, you know, Mr. Roe used the expression there are no innocents here and I would agree with him except to say that I think the patients are the innocents. And so, there is an innocent party here.

Mr. Isasi, you seem to want to say something so please.

Mr. ISASI. I was going to say I think there are so many observations that we would agree with, but in particular, you're saying, you know, what is the workable solution here? What—I can't see the constructive, what—how do we move the ball forward? And what I would say is there is a concept here which is what does in-network mean? Right.

When you sit down with your husband or your partner and decide what kind of insurance do we want for our kids? Right? We want to make sure that they can go to the ED if they're playing soccer they get hurt, all those sorts of things.

The question is when you make that decision and you say oh look this hospital is in-network. Right. But what does that mean? If you can go to that hospital and all the services they're providing are out-of-network, right?

And I think as you've said and as we have heard from other folks, the patient is not the person who should be responsible for that. It's the folks who are negotiating. It's the hospital, it's the docs and the payers that should bear that responsibility.

So, let's start by clarifying what does in-network mean so that we have some way of making educated decisions about the insurance that we are purchasing and putting our trust in.

Chairwoman WILSON. Thank you. Thank you so much. And now we will hear from Mr. Meuser.

Mr. MEUSER. Thank you, Madam Chair, for holding this hearing and for allowing members and staff to learn more about the issues of surprise billing and thank you certainly to our witnesses for sharing your expertise. I have and I would venture to guess many of my colleagues if not all have heard stories from distraught constituents about what is very appropriately named surprise billing where they go for an emergency visit or often, a scheduled planned medical procedure or surgery which goes according to plan and then receives a surprise bill often in the tens of thousands of dollars.

So, Ms. Schuman, lets walk through a scenario please. And I have heard from individuals have experienced similar scenarios firsthand. At the advice of a doctor, an individual schedules a surgery and confirms that the hospital is—in-network. The surgery is scheduled 8 weeks in advance and the individual assumes that there will be no issues with undergoing surgery in an—in-network hospital.

Only after the surgery does the individual learn that the surgeon was out-of-network. The primary surgeon mind you and receives a bill for $25,000. Had the individual known the surgeon was out-of-network, they would have very likely found an—in-network surgeon. Doesn't that sound reasonable?

Ms. SCHUMAN. Absolutely.

Mr. MEUSER. Okay.

Ms. SCHUMAN. And I think that that—I think that exactly the situation with the patient is doing their homework, they're doing

their research. How are they to expect that some of those other services would be out-of-network?

Mr. MEUSER. Okay. Well, what would the patient—what do you recommend that the patient do differently? Ask further questions?

Ms. SCHUMAN. Well, I think in this kind of situation, the patient did everything that they could be doing. And the problem is not the patient. The problem is not the consumer. The problem is that the consumer didn't have knowledge and didn't have a choice.

And again, in some situations even when they have knowledge upfront and they are informed of that, they still may not have choices. So, I think it's knowledge and choice that the consumer needs.

Mr. MEUSER. Choice would be understandable. Knowledge not so much. What about the hospital? Do you feel they have any responsibility here in this scenario?

Ms. SCHUMAN. Absolutely. Hospitals play a critical role in this. When you go to a hospital, again, they have the ones, they have the leverage, they have the ability to negotiate with those physicians that are practicing in their hospital.

Getting back to something from my testimony, it stands to reason that when you contract with a hospital all of those essential services that are performed in the hospital under that roof like anesthesiology or radiologists, would be in-network. How can you go to a hospital? How can you have surgery without anesthesiology or a hospital operate without radiologists?

Mr. MEUSER. So you also feel the surgeon in that scenario would have responsibility or would it be the hospital?

Ms. SCHUMAN. Absolutely. And I think getting back to this point, everyone has a stake in this. All of the stakeholders have a role to play.

Mr. MEUSER. Okay. So what would you offer that could be done during that 8 week period leading up to the surgery to help assure that the patient would not receive a surprise bill?

Ms. SCHUMAN. Well, I think we have to look at this in a comprehensive way. And I think again we had talked about transparency, upfront disclosure. So at the time of scheduling, not when they get into the emergency—not when they get into the surgery room, to be able to make a decision based upon their action.

But even that alone is not enough. And I think what we have to talk about is getting behind the reason why the patients might not have a meaningful choice or might not even know. And that's why I think a Federal standard, a Federal solution that does not discourage these out-of-network specialists to stay out-of-network and generate these surprise bills in the first place is the core of the solution.

Mr. MEUSER. Okay, thank you. Madam Chair, I yield back the remainder of my time.

Chairwoman WILSON. Thank you, Mr. Meuser. And now McBath? Okay. Ms. McBath. Welcome.

Ms. MCBATH. Thank you, Madam Chairman, Chairwoman, excuse me, for holding this important hearing today. And I have been hearing about surprise medical bills from constituents in my district and from many stories in the news and like I'm sure that we all have.

The recent statistics have been alarming to say the least. I will tell you I'm a two-time breast cancer survivor. I have had many surgeries in my time and I can tell you the number of times that I was surprised myself by these surprise bills that came in unexpectedly.

A recent Kaiser Health survey showed that two-thirds of American are very worried or somewhat worried that they or a family member will receive a surprise medical bill.

In another survey, we see that 57 percent of American adults have been surprised by a medical bill for something that they expected to be covered by their health insurance.

Now I have here a whole number of individuals just within Georgia alone, and I'm sure there will be millions more that represent just these very things that have happened, these surprise bills.

These Americans, they are our friends, they are our neighbors and our family members. And I brought these stories from individuals in my district who have been affected by these surprise bills.

There is Michelle from Alpharetta and then also there is Tom from John's Creek, Elaine from Roswell and countless others. And like other Americans across the country, they were taken by surprise by a medical bill.

These men and women are worried about the financial impact that these bills have on themselves and their families. Some are able to get their bills reduced but most aren't and most aren't that lucky.

Now for me these stories make it clear that we have got to do something at the Federal level to address the financial impacts and emotional distress these surprise medical bills have on patients.

Mr. Isasi, I would like to ask you and thank you for your testimony. As Sarah Kliff of Vox and others have extensively documented, surprise medical bills lead to devastating consequences for consumers throughout our country. Now I really like evidence and data and could you talk about what data exists that could help us here in this room and in Congress understand just how large these expenses can be for consumers?

Mr. ISASI. Absolutely. So, as we have heard today there are a few facts. One, almost a fifth of all emergency department visits involve surprise bills. Right. So, for all of us, you know, as I was saying earlier, if your kid gets hurt playing soccer and you go to an ED, there is a really good chance you are going to get a surprise bill.

As you mentioned, we know that right now almost half of Americans' health care costs are top of mind and they are—they report they cannot meet basic, their basic health care needs with—because the costs are too high.

They won't go see a doctor, they won't get their meds, because they can't afford it and a third of people in this country right now are saying that their basic needs of life, their rent, their heat, their food, they cannot pay for those things because of health care costs.

So, this question of surprise billing is falling into much largest context which is that American families are overwhelmed by health care costs. And surprise bills are just that moment where despite trying everything, paying your premiums, checking to see if you're in-network, right, you find out now I owe $5,000, $10,000.

And what we know as we have heard is those bills typically are about three times more than they would be paying in-network but they can be tens of thousands of dollars more. Because as we have heard, there isn't a structured contract between that patient and that doctor. And therefore, they can charge whatever they can get away with. Right. So, I would say that to your question one of the most important concepts here is and we have heard this and I actually in a previous life saw this happening, right.

The negotiations between an insurer, a hospital, and a physician group are some of the most intense and sophisticated negotiations occurring in markets in this country. And the notion that you or I as a patient, as a person in need of health care services has to be able to track all of that and then be responsible because my hospital could not negotiate an in-network contract with an ED doctor so now I'm going to get stuck with the bill.

Is the tail wagging the dog? Right. That hospital should have the responsibility of saying if I am an in-network provider for you, you can come to my ED and not get stuck with a hospital bill that is three times larger and my cost-sharing is much larger, right. That is the tail wagging the dog.

Ms. MCBATH. Thank you. So how prepared are Americans for these unexpected expenses and could you speak on the impact that these expenses also have on individuals' overall wellbeing?

Mr. ISASI. You bet. Absolutely. And as I noticed in my testimony that right now what we know is that more people are scared of hospital bills and health care bills than getting sick. I mean, that's where we are as a Nation.

So we are—there is more harm right now happening in this country in some way psychologically around the cost of health care than actually being scared about their health. Okay. And in terms of the—what was the, I'm sorry, I missed the first part of your question.

Ms. MCBATH. Oh, I was just saying how prepared are Americans for these unexpected.

Mr. ISASI. Oh. Well, this is another thing we know is that almost half of Americans, they don't—they have less than $400 in savings, right. And so, a surprise medical bill for $2,000 means I'm going to have to miss my car payment, miss my mortgage payment. I'm going to have to take out of my retirement account. Right.

These are—when people pay for health insurance, what they are trying to pay for is financial security. To know I am doing my part, I am paying into a system, now I get sick and now that system takes care of me and makes sure that I don't lose everything I worked for in my whole life because I got sick.

Ms. MCBATH. Right.

Mr. ISASI. And what we know is a surprise medical bill is a, can be a devastating blow on a family that is trying to live that life and be self-actualized.

Chairwoman WILSON. Thank you. Thank you. And now, Mr. Allen. Thank you.

Mr. ALLEN. Thank you, Chairwoman and thank you, panel for giving us some insight onto just how magnified this problem is and of course, you know, I hear from constituents that surprise medical billing has become a significant concern for Georgia families.

You know, the problem is this whole process of health care is so complex that you have a, if you are—out-of-network, or in-network, you know, deductibles, and, you know, is your doctor in-network? I mean, you were supposed to be able to keep your doctor, it's just a total mess. And it needs to be fixed sooner than later.

But you know, 2/3 of Americans say they are somewhat worried about being able to afford their own family members unexpected medical bills and as we said, these surprises, how does a family deal with it?

Ms. Schuman, 22 States have passed legislation on surprise billing. What are the different models that States have enacted and are there any lessons learned from their approach to this problem?

Ms. SCHUMAN. Thank you. Yes, a number of States have acted to address surprise billing in a number of circumstances, some of which we have discussed here ranging from purely protecting the patient to requiring for example binding arbitration between the payer and provider to resolve that dispute.

Or in some cases California for example requiring setting a reimbursement that's the greater of 125 percent of Medicare or the average in-network rate. There are some lessons to be learned from that, but they are limited. They're limited by time and scope.

By time, because for example the California law just became effective at the beginning of this year so we really don't know the impact it's having.

But I think more critically they're limited in terms of scope because they don't cover ERISA self-funded plans 60 percent of employer sponsored coverage. So we don't necessarily know if those some lessons would apply on a national level.

And I do want to say just with respect to Texas, there could be some important lessons there with respect to a binding arbitration or dispute resolution process. In terms of a backlog of cases in the Texas system to try to address this through managed through dispute resolution.

They have changed the law but again, I think we need to be careful of that if we are thinking about employing that on a nationwide level.

Mr. ALLEN. Well, certainly we need to look at these models and see what we need to do at the Federal level because health and the other problem is healthcare costs are just accelerating like nobody has ever seen in the country.

We have heard a lot about the role of patients and providers and employers and finding a solution through surprise billing. Should hospitals also have a role in addressing surprise billing? In other words, should the hospital know that hey, you know, you are going to get a bill from, you know, this group or that group? I mean, it looks like full disclosure should be on the agenda here.

Ms. SCHUMAN. Absolutely. Hospitals play a critical role in this. The hospitals are the one with these hospital-based physicians. Often times those specialties that are integral to being able to operate that hospital and treat patients are not employed by the hospital. They're not in that hospital network.

And that leverage, that relationship between the hospital and the physicians that are practicing at that hospital is key and I think fundamental to addressing this problem in a way that works.

Mr. ALLEN. We have got about a minute. Many of the patients that receive surprise bills are covered through employer sponsored plans. What are employers doing and of course, you know, the business community is trying their best to address this accelerating cost of health care.

What are they doing to provide more information and transparency for their employees to help avoid these situations?

Ms. SCHUMAN. Well, thank you so much for that question. And this is a deep concern for employers. And council member companies are taking steps to limit the incidents of surprise billing in the first place, through for example enhanced communications to their employees about the potential for balance bills. And also, provide assistance to their employees who do receive a balance bill in the form of contracting with other entities to try to negotiate that down or providing some sort of legal defense funds. But despite these efforts of employer, the problems still persist.

Mr. ALLEN. Yes. Well, thank you so much and I yield back

Chairwoman WILSON. Thank you. Ms. Underwood.

Ms. UNDERWOOD. Thank you, Madam Chair.

Chairwoman WILSON. You're welcome.

Ms. UNDERWOOD. Thank you for holding this really important hearing today and I would like to thank our panelists for being here and for your really comprehensive written testimony. I have enjoyed reading through your comments.

Like many of us, people in my community in Illinois have experienced surprise billing and I frequently hear from constituents about their struggles to afford health care even health care more broadly when I'm home.

And so according to the Health Care Cost Institute, in my home State of Illinois, about 15 percent of in-network hospital admissions resulted in at least one out-of-network claim in 2016. And so, my questions are for you, Dr. Hoadley.

I'm proud that Illinois has taken a leading role in addressing this issue by enacting consumer protections that you have described as comprehensive in your research. Given your expertise on these State approaches, I was interested in getting your perspective on how effectively Illinois has addressed this issue.

So first, what are some of the strengths of the Illinois law in terms of its scope and protections for consumers?

Dr. HOADLEY. Well, certainly one of the strengths of its law is that it does apply to a broad variety of circumstances. They regulate both the HMO environment, the PPO environments regardless to the type of insurance.

They address both situations that arise in emergencies as well as those that arise in more elective procedures as we have heard talked about, some of the circumstances where you go in to get a particular elective surgical procedure but might encounter an out-of-network anesthesiologist. So, Illinois does have a good law in place.

Ms. UNDERWOOD. Great. And so how does the Illinois law resolve disputes between the providers and insurers?

Dr. HOADLEY. So, what they really look to is to try to get the provider and the insurer to negotiate a private amount. There is a dispute resolution option in Illinois. When we last talked to the

folks in Illinois, they said that had not actually been invoked. So, it was there perhaps as a backup, a backstop but for the most part things got resolved privately.

They did have some concern when we talked to the Illinois officials that there may be instances where consumers get bills sent to them, aren't aware that they don't need to pay them, so don't start the process. And that goes to this sort of point of how do you really make sure it's not the consumers responsibility to figure out that oh, I don't—by law I don't actually have to pay this bill. Now what do I do to make sure that happens? If you don't know that, that doesn't really help you.

And so, what some other States like California has done is to include a provision that says the provider really can't send a bill and if they do end up sending a bill and the consumer pays it, there is an obligation on that provider to refund the amount that was paid back to the consumer. And that's something we haven't seen in some of the other States.

Ms. UNDERWOOD. That is interesting, thank you. As we look to develop this comprehensive Federal solution, what lessons do you think we can learn from how Illinois has tackled the issue?

Dr. HOADLEY. So certainly, you know, trying to do something that is comprehensive is an important part. I think one thing that is also a somewhat of a limitation in the Illinois law is that in the non-emergency situations, it limits the protections to a certain specified list of provider types.

So, you know, it does cover the emergency room doctor, the most common ones that come up. The anesthesiologists, the radiologists and so forth. But it doesn't necessarily address an issue of when there is a consulting cardiologist that's called into your case or where maybe an orthopedist is called in because you came in with some situation that involved a bone injury.

And so, you know, one of the things that other States have done is to make sure that the law applies comprehensive to all types of providers rather than specifying the list of the ones. And yes, they do list the ones that are most commonly come up. But that doesn't mean it necessarily works in your particular case.

Ms. UNDERWOOD. Thank you. Speaking of the providers, I was reading in Christen Linke Young's testimony about the neonatologists and some specific surprise bills that often arise upon the likely early birth of a child and some unexpected out-of-network claims. I just was wondering if you wanted to expand a little bit on that.

Ms. YOUNG. Absolutely. Thank you for the question. So, we have talked a lot about the, this issue from the patient's perspective which I think is extremely important. But it is also helpful to think about the issue from the perspective of one of these providers.

Once a provider like an anesthesiologist or a neonatologist is in the hospital practicing, they will receive a flow of patients regardless of whether or not they join insurance company networks and regardless of what price they set.

So, for that neonatologist, once they're in the hospital, they're going to be the neonatologist taking care of those babies and they

have a very limited incentive to join insurance company networks and accept a negotiated contract rate from an insurance company.

It's the same dynamic that all of these provider types face. And the key to a solution is to get rid of that set of incentives and instead encourage those folks to come back in-network or work with hospitals for their payment.

Ms. UNDERWOOD. Well, I would like to thank you all so much—

Chairwoman WILSON. Thank you.

Ms. UNDERWOOD [continuing]. for your expertise and I yield back my time.

Chairwoman WILSON. Thank you Ms. Underwood. Now Dr. Foxx, our distinguished ranking member of the Education and Labor Committee.

Ms. FOXX. Thank you.

Chairwoman WILSON. For 5 minutes.

Ms. FOXX. Thank you, Madam Chairman, and thank you for organizing this hearing and I want to thank all of our witnesses for being here today. They've been very, very informative.

Ms. Schuman, I know that surprise billing impacts patients on a personal level. On a larger scale, how often do patients receive surprise bills? Do we have information on that?

Ms. SCHUMAN. Sure. Kaiser Family Foundation of medical debt found that among individuals who faced—out-of-network bills that they could not afford, nearly seven in 10 of those didn't even know the provider was—out-of-network at the time they received care hence the survive—the surprise. Another analysis of medical bills from large employer plans found that nearly one in five inpatient admissions included a claim from an out-of-network provider that could result in a surprise bill.

Even when enrollees choose in-network facilities, 15 percent of inpatient admissions include a bill from an out-of-network provider such as an anesthesiologist.

Ms. FOXX. So does the percentage change based on whether the patient is receiving emergency care? Do we have information about that?

Ms. SCHUMAN. Yes. And for inpatient admissions that include an emergency claim, they're much more likely, 27 percent to include a claim from an—out-of-network provider that admissions without an emergency room claim 15 percent. That's the case whether or not employees, enrollees use an in-network or—out-of-network facility.

Ms. FOXX. All right. What about when ambulances are provided.

Ms. SCHUMAN. Well, for ambulance services, the figures are even more alarming for patients in the most dire of circumstances.

As Ms. Young's testimony notes, among people with employer sponsored health plans, 51 percent of all ambulance cases involved out-of-network ambulances. And according to a recent GAO analysis of air ambulance transports of privately insured patients, 69 percent were out-of-network.

Ms. FOXX. Okay. So let's talk a little bit about what happens after a patient receives a surprise bill. What—are patients able to successfully negotiate down the amount? Professor Hoadley alluded

to this in his comments recently but are they able to negotiate down the amount or are they forced to pay the entire bill?

Ms. SCHUMAN. Well, generally a patient does not have much recourse after he or she receives a balance bill. And that's because State laws generally hold individuals liable for the cost of goods and services received not just with consumer's goods but for medical care as well.

And to that end, providers generally have individuals sign a contract prior to service indicating that they agree to be responsible for all billed charges. And it's these contracts and the related State laws the providers use as the basis for balance billings.

Now in some instances, employers do try to protect their patients from receiving or otherwise having to pay these balance bills by negotiating with the—out-of-network provider but these employer actions themselves are not without costs because employers that voluntarily try to protect their employees from balance bills have increased plan costs because in most cases they end up having to pay more to settle the balance bill and this gets reflected into higher premiums for all consumers.

Ms. FOXX. Lets pursue that a little bit more. Determining whether providers are in or—out-of-network can be confusing and obviously it sounds like for plan providers as well as patients.

So what influences a provider's decision to participate or not participate in insurance network and are there incentives or tradeoffs for participating?

Ms. SCHUMAN. This is the key question. And the incentive for providers to participate in the network is to have access to a volume of plan enrollees whose plans are trying to drive patients to a high value network.

The tradeoff for a lower—in-network reimbursement rate is a provider is going to more than make up for that in volume. But for some of these hospital based specialists that we have been talking about, they have inelastic demand. The patients are going to come to them anyway so that incentive is not there and the market is therefore supported and surprise medical bills ensure.

Chairwoman WILSON. Thank you.

Ms. FOXX. Thank you, Madam Chairman, I yield back.

Chairwoman WILSON. Thank you, Dr. Foxx. Mr. Courtney.

Mr. COURTNEY. Thank you, Madam Chairwoman, and thank you for your leadership on this issue which is definitely sweeping the country. It is partly because of some great reporting.

Sarah Kliff from Vox has done a great service in terms of a series of articles on this as well as National Public Radio. Congressman Doggett from Texas has a bill that's pending in Congress that again would take the patient out of the cross fire.

And as we have heard, a number of States have actually moved forward with legislation like the State of Connecticut which in 2016 passed a bill on a bipartisan basis by the way that again at least focused on the question of emergency room billing which again took the patient out, set up a standard in terms of reimbursement and also limited the out-of-pocket loss that would be credited against people both for out-of-network bills in terms of their overall deductibles.

You know, again, this committee which has jurisdiction over ERISA is exactly where this issue belongs. As I think we have heard, the Employment Retirement Income Security Act preempts State regulations. So, the fact that Connecticut or Illinois or other States have done good work in terms of moving forward, again, there is a huge number of employment-based plans that again are unaffected by this.

And again, I think it's just so important to foot-stomp that and I guess I would just ask Ms. Schuman again that again ERISA really has to be dealt with if we are going to really have a comprehensive solution for America's patients, is that correct?

Ms. SCHUMAN. That's exactly right. For the self-funded plans at 60 percent of employer-based plans that are not subject to these State laws like in Connecticut or other States, we have to have a Federal solution that addresses ERISA so that we deal with this problem in a uniform, nationwide way.

Mr. COURTNEY. And when we passed patient protections with the Affordable Care Act in 2009, again it was this committee that really crafted the language regarding preexisting conditions, lifetime limits, essential benefits which again removed the ERISA preemption and again set a standard that was universal in terms of all health plans.

So again, I think it's unfortunately the President has declared war again on the Affordable Care Act but again, our mission is just to keep again using the best information possible because health care is such a dynamic issue and this surprise billing issue obviously has really popped up that really escaped the Affordable Care Act's scope of patient protections.

So, again, I would like to ask Professor Hoadley about the Connecticut law which again as far as emergency rooms, used a different approach than the negotiated process of resolving some of these bills and again, established a standard which would appear at least in some respects to have the salutary effect of having a pretty sort of standard process that can be dealt with—can be implemented in a timely fashion versus a negotiated arbitrated. I am just sort of wondering if you could kind of tease out the pluses and the minuses from those two approaches.

Dr. HOADLEY. Yes, there are definitely pluses and minuses to the two approaches and, you know, we haven't had enough time on a lot of the laws like Connecticut's and New Jersey's to really gain a longer, richer experience to draw from.

But we can look at some of the differences, I mean, what the payment standard that Connecticut and other States use. One of its advantages is that it sets a clear number. It's there for everybody to see. There is sort of no ambiguity. Now if you don't like the number that it sets, or you think the number that it sets has consequences so States will vary between using a Medicare-based rate, a rate based on network charges or sorry, network allowed amounts or a standard based on charges.

And it makes a lot of difference which of those because the numbers involved are quite different. In any of those cases, it's a percentage of that standard so, I mean, it's not necessarily at the Medicare level. It might be as others have suggested 125 percent of Medicare.

The advantage of the arbitration process is it allows the individual circumstances of a particular case to be dealt with. Most States that have used an arbitration process have set it up in a way that really views it as something as kind of a last resort. Not something that is going to be used on case after case.

And so a combination of when they do adjudicate cases and make a decision, those amounts become a part of public information and so they can be a lesson to others. But simply the fact that there is a potential way to solve a number if you can't get to a resolution actually does create the incentive for the parties to get together and resolve it on their own.

They want to avoid the cost of going through that process. So there really are some merits and disadvantages on both of those approaches.

Mr. COURTNEY. Hopefully we will move swiftly and make a choice because again, this is an issue that can't wait. With that I yield back, Madam Chairwoman.

Chairwoman WILSON. Thank you, Mr. Courtney. Mr. Taylor?

Mr. TAYLOR. Thank you, Madam Chair. And I will just, you know, particularly for the chairwoman that, you know, I consistently voted in the State legislature to address this particular issue on a bipartisan basis in my time in Texas. And it certainly is an issue that we as State legislatures in Texas saw as a problem and addressed of course, you know, most Americans, you know, over half of Americans are on ERISA plans. So we are talking about the big plan, right.

This is really where the show is from a policy point of view. And so one of the questions I had, Ms. Schuman, is just what is—and let me just reiterate. It is so important that we solve this problem. This is a real problem and it is affecting people every single day. And I hope that we craft a bipartisan solution in this committee because only a bipartisan solution can actually go be signed by the President—can be passed the Senate and go be signed by the President.

Otherwise, we are just sending another messaging bill which will have no impact and not really solve the problem. So I would rather have something that is going to go all the way to the President's desk than something that is going to not get anything done.

But, Ms. Schuman, in your mind, looking at the State solutions, I know we have had some discussion about different State solutions. What have they done that in your mind is a model for us that you think could be supported by Republicans and Democrats, get through the Senate and be signed by the President?

Ms. SCHUMAN. Well, thank you so much and I think there are some lessons to be learned and maybe drawing from different States and taking pieces of different State legislation.

The California State legislation that we have talked about does include a component of capping reimbursement at 125 percent of Medicare or the—in-network rate as a way to again cap reimbursement so as not to undermine network participation. Other States that have adopted an arbitration model—

Mr. TAYLOR. So you're—that's an acceptable solution for you? 125 percent?

Ms. SCHUMAN. Well, I think—

Mr. TAYLOR. Because your original testimony I thought you were saying we shouldn't set prices but it sounds like you are—

Ms. SCHUMAN. Well—

Mr. TAYLOR [continuing]. saying set prices.

Ms. SCHUMAN. I think there is two—I think our recommendation is twofold and deals with a situation of an—out-of-network emergency service facility for emergency services different than for an in-network hospital.

Mr. TAYLOR. Okay.

Ms. SCHUMAN. For emergency services at an—out-of-network facility, that means a hospital didn't even contract with the plan emergency services, that's what I would suggest that capping it at 125 percent of Medicare is a reasonable way of approaching that and to foster some sort of equitable competition.

With respect to an—in-network hospital, that—in-network hospital should ensure that providers practicing at that hospital would pay an—in-network rate.

So the Medicare reimbursement structure is only with that I recommended is only with respect to the—out-of-network emergency. Otherwise, you go to a hospital, an—in-network hospital,—in-network rate, contracted rate. And that would remove the disincentive for these specialties, these hospital-based specialties not to join the network.

Mr. TAYLOR. Have you seen the legislative support for those two solutions in other States on a bipartisan basis the way that we been able to do it—we have not approached it the way that you are suggesting. But what we did in Texas was bipartisan. I mean—

Ms. SCHUMAN. Yes.

Mr. TAYLOR [continuing]. everybody voted for it. It was or pretty much everybody voted for it. So it was something that we can all agree on. And again, I want to solve this problem here.

Ms. SCHUMAN. Yes.

Mr. TAYLOR. At this level. So my question to you is that something that you have seen yes, there is a lot of bipartisan support for or did that get kind of caught up in a lot of partisan politics?

Ms. SCHUMAN. We are crafting solutions right here. We are looking at the problem. We are looking at States like Texas, California, no one has come up yet with a comprehensive solution that gets it right and gets it right for everyone and I think that is what this committee has an opportunity to do.

Mr. TAYLOR. Okay. And, Madam Chair, I will just reiterate, you know, I voted for every effort in Texas to try to address this issue because this is a real issue as you point out. I think we all know this is a real issue and I just want to entreat you as the chair of this subcommittee that you reach out and let's get something done on a bipartisan basis so that it can go through the Senate and be signed into law by the President and we can address some of this problem.

I know we are not going to probably get a perfect solution if it is a bipartisan solution unlike I am sure you could draft a perfect solution over on your side. But the problem is a perfect solution that doesn't go anywhere is of no help to the people that we are trying to help.

So I am with you and I look forward to working with you on this. With that I yield back.

Chairwoman WILSON. You got a deal. You have got a deal. All right. Thank you, Mr. Taylor. And now, Dr. Shalala.

Ms. SHALALA. Yes, thank you very much, Madam Chair. I have always been interested in building on when States have taken on an issue building on their experience and it looks to me like it is the payment standard and the dispute resolution standard that differ between the States.

Some of the other elements there seems to be consensus on, so it sounds like this committee has to focus on those two things. And I am with Mr. Taylor. If we can figure out how to get a compromise somehow but here is my question because you have been answering questions about individual States. Has there really been a decrease in the number of out-of-network bills since States have adapted, particularly the comprehensive States?

Have these—I haven't seen the answer to the question on whether it is actually worked, particularly in the comprehensive States. I think Texas is sort of a moderate, somewhere in between, but I am particularly interested in the comprehensive States.

My own State, Florida, which is for the most part represented by my colleagues on the other side, has had a comprehensive approach. California has had a comprehensive approach. So, could you talk a little about how effective these approaches have been?

Dr. HOADLEY. Yes, I can talk about that. It's a really good question. One of the challenges we have is that a lot of these have only been in effect a relatively short time and it is noteworthy that many of these solutions, I think really all of the States have done this in a very bipartisan way. And have brought together—and the ones that have been most successful is when they have really brought both parties and all the different stakeholders to the table.

Now there has been some look at the track in New York because it is one of the ones that has been in effect a few years now and I think we are finding, I have colleagues at Georgetown that are taking a closer look at sort of what's worked and what hasn't in New York and they'll have that report done soon.

But what I understand they're finding so far is a general degree of satisfaction. That stakeholders across the spectrum do think that things have worked out pretty well and there is some research evidence that there has been no particular inflationary effect coming out of the process they've used in New York and so that's an encouraging sign.

You know, Florida has had a different approach in for a few years and then they revised the approach just a couple of years ago. I have not heard any particular feedback yet from Florida on how well that's played out. California's is relatively new. New Jersey is quite new and so that's the—that's really the challenge in trying to learn the lessons.

But I think the overall impression at least qualitatively, when we interview stakeholders and insurance department officials and others that are involved in this is that they feel like the solutions they've had have been pretty successful and then they go back and make adjustments where they find gaps and maybe that's a little easier to do in a State legislative context than it is in Federal legis-

lation, but they have been able to go back in many of these States and make adjustment and try to improve their law.

Ms. SHALALA. But it sounds to me like we have to learn from the adjustments.

Dr. HOADLEY. Yes.

Ms. SHALALA. As we are crafting national legislation. I have one other quick question and that's about air ambulances. I live in Florida. Air ambulances are often out-of-network. And I think the GAO recently said that 69 percent of the air ambulances were out-of-network. Have any of you thought about that in particular? Yes, Ms. Young.

Ms. YOUNG. Yes. So, as you know, this is an acute problem in the air ambulance context for exactly the same reason it's a problem in the other areas of the market that we have been talking about.

Because there is no incentive for these providers to go in-network because when somebody needs an air ambulance, they're going to be picked up by a particular air ambulance and a patient just doesn't have a choice about the network status. So, the solution here is the same as we have been talking about for all other provider types.

You need to sort of create conditions that diminish the attractiveness of remaining out-of-network and encourage these folks to come in-network at a reasonable price or to otherwise sort of get paid an appropriate amount, so by setting a payment standard or otherwise establishing a mechanism by which these folks can get paid an appropriate amount.

The other complication with air ambulances which I think is important for this committee to consider is that States are generally preempted from regulating air ambulance conduct and so it's a place where in particular you need Federal activity. The one other thought that I think is important as we think about evaluating State solutions is and what States have done so far is not just whether or not the State law has decreased surprise bills or out-of-network bills but also what effect it has had on overall health care costs. Because you can have a law that sort of makes a lot of people happy by paying more money to these specialties and we also need to be considering the effect we are having on premiums and overall spending.

Ms. SHALALA. Thank you.

Chairwoman WILSON. Thank you, Ms. Young.

Ms. SHALALA. I yield back.

Chairwoman WILSON. Thank you, Dr. Shalala. Mr. Banks.

Mr. BANKS. Thank you, Madam Chair. Consolidation of the health care sector is something that we need to consider when looking at some of the high hospital costs faced by our constituents. A number of government policies discourage a thriving and competitive hospital market including lack of site neutral payments at the Federal level and certificate of need regulations at the State level.

While I agree that surprise billing is a problem that we need to address, it is important that we not pursue policies that encourage even more consolidation in the hospital market which countless studies have shown drives prices up to unaffordable levels.

Ms. Schuman, your testimony mentions bundled payments as a possible remedy for surprise billing. First, can you explain to the committee how bundled payments would look different from the system that we currently have?

Ms. SCHUMAN. Sure. You'd get one payment from the hospital for all of the services that were provided at that hospital. So instead of getting one bill from an—in-network facility and the anesthesiologist that was out-of-network and you get a different bill from their practice and the radiologist that did an MRI on you and they're out-of-network. You get a different bill from them. A balance bill by the way that oh, it was a surprise, you didn't know about.

The idea of a bundled service is its one stop shopping at an—in-network hospital, an in-network facility. So they make sure that when they contract with the plan you're contracting for a bundled of service, that continuum of care that the patient is going to receiving.

And I do think that there is some promise in looking at that and it certainly does bring hospitals into the equation and they're a necessary partner. But we do have to have some guardrails around there to make sure that doesn't further escalate and increase costs and just become a bundled payment of a much higher billed charges. And that it's also indeed a final payment, not a starting point.

Mr. BANKS. I have another question to followup with it you had a quick—

Mr. ISASI. I was just going to say, Congressman, it's such an important question you are asking which are the unintended consequences in trying to solve this problem. And this idea that by trying to get providers to coordinate and work in networks, you can create consolidation and then you can really damage competition and price goes up. And it's a very valid concern.

In this instance, however, we are dealing with these, what folks refer to as auto-referrals or inelastic demand where these providers' are—this isn't a situation in which you have two competitive providers who are operating. And then you are bringing them together and you're killing competition.

It's an instance where you have these providers who are protected from competition because they get these auto-referrals, right. And it could be because when I come in for a service in this facility the lab service goes here and there is no competition, right.

So, I think it is a really important question. We are doing a lot of thinking about that at Families. It's a central part of a focus of our work in the coming year, but in this instance, because you are in this auto-referral environment with inelastic demand, it's actually the opposite problem. These guys never compete because they can just count on this volume no matter what.

Mr. BANKS. And thank you for that. Let me move on really quick. Because Medicare pays hospital owned outpatient departments more than independent practices, hospitals have a strong incentive to purchase outpatient departments in clinics. Not only does this results in higher copays and out-of-pocket expenses for patients, it pushes overall costs higher through increased consolidation.

Ms. Schuman and Mrs. Young, or the other of you who want to weigh in on this too if we have time left, is it fair to worry that a bundled services model of payment could encourage even more vertical consolidation in the hospital market and further drive up costs just like the lack of site neutral payments? Ms. Young?

Ms. YOUNG. Sure, I can start. So I think that in this arena, these are already providers that are sort of by definition practicing in the hospital. Your anesthesiologists, your radiologists, they are already delivering the services in the context of a hospital inpatient stay or an emergency department visit. So, I think there is less reason to be worried about it in this context of others.

I would also add that these provider groups and hospitals typically have, already have sort of linked financial relationships so there is—you're not creating a new dynamic or a new set of incentives here.

Mr. BANKS. Ms. Schuman, I got 20 seconds left.

Ms. SCHUMAN. Yes, so I would just reiterate those same comments and want to do—and also the importance and advocacy for site neutral payment reform as a way to remove some of the disincentives to a lack of competition and consolidation. And as I said before, I think the bundled payment model could have some promise here but we need to include the appropriate guardrails.

Mr. BANKS. I wish I had my—

Chairwoman WILSON. Thank you.

Mr. BANKS [continuing]. more time for the rest of you but my time has expired.

Chairwoman WILSON. Thank you, Mr. Banks. Mr. Morelle.

Mr. MORELLE. Thank you, Madam Chair, for holding this very important hearing. I just want to note that during my time in the New York State Assembly tackling the issue of surprise billing was priority for me when I serve as chair of the insurance committee. And then as majority leader, I am very proud that our work culminated in the bipartisan passage of New York's groundbreaking out-of-network consumer protection law.

And I just want to take a moment or two to just describe what we did and then to get some feedback from the panel. This law took effect in 2015, so it has been on the books now for several years.

And the law created transparency and a simple system for resolving out-of-network medical bills which we believe makes life easier for every New Yorker that would otherwise be hit with costly bills that would devastate their families.

In addition—and this was really important to us as we were drafting—that the law did not in my view create a perverse incentive for people, providers to move out-of-network because they would get a benefit financially from doing so, and we avoided that.

In New York, hospitals, clinics, physicians, provide patients with public information regarding standard charges for medical services and insurance plan participation, and the law allows patients to be smart consumers of medical care, reducing the possibility of the first place of being hit with an out-of-network charge.

But even more importantly, the law provides a mechanism for providers and insurers to come together to resolve out-of-network charges without stress or additional costs to the patient.

In cases where patients received emergency services at an out-of-network facility, the patient is held harmless paying the same exact copay or deductible as they would as an in-network emergency department.

And even patients without insurance or those with non-State regulated health insurance are eligible to file a dispute for an emergency services bill so those self-insured and other plans covered by ERISA not regulated by the State.

In addition to surprise emergency room bills, New York patients are protected when a non-emergency provider sends them an unexpected bill and rather than being forced to cover out-of-network costs from their own pocket, patients do an assignment of benefit to their provider who then has to negotiate a reimbursement amount with their health plan. So again, the consumer is taken out of it.

In the rare cases that negotiation is unsuccessful, an independent arbitrator is able to make the determination to set a reimbursement rate within 30 days.

I think it says a lot that in most cases arbitration is not necessary. I heard yesterday, and I have got to verify this, but roughly 800 arbitrations out of 7 million claims information. Instead insurers and providers can reach an acceptable deal without the consumer having to pay any—devote any more time, money or any more headaches.

The law has helped settle about 2,000 billing disputes and protecting those New Yorkers from potential harmful medical debt.

To my colleague, Ms. Shalala, I just want to note my data shows that out-of-network bills in New York has declined 34 percent since the law took effect in January or I think January 2015.

In addition, prices charged by in-network emergency room doctors have dropped by 9 percent. So, it is rare but in New York and I have talked within the last several days in advance of this hearing to insurance plans, consumers, and health care providers and they all agree that the system has changed for the better and frankly there is not much that those three groups necessarily agree on.

So to any of our panelists and I apologize, that was sort of a long intro to this, but I would be curious as to your observation of New York's law which has been in place now three plus years and whether or not there are things that New York has done that could be done better in your view and what barriers there would be to putting those protections at the Federal level? And I would ask each of you to quickly just—

Ms. YOUNG. So, I'll be quick. I think the strengths of the New York law are that it is very comprehensive and it's clear to stakeholders what the process looks like.

The potential reason for concern is that I think that because the New York law gives guidance to arbiters that's based on charges for services, it has the potential to be inflationary over time. It is a concern that a lot of observers have about how the New York law may evolve and I would encourage folks to think carefully about that.

Mr. MORELLE. And the direction we use is that 80 percent of the usual and customary charge is determined by the Fair Health Plan.

Ms. YOUNG. Right. So, it is 80 percent of charges. The problem with charges is they're not market-determined. So, it's a bit like saying sort of, you know, the 80th percentile of your wish list to Santa. Over time there is no constraint on what you ask Santa for, so it can be inflationary over time in ways that we should think carefully about.

Mr. MORELLE. Got you. Any others?

Ms. SCHUMAN. Yes, I want to just raise that same sentiment and the concern that an arbitration model that in any way uses a reference to billed charges is just going to billed in those same perverse incentives that we're trying to address.

Mr. MORELLE. I do note—

Chairwoman WILSON. Thank you.

Mr. MORELLE [continuing]. the end response.

Chairwoman WILSON. Thank you.

Mr. MORELLE. I'm sorry. Let me just do this, Madam Chair. I would ask unanimous consent to submit the following letter from the Heath Association of New York State which highlights the success of comprehensive legislation in New York to eliminate surprise billings and the benefits it's created for New Yorkers.

Chairwoman WILSON. Without objection.

Mr. MORELLE. Thank you.

Chairwoman WILSON. Thank you so much, Mr. Morelle. Mr. Watkins.

Mr. WATKINS. Thank you, Madam Chairwoman. Nobody likes going home, opening the envelope and finding a surprise medical bill. Lack of network and cost transparency seems to be a problem. As Congress members, where should we start looking to find a solution to this? Are there State law or State law models that we could adapt at the national level? Ms. Schuman?

Ms. SCHUMAN. Sure. Sure, happy to talk about that. and I think your—we can look to the State models as examples. As we talked about before, they have limited application in the sense that they don't include ERISA plans so that's a large swath of people that aren't going to be protected by State laws.

So and also some of them are rather new. So we don't really know what their application over time is and just the discussion we were just having for example with respect to New York and the arbitration model there, I think we can, we need to guard against any sort of structure in an arbitration model that would use billed rates as direction to the arbitrator. Because that would I think just fuel and further incentivize out-of-network providers to stay out-of-network and raise their bill charges.

So we have got certainly lessons that we look to the States but recognizing again that to get at the problem and its root and in a uniform matter we need Congress to act.

Mr. WATKINS. Thank you, Ms. Schuman. Mrs. Chairwoman, I yield my time.

Chairwoman WILSON. Ms. Trahan.

Ms. TRAHAN. Thank you, Madam Chairwoman. Thank you all for your testimony today, it has been very helpful.

My father was an ironworker before he was diagnosed with multiple sclerosis. MS as you all know is an unpredictable and disabling disease of the central nervous system. And for those living with a chronic and progressive disease like MS, surprise billing adds undue stress and financial uncertainty.

For instance, an individual living with MS might go to an in work facility—an in-network facility but be seen by an out-of-network neurologist.

So, Ms. Young, we all have heard stories from family members and from our constituents who have received surprise medical bills even after carefully researching their provider networks. How can we best protect these individuals who suffer from chronic diseases like MS from surprise medical bills in all settings of care, including those non-emergency situations?

Ms. YOUNG. Thanks for that question. So, there are two key principles in designing a solution. The first is to take patients out of the middle as we have talked about. It's essential that patients not be responsible for these balance bills and not have the burden placed on them to navigate the system.

And the second principle in designing a solution is to create a system that doesn't drive up overall health care spending. And with the group of scholars at the Brookings Institution, we have recommended two potential policy solutions.

One we call billing regulation. It's something that we have talked a lot about this morning where we would use policy to set a cap on what providers can get paid out-of-network. Again, our goal here isn't to determine the ultimately correct commercial payment rate, it's just to end the lucrative out-of-network billing option and instead restore sort of a more normal set of market incentives for these folks. So that's one option.

And that's what we see in all States or the vast majority of States that have tackled this problem. They use a model that looks like that.

The other potential approach is something that we have called contracting regulation, you have heard from others under the name of bundling but the idea is simply to get this group of providers out-of-the business of billing patients directly at all. That's a big step, it's a big change from the way these services are billed today but it does have analogs in other parts of our health care system. It is how nurses and nursing services are paid and billed today. So, I think it is an area worthy of exploration.

Ms. TRAHAN. Great, thank you. Thank you for that. Mr. Isasi, I—the workplace is a single, is the single largest source of health coverage in the United States. According to the Kaiser Family Foundation about 152 million Americans, which is about half of our non-elderly population, are enrolled in employer-sponsor health insurance.

So, I think it is critical for us to highlight how surprise billing impacts employer-sponsored insurance specifically. How common are surprise bills among enrollees in employer-sponsored plans?

Mr. ISASI. Yes. Well, what we know is the research is very clear. They are as common in employer-sponsored coverage as they are in insured or individual plans. There is no difference. It happens just as often.

Ms. TRAHAN. So same—no difference between individual and group market?

Mr. ISASI. Exactly. Exactly.

Ms. TRAHAN. How should the committee proceed then in order to fully protect workers in terms—from your view?

Mr. ISASI. Yes. Well, I think the principles we are hearing, there's such broad agreement on the panel and amongst all the members. This is really clear. As we talked about earlier, this is a situation in which the tail is wagging the dog, right.

When you enroll in health insurance and your hospital says this is our network, you get to go to that hospital and get services and be in-network. Right. You don't get to be surprised because your hospital decided, you know what, we are not going to negotiate with the ER docs, they will be out-of-network. Or we are not going to negotiate for laboratory services, right.

So, this principle that the entity that should bear the risk of building the network and paying for it and making sure those services are part of the contract is the hospital, the payer and the provider. Not the consumer. So, the consumer is taken out-of-the equation is a really important one.

The second one is the idea that transparency is not nearly enough. We all know this, we know this from our experience, we know this from the research that the health care sector cannot provide real, actual information to consumers at point of service about what their network looks like, what their costs are. There is lots and lots of data about this.

And so you can't put the onus on the consumer to just simply figure out what the price is or whether or not they are in-network.

I think the third is this idea that patients—this is not just about emergency services. Right. It's about ancillary services that can occur without your even knowing. So, if you go get surgery, your surgeon is in-network, your hospital is in-network, but your anesthesiologist is not. That can't happen either.

Ms. TRAHAN. Well, great.

Chairwoman WILSON. Thank you.

Ms. TRAHAN. Thank you so much. I yield back.

Chairwoman WILSON. Thank you, ma'am. There are no more members here. Anyone else—questions? Wow. Okay.

I want to remind my colleagues that pursuant to committee practice, materials for submission for the hearing record must be submitted to the committee clerk within 14 days following the last day of the hearing. Preferably in Microsoft Word format.

The materials submitted must address the subject matter of the hearing. Only a member of the committee or an invited witness may submit materials for inclusion in the hearing record. Documents are limited to 50 pages each. Documents longer than 50 pages will be incorporated into the record via an internet link that you must provide to the committee clerk within the required timeframe. But please recognize that years from now that link may no longer work.

Again, I want to thank the witnesses for their participation today. Thank you so, so much. This was fabulous. What we have heard is very valuable.

Members of the committee may have some additional questions for you and we ask the witnesses to please respond to those questions in writing. The hearing record will be held open for 14 days in order to receive those response. And I will guarantee you, you will have lots of questions. Everyone seemed to have run out of time.

I remind my colleagues that pursuant to committee practice, witness questions for the hearing record must be submitted to the majority committee staff or committee clerk within 7 days. The questions submitted must address the subject matter of the hearing.

I am now going to ask the ranking member, our distinguished Mr. Walberg for his closing statement.

Mr. WALBERG. Thank you, Madam Chairwoman, and thank you for leading this hearing today. It is something that I think a lot of us have looked forward to as we have begun to hear more and more of the problem and it is not just my situation. Or yours. It's running rampant at this point in time.

It's impacting our employees, its impacting our employers. It's impacting our health care providers, our insurance industry.

But I think what came out today to me most importantly was that No. 1 concern we need to address and I think in unanimity here on this panel as well. We believe it is the patient. The patient who has the need at the moment, seeking the care from probably the best health care opportunity in the world, and yet some of the highest costs that continue to be there because a system is literally confused if not broken. And so as I have listened today, Madam Chairwoman, I think we can come to an agreement and I think the fact that we have people here on this panel, this committee, who have done yeoman effort in their own States to come up with solutions, I think we have had a head start in understanding some of the pitfalls we can stay away from.

Some of the benefits we can go directly toward and ultimately a solution that will indeed be a compromise, but a compromise that is a long way ahead of where it could have been had we not had the expertise or the experience involved.

In the end, with a society that is not only intent on having health care available, and we do our effort, our research to find our physician that is in-network, our hospital that is in-network and we think we have it all done for ourselves. We need to make sure that is the case.

But I think also let's not forget the fact that we are a mobile society. We travel all over. And one of my passions, indeed maybe my only advice—only vice that I will admit to, other than fly fishing is motorcycling.

When I travel around the country on my motorcycle, if something perchance would happen, I want to make sure I am taken to a hospital, hopefully not by a helicopter but hopefully not by even an ambulance, but if I am, that I am cared for.

And ultimately in this great country, I am not put into a situation that's financially impossible as a result of taking the care that is good care but in a place that happens to be out-of-network.

So I am, I commit myself for working with you, Madam Chairwoman, and appreciate your efforts on this behalf and hopefully we will come to a conclusion sooner rather than later. I yield back.

Chairwoman WILSON. Thank you, Mr. Walberg. We are going to work toward that goal together. Yes. Okay. I now recognize myself for the purpose of making my closing statement.

Again and again I would like to thank the witnesses for providing their testimony today. This has been fabulous. This hearing is the first step in what I hope can be a bipartisan conversation as we work to develop a solution to the challenge of surprise medical billing.

As the committee of jurisdiction over employer-sponsored health coverage, we have a crucial role to play in developing comprehensive legislation to address this problem. Our witnesses' testimony will prove invaluable as we move forward. We heard from Ms. Young about the prevalence and impact of surprise bills as well as some potential ideas for solutions to this problem.

We heard from Ms. Schuman about the perspective of large employers regarding surprise bills.

We heard from Mr. Isasi about the devastating impact these bills have on consumers, as well as some key principles that should guide us as we look forward toward reform.

And we heard from Dr. Hoadley about the innovative solutions that States have taken to protect consumers from surprise bills.

As our witnesses have made it clear, it is up to Congress to move forward to comprehensively address this issue on behalf of our constituents.

I look forward to continuing this process in the weeks and months ahead.

I thank my colleagues for an informative and productive discussion, and I yield back my time.

If there is no further business, without objection, the committee stands adjourned. Thank you.

[Additional submissions by Mrs. Foxx follow:]



Statement for the Record

of the

American Medical Association

for the record

U.S. House of Representatives Committee on Education and Labor
Subcommittee on Health, Employment, Labor and Pensions

Re: Examining Surprise Billing: Protecting Patients from Financial Pain

April 2, 2019

Division of Legislative Counsel
(202) 789-7426

STATEMENT

of the

American Medical Association

to the

U.S. House of Representatives Committee on Education and Labor
Subcommittee on Health, Employment, Labor and Pensions

Re: Examining Surprise Billing: Protecting Patients from Financial Pain

April 2, 2019

The American Medical Association (AMA) appreciates the opportunity to present our views to the U.S. House of Representatives Committee on Education and Labor, Subcommittee on Health, Employment, Labor and Pensions concerning unanticipated medical bills. As health insurance plans increasingly rely on narrow and often inadequate networks of contracted physicians, hospitals and pharmacies to control costs, even patients who are diligent about seeking care from in-network physicians may face unanticipated medical bills from out-of-network providers that participate in their care. Physicians are limited in their ability to help patients avoid these unanticipated costs because like patients, they may not know in advance who will be involved in an episode of care, let alone other providers' contract status with all the insurance plans in their communities. Health insurers must be incentivized to negotiate fair contracts with physicians to ensure that networks are sufficiently robust.

The problem of unanticipated out-of-network bills is complex and requires a balanced approach to resolve. The AMA agrees that any solution must keep patients out of the middle of payment rate negotiations and ensure that when patients seek emergency care or otherwise do not have the opportunity to select their provider, they should not be responsible for cost sharing beyond what they would face if they had seen an in-network provider. Any proposed solutions should also require both providers and insurers to be transparent about anticipated charges and the amount of those charges that insurance will cover. We also agree that if balance billing is banned, there must be a process in place to ensure that providers receive fair reimbursement for their services.

The AMA encourages Congress to look to states that have already acted to address unanticipated medical bills, specifically those state laws that have functioned well such as New York and Connecticut. The AMA is committed to working with Congress to find a workable solution for all stakeholders that protects patients from unanticipated out-of-network bills.

Key Principles in Addressing Unanticipated Medical Bills

There are several key principles that must be a part of any solution proposed to address unanticipated out-of-network medical bills. First, oversight and enforcement of network adequacy is needed. Robust network adequacy standards include, but are not limited to, an adequate

ratio of emergency physicians, hospital-based physicians, and on-call specialists and subspecialists to patients, as well as geographic and driving distance standards and maximum wait times. Provider directories must also be accurate and updated regularly to be useful to patients seeking care from in-network providers. In addition, insurers should be held to complying with the prudent layperson standard in existing law for determining coverage for emergency care, so that insured patients are not liable for unexpected costs simply because they were unable to accurately self-diagnose ahead of time whether their symptoms were, in fact, due to an emergency medical condition.

Any solution to address unanticipated medical bills must also require transparency so that all patients who choose in advance to obtain scheduled care from out-of-network physicians, hospitals or other providers are informed prior to receiving care about their anticipated out-of-pocket costs. When scheduling services for patients, providers should be transparent about their own anticipated charges, and insurers should be transparent about the amount of those charges they will cover.

In general, the AMA urges Congress to avoid any solutions that arbitrarily cap payment for physicians treating out-of-network patients. If pursued, guidelines on what out-of-network providers are paid should reflect actual charge data for the same service in the same geographic area and should not be based on a percentage of Medicare rates, which have become increasingly inadequate in covering overhead costs or be based on in-network rates, as either standard would eliminate the need for insurers to negotiate contracts in good faith.

The AMA could support a legislative solution that provides for a mediation or sequential alternative dispute resolution (ADR) process for those circumstances where the minimum payment standard is insufficient due to factors such as the complexity of the patient's medical condition, the special expertise required, comorbidities, and other extraordinary factors. Arbiters should not be required to consult in-network or Medicare rates when making final determinations regarding appropriate reimbursements.

Finally, as noted previously, the AMA strongly supports solutions that keep patients out of the middle of payment rate negotiations. Patients should only be responsible for in-network cost-sharing amounts when experiencing unanticipated medical bills.

Successful State Models

Many states have acted to address unanticipated out-of-network billing and there are several existing state models that have worked well to protect patients from surprise medical billing. The AMA points to New York's balance billing law as a well-functioning model for several reasons including:

- The law protects patients from unanticipated out-of-network bills.
- The law emphasizes the role of network adequacy in solving the "surprise" billing problem and puts in place new requirements to regulate networks and affords patients the right to an independent external appeal to be treated by a non-network provider if the network is inadequate.
- The law establishes a strong independent dispute resolution (IDR) process made by a reviewer with training and experience in health care billing, reimbursement, and usual and customary charges in consultation with a licensed physician in active practice in the same or similar specialty as the physician providing the service that is the subject of the dispute.

- The IDR process requires consideration of factors, including the rate that non-participating physicians charge for the service in the area based on independent data, usual and customary charge for the service based on independent data, the complexity of the case, and the physician's experience, training and education.
- There are no data that we know of that suggest that the law has resulted in either premium increases or a dramatic narrowing of networks.

The AMA also views the Connecticut law on unanticipated out-of-network care for emergency services as a potential model for all unanticipated out-of-network care situations because:

- The law protects patients from unanticipated out-of-network bills for care received at an in-network hospital.
- The law creates a solution by establishing a payment standard that incorporates charge data from an independent data source.
- There is no evidence that we know of that suggest law has resulted in premium increases, dramatic narrowing of networks, or higher rates of out-of-network physicians.

Facilitating In-Network Contracting

It is important to recognize that most physicians want to be included in payers' networks, if fair contracts are offered. However many physicians are in a weak bargaining position relative to commercial health insurers. Therefore, Congress must incentivize insurers to come to the negotiating table with physicians and offer fair contracts. The most promising way for policymakers to facilitate contracting between providers and health plans is to ensure regulation of provider networks. Strong network adequacy requirements create a more balanced environment for all stakeholders where: insurers are incented to maintain meaningful access to in-network providers by offering providers competitive contracts; providers are incented to come to the table knowing that it will be a fairer process; and patients will have access to in-network care and get greater value for their premiums paid.

While there has been a great deal of discussion about the growth of narrower provider networks, relatively little has been done to create or enforce network adequacy requirements, especially as they relate to hospital-based providers. Ensuring that, at a minimum, in-network providers are available at in-network hospitals should be the first step for legislators and regulators in addressing unanticipated out-of-network care at in-network hospitals. Moreover, ensuring that patients have appropriate access to primary and specialty care will go a long way in preventing emergency department visits and other hospitalizations that may lead to unanticipated out-of-network bills.

The basis of network adequacy standards should be quantitative, measurable requirements on the front-end, before insurance products are brought to market. The quantitative standards should include minimum time and distance requirements, maximum patients-to-provider ratios, and maximum wait times. In addition, and specific for hospital-based specialties, it is critical that standards also measure access to in-network physicians at in-network hospitals.

Meaningful regulation of provider networks must also be ongoing. Consistent monitoring of the network's ability to provide in-network hospital-based care is particularly important, given that patients may not evaluate access to these providers simply through a directory or other tool, as is normally the case when choosing a provider.

Finally, it is important to recognize the connection between accurate provider directories and meaningful access to in-network providers for patients. The AMA encourages greater oversight of provider directories and stronger requirements that they be transparent and up-to-date. Patients need access to robust, up-to-date provider directories to enable them to determine which providers are in-network as they purchase their plans, and which providers continue to be in-network as their medical needs change. Additionally, providers need accurate information from health plans to allow for in-network referrals when further treatment is needed.

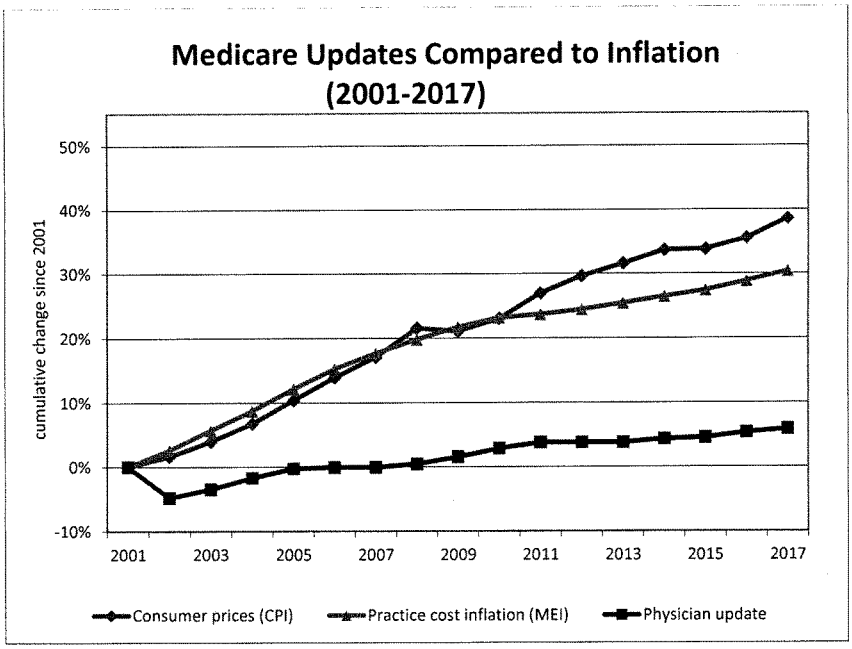
Payment Standards

As AMA has repeatedly pointed out, Medicare payment rates do not reflect the costs of providing care, especially in the commercial market where the population varies greatly. Medicare uses the resource-based relative value scale (RBRVS) system to establish physician payments, determined by the resource costs associated with the total amount of physician resources required to provide a specific service. However, before Medicare rates are finalized, they go through adjustment and conversion processes to meet federal budgetary requirements. Adjustments are done in a budget neutral manner, meaning that if an adjustment increases the payment for one service, it must account for this increase by decreasing payment in another. This establishes artificial decreases in payment for many physician services ever year. And before the final Medicare payment is set, geographically adjusted values are multiplied by a conversion factor - a monetary payment determined by Medicare each year that changes based on the Medicare economic index, adjustments pertaining to budget neutrality and other adjustments stipulated by legislation. After everything is complete, the resulting payment rates are not reflective of markets rates for physician services.

As illustrated by the chart below, Medicare physician payments have not kept up with inflation over the past decade. According to data from the Medicare Trustees, Medicare physician payment rates have barely changed over the last decade and a half, increasing just six percent from 2001 to 2017, or just 0.4 percent per year on average. And, under the Medicare Access and CHIP Reauthorization Act (MACRA), physician payment rates will be frozen for calendars years 2020 through 2025.

In comparison:

- The cost of running a medical practice has increased 30 percent between 2001 and 2017, or 1.7 percent per year. Inflation in the cost of running a medical practice, including increases in physician office rent, employee wages, and professional liability insurance premiums, is measured by the Medicare Economic Index, or MEI.
- Economy-wide inflation, as measured by the Consumer Price Index, has increased 39 percent over this time period (or 2.1 percent per year, on average).



Sources: Federal Register, Medicare Trustees' Reports and U.S. Bureau of Labor Statistics

Over time, the adequacy of Medicare physician payment rates has eroded significantly. Adjusted for inflation in practice costs, Medicare physician payment rates have declined 19 percent from 2001 to 2017, or by 1.3 percent per year on average. As such, the AMA opposes efforts to cap or benchmark out-of-network physician payments on a percentage of Medicare. Linking out-of-network rates to Medicare would eliminate any incentive for insurers to build adequate networks or offer physicians fair contracts.

Thank you for the opportunity to offer our input. We look forward to working with you and your colleagues to help determine the best way to protect patients from costly surprise medical bills.



Statement for Hearing on

"Examining Surprise Billing: Protecting Patients from Financial Pain"

Submitted to the
House Education and Labor Committee
Subcommittee on Health, Employment, Labor, and Pensions

April 2, 2019

America's Health Insurance Plans (AHIP) and our members are committed to finding solutions to alleviate the financial burdens imposed on patients by surprise medical bills. Everyone in America deserves affordable, high-quality coverage and care, and control over their health care choices. Surprise medical bills undermine these values, putting the health and financial stability of millions of patients at risk every year.

Surprise medical bills are a major national problem affecting at least one in five Americans annually. These bills—for unjustifiably high prices for medical treatment—create tremendous financial burdens for families and can even lead to bankruptcy. In addition, the inflated prices typically lead to health insurance providers and employers paying far more than negotiated rates for care, which increases premiums for everyone. Federal legislation is needed to end this practice and protect patients, particularly for the more than 100 million Americans who have coverage through an ERISA plan not covered by state reform efforts.

Our statement focuses on the following:

- Why people receive surprise medical bills and how this impacts hardworking Americans;

America's Health Insurance Plans (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 affordability, value, access, and well-being for consumers.

- Principles and legislative recommendations for protecting patients from surprise medical bills; and

- The importance of developing and maintaining strong provider networks to achieve lower costs and high quality care for patients.

Surprise Medical Bills Harm Americans

When consumers are enrolled in health care coverage and receive services through their plan's provider network, the health insurance provider typically covers the cost of medical care beyond the required copayment, coinsurance, or deductible. 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. This can be particularly challenging for patients who go to a hospital that is in their health plan's provider network, but see a doctor at that hospital who is not in the network.

When it comes to paying for services in a hospital, patients often don't realize that many physicians are independent contractors who work *at* the hospital, but not *for* the hospital. That means that hospitals can have "in network" status as part of a health plan's provider network, but the doctors delivering care to patients at the hospital might not.

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. But those charges become truly problematic for patients when out-of-network providers—who are not bound by contractual, in-network rate agreements with an insurance provider—bill patients for the entire remaining balance.

Surprise medical bills mean that patients are often burdened with thousands of dollars of costs—or even tens of thousands of dollars—for the care they received in an emergency room or at the hospital, often without even knowing the doctor who treated them. This can be financially devastating for most American families. Forty percent of American families cannot afford an unexpected $400 expense.[2]

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[2] Board of Governors of the Federal Reserve System. (May 2018). "Report on the Economic Well-Being of U.S. Households in 2017"

The problem of surprise medical bills tends to be concentrated among certain medical specialties where providers are likely to charge substantially more than their peers in other specialties and not accept private insurance. 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]

Research also shows that 14 percent of all patients treated in an emergency room were likely to receive a surprise medical bill in 2014, as well as 9 percent of all admitted hospital patients.[4] The figure more than doubles to 20 percent for hospital inpatient admissions that originated in the emergency room. In addition, 51 percent of ambulance rides nationwide were likely to result in a surprise bill in 2014.[5]

There is substantial geographic variance in the likelihood of receiving a surprise medical bill, largely because specialists and emergency rooms in some parts of the country are noticeably less likely to accept private insurance. In these instances, the market power obtained through aggressive provider consolidation prevents contractual network agreements. For example, patients treated in McAllen, Texas and St. Petersburg, Florida had an 89 percent and 62 percent chance, respectively, of receiving surprise medical bills. In Boulder, Colorado and South Bend, Indiana, researchers found the rate of surprise bills to be nearly zero.[6]

Finally, even for those who never receive a surprise medical bill, this practice translates into higher premiums. A 2015 analysis of out-of-network charges in New Jersey highlights the

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[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

[4] Garmon, C., & Chartock, B. (2017). One In Five Inpatient Emergency Department Cases May Lead To Surprise Bills. Health Affairs, 36(1), 177-181. _jun_lucia_balance_billing_ib.pdf

[5] Garmon and Chartock (2017)

[6] Cooper and Morton (2016)

impact of these charges on consumer premiums.[7] For the largest health insurance provider in the state, out-of-network claims comprised 8 percent of their total commercial spending in 2013. If the insurer had paid these out-of-network claims at 150 percent of Medicare rates, rather than the billed charges, the insurer would have paid 52 percent less for out-of-network services, amounting to savings of $497 million, which could result in a reduction of 4.3 percent in total commercial claims and consumers paying 9.5 percent less out-of-pocket.

The bottom line is that surprise medical bills create financial hardship for millions of Americans, and legislative action is needed to address this problem.

Patients Should Be Protected From Surprise Medical Bills

Health insurance providers act as the consumers' advocate and bargaining power, ensuring that they have affordable choices for coverage so they can get the care they need. We believe every American deserves affordable, high-quality coverage and care, as well as control over their own health care choices.

In December 2018, AHIP joined other leading organizations representing consumers, businesses, and health insurance providers, voicing our support of a set of core, guiding principles to protect patients from receiving surprise medical bills after getting the care they need.[8]

By signing onto these guiding principles, we agree that:

- **Patients Should Be Protected from Surprise Medical Bills Through Federal Legislation.** We support federal legislative action to end surprise medical bills.

- **Patients Should Be Informed When Care Is Out of Network.** Patients have a right to know about the costs of their treatment and options.

- **Federal Policy Should Protect Consumers from Surprise Medical Bills While Restraining Costs and Ensuring Quality Networks.** Putting patients first means enacting

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[7] 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

[8] https://www.ahip.org/wp-content/uploads/Surprise-Billing-Consensus-Statement-12.10.18.pdf

policies that protect consumers from surprise medical bills, while ensuring that those policies do not simultaneously increase premiums or other costs for consumers.

- **Payments to Out-of-Network Doctors Should be Based on a Federal Standard.** More than 100 million Americans are enrolled in a self-funded health plan. Protecting them requires a federal standard that reduces complexity while ensuring they cannot be surprise-billed for emergency or involuntary care.

We also recently joined 16 other organizations representing employees, large and small businesses, health insurance providers, and brokers in sending a letter to congressional leaders, calling for meaningful steps to address surprise medical bills.[9] Our letter urged Congress to "take action this year to pass legislation that will protect patients from surprise medical bills and rein in out-of-control health care costs."

Building on the principles we endorsed and our work with other health care leaders, AHIP is advocating for federal legislation that would protect patients from egregious out-of-network surprise medical bills. We have four recommendations for legislative action on this issue.

First, hospitals and other health care providers should be prohibited from sending a surprise medical bill for: (1) emergency health care services provided at any hospital; (2) ambulatory transportation (either ground or air) to any health care facility in an emergency; or (3) any involuntary health care services or treatment performed at an in-network facility by a non-participating (out-of-network) provider. In situations involving emergency or involuntary care, patient cost-sharing should be limited to the amount that would apply if the patient had been treated by a participating network provider.

Second, hospitals and other health care providers should be required to provide an advance notice to patients, which informs them of their providers' network status and possible options for seeking care from a different provider. Patients have a right to know about the costs of their treatment and options. They should receive complete information about whether facilities or providers do not participate in their health plan and what that could mean for their financial obligations. 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.

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[9] https://www.ahip.org/wp-content/uploads/Hill-Sign-on-Letter-Surprise-Medical-Bills-031819-2.pdf

Third, in situations involving emergency or involuntary care, criteria should be established—based on market rates determined by reasonable, contracted amounts paid by private health insurance providers or Medicare—to determine the reimbursement paid to non-participating health care providers. Without reasonable reimbursement criteria, arbitrary and excessive payments to out-of-network providers will continue to increase premiums for everyone and undermine both health plans' provider networks and care coordination—leading to higher costs and decreased value for patients. In setting reimbursement criteria, Congress should take an approach that does not lead to increased health costs for either individual consumers or the overall health care system.

Fourth, these protections should apply nationwide to all self-funded plans governed by the Employee Retirement Income Security Act (ERISA) with the option for states to establish standards for reimbursement through enacted legislation. While states have taken varying approaches to addressing surprise medical bills, they lack the authority to protect the more than 100 million Americans enrolled in employer-provided coverage that is self-funded by their employer and regulated under ERISA (which specifically precludes states from regulating these plans). For this reason, federal legislation is necessary. ERISA has been amended in the past to require mental health parity, establish out-of-network emergency room payment amounts, cover clinical trials, and prohibit annual and lifetime dollar caps. However, we recognize that ending surprise billing would place new requirements on health plans, hospitals, and health care providers.

Improving Affordability by Reining in Out-of-Network Costs

Egregious surprise medical bills are not only a financial burden on the patients billed, but a cost-driver for the entire health care system. Certain provider groups recognize they have market leverage heavily weighted in their favor and therefore are empowered to bill in amounts that do not reflect the actual costs of care or good faith negotiations. These bills are a key part of the reason health costs are so high – the prices demanded by certain physicians inflate costs for everyone. The prices are too high, and not based on any market force.

Benchmarking rates to market-based negotiations will help address these high prices. We noted above the detailed inflation for certain specialty providers compared to other provider groups and the amounts reimbursed by Medicare. Researchers from the University of Southern California and the Brookings Institution note that "ED and ancillary physicians, as well as hospitalists,

neonatologists, and ambulance companies…have a potentially lucrative out-of-network billing option that is unavailable to most providers. The amount charged to out-of-network patients face few market constraints…"[10] Given the lack of a free market and a clear leverage imbalance, the problem will not be fully solved without addressing the root cause. Doing so will help reduce costs for all, if properly regulated through a payment benchmark that drives rates to result from negotiations between payors and providers.

With a level-playing field, out-of-network billing becomes less lucrative and consumers will pay less. It is worth noting that requiring out-of-network bills to be reimbursed based on negotiated in-network rates brings the rates back to a place where they are set by the market, rather than one-sided demand. Health insurance providers and doctors routinely negotiate rates based on the cost of care, demand for services, expertise of the provider, and other factors that ensure fair compensation at costs that reflect competitive market realities. This process gives leverage to both the health care provider and the payor, resulting in a rate set not by the health insurance provider, but rather mutually agreed upon by both parties.

Some proposals would rely not on negotiated rates, but on billed charges. Reimbursements based on billed charges do not address the root cause of surprise medical bills and will not meaningfully reduce health care costs. Indeed, researchers reached the same conclusion, finding that "basing an out-of-network charge limit on billed charges would likely lead to too high a limit and drive up health costs and insurance premiums. Charges (or list prices) face little constraint from market forces and tend to be extremely high relative to objectively reasonable prices."[11] These proposals include those that create an independent dispute resolution process, such as "baseball style" arbitration, that gives billed charges equal consideration as negotiated rates. When the process relies on inflated charges to begin with, the end result will similarly be inflated payments.

The problem of highly inflated billed charges is one that has increased exponentially in recent years and driven not by greed on the part of doctors who are focused on practicing medicine, but rather by for-profit staffing firms that have driven provider consolidation and raised prices as the central component of their business strategy. Researchers at the American Enterprise Institute (AEI) looked into this and reached a similar conclusion as Brookings researchers: that provider

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[10] Adler, L., Fieldler, M. et. al., (February 2019) *State Approaches to Mitigating Surprise Out-of-Network Billing.* USC-Brookings Schaffer Initiative for Health Policy White Paper: https://www.brookings.edu/wp-content/uploads/2019/02/Adler_et-al_State-Approaches-to-Mitigating-Surprise-Billing-2019.pdf

[11] *Id.*

consolidation and staffing companies' profit strategies have escalated this problem. Indeed, that is why AEI notes that "surprise out-of-network billing does not appear to be a problem for most hospitals" but rather where provider consolidation has made high out-of-network bills an attractive business strategy, finding that "some providers actively take advantage of this fact."[12] AEI singled out one of the largest physician staffing companies in the U.S., EmCare, and pointed to research finding that "EmCare raises list prices by 96 percent on average, which dramatically increases the size of potential balance bills."[13] The same researchers found that "at many facilities, 100 percent of ED patients receive an out-of-network physician bill from their otherwise in-network ED when EmCare enters." When providers consolidate and going out-of-network becomes the business model, patients suffer financially and we all pay more.

By requiring providers to accept market-based benchmark rates rather than continuing to allow their staffing firms to derive profit from inflated charges, we can address the problem of surprise medical bills at the source and rein in health care costs that increase premiums for everyone.

Health Plans' Provider Networks Drive Affordability and Access

Health plans' provider networks are an essential part of health care coverage. They help ensure that enrollees have access to the best doctors and health care settings, and that these providers are held accountable to high standards for care quality at reasonable, market-driven rates.

Health insurance providers rely on networks to ensure patients have access to the care they need from doctors they choose and trust. They negotiate payment rates that fairly and reasonably compensate providers for their services and expertise, increasingly with models that reward doctors for delivering higher value care at lower costs. As a result, when doctors and hospitals join a network, patients have greater confidence that they will be protected from high costs when they get sick or injured, particularly in emergency situations.

Many, if not most, health insurance providers cover a portion of the costs for services performed by an out-of-network provider. However, because out-of-network providers are not in a contractual agreement with the health insurance provider, there is nothing to stop the provider

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[12] Hyman, D. and Ippolito, B. (March 2019) *Solving Surprise Medical Billing.* American Enterprise Institute: https://www.aei.org/wp-content/uploads/2019/03/Solving-Surprise-Medical-Billing.pdf
[13] *Id.*

from sending bills to patients when a plan does not pay the full amount they charge. Our legislative recommendations directly address this concern.

Health plans' provider networks also help to ensure that consumers have access to high-quality and effective care. Health insurance providers evaluate doctors and hospitals for quality and safety performance before including them in a network. This involves ensuring that facilities and providers meet patient safety goals and credentialing standards.

In fact, performance on quality measures is a key part of the criteria used by health insurance providers when selecting and including providers in their networks—including high-value network plans. In developing their networks, health insurance providers also make sure they have the variety of primary care doctors, specialists, hospitals, and other providers that consumers need and can access in a variety of locations. Health insurance providers periodically reevaluate the qualifications of the health care providers and their performance within their networks to make sure the consumers' needs are met.

Developing strong provider networks that ensure patients have access to the care they need from providers they choose is not only a top priority for health insurance providers, it's also the law. Most health insurance providers are required by law to meet either federal or state standards for network adequacy; many state standards are based on the National Association of Insurance Commissioners' Managed Care Plan Network Adequacy Model Act. Although the standards vary between different states, they reflect the common theme that plans must provide options that minimize the distance a patient would have to travel for care. In other words, the law requires that private health plans have robust provider networks and also requires regular verification of their continued compliance.

Health insurance providers have incentives to work closely with doctors and hospitals. Similarly, doctors and hospitals have incentives to contract with health insurance providers. We know that health plans, providers, and hospitals are committed to promoting the best outcomes for patients, and quality provider networks are an essential part of this. Federal legislation should create a market environment where payors and providers can continue to actively collaborate on offering affordable, high quality care that puts patients first. Legislation should not just end balance billing and turn over out-of-network claims to an arbitration process. This would increase costs and not provide needed certainty for consumers.

Our recommendations would help level the playing field for patients when receiving treatment in a hospital while promoting strong provider networks that reward the best care at rates consumers can afford.

Conclusion

Health insurance providers develop networks to negotiate better value and lower costs for the consumers they serve. When doctors, hospitals, or care specialists choose not to participate in health plans' provider networks—or if they do not meet the standards for inclusion in a network—they charge whatever rates they like. The consequence is millions of consumers receiving surprise, unexpected medical bills that can often break the bank. By working together, we can take consumers and patients out of the middle, and solve the surprise medical bill problem. We look forward to working with you on legislative solutions to alleviate the financial burdens imposed on the American people by surprise medical bills and improve affordability of health care for millions of Americans.

American Heart Association.

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April 2, 2019

The Honorable Bobby Scott
Chairman, Education & Labor Committee
2176 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Virginia Foxx
Ranking Member, Education & Labor Committee
2101 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Scott and Ranking Member Foxx,

The American Heart Association (AHA) appreciates your interest in addressing balance billing. The rising cost of healthcare continues to be a barrier to treatment and recovery for millions of Americans, including many with cardiovascular diseases and stroke. The expansion and prevalence of balance billing practices in the U.S. exacerbates an already untenable situation and places additional unnecessary strain on the health and financial wellbeing of patients. We therefore urge you and your colleagues to take swift action to limit surprise billing to protect consumers and patients.

AHA is the nation's oldest and largest voluntary organization dedicated to building healthier lives free from heart disease and stroke. Our nonprofit and nonpartisan organization represents over 100 million patients with cardiovascular disease (CVD) and includes over 40 million volunteers and supporters committed to our goal of improving the cardiovascular health of all Americans.

For many Americans, an unexpected or surprise medical bill is an expense they cannot afford. Most insured consumers expect their plan will provide protection from unexpected medical bills; however, 57% of insured Americans have been caught off guard by a bill for care they thought would be paid for by their insurance plan. For thousands of CVD and stroke patients, bills that result from emergency or routine care, including emergency air or ground transportation, can be life-altering. Frequently, surprise bills arise from emergency situations when the patient is unable to select an in-network physician or treatment facility. However, balance billing practices extend far beyond emergency situations. Surprise bills can also arise from medical care unknowingly provided to the patient by an out-of-network physician or in an out-of-network facility. For example, this can happen if a patient's lab results are processed at an out-of-network facility, or if an out-of-network

anesthesiologist assists during a covered surgical procedure, even in an in-network hospital.

While 21 states have already passed laws or issued regulations aimed at protecting patients from balance bills, the protection and comprehensiveness offered by these proposals vary significantly from state to state and none are comprehensive enough to protect all consumers. The need for a comprehensive, uniform policy to protect all Americans from balanced bills as a result of medical transport or treatment necessitates action from federal policymakers. We recognize that differences in the regulation of emergency transportation will require lawmakers to re-examine authorities currently assigned to the Department of Transportation in order to adequately protect patients.

Access to quality, affordable health care is a priority for AHA and represents a key concern for the patients we represent. We implore policymakers to take a multi-faceted approach to comprehensively address balance billing:

- **Patients should be protected from balance billing.** In instances when a patient unknowingly receives care from an out-of-network provider or in emergency situations, patients should not be held responsible for resulting balance bills. In these circumstances, the maximum financial liability should be no greater than the in-network cost-sharing amount would be for the same services. This protection should exist regardless of the health insurance plan the patient holds.

- **Actionable and meaningful transparency.** Timely, actionable, and easily understood information should be provided to patients to help them avoid out-of-network services for non-emergency care. Resources should be up-to-date and easily available so consumers can make informed choices and not be held responsible for bills that result from inaccurate or outdated information. Individuals who live in areas with limited provider networks should be protected from balance bills if an in-network provider is inaccessible.

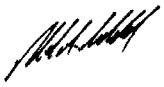
- **Adequate consumer rights and communications.** Prior to receiving non-emergency care, patients should receive prior notification that they will be receiving care from an out-of-network source. This notification should provide concrete information on estimated costs and the opportunity to seek in-network care. Prior notification should not preclude the dispute of a balance bill if there is not a reasonable opportunity to seek alternative in-network care.

- **Acknowledge existing state statutes**. Federal action to address balance billing should take into consideration potential interactions with current state law. Policymakers should be careful to not undermine any existing state laws that provide consumer protections. Instead, federal remedies must ensure a minimum standard of patient protections which states can further build upon.

AHA is ready to work with Congress, the Administration, and other stakeholders to ensure all Americans are protected from financial hardships as a result of balance bills. As patient and consumer advocates, we look forward to working with the Committee to ensure patients and consumers are not saddled with additional medical bills through no fault of their own.

Thank you for the opportunity to share our thoughts with you as you work to address balance bills. If you have any questions or would like to discuss these comments further, please contact Katie Berge, Federal Government Relations Manager for the American Heart Association at katie.berge@heart.org or (202) 785-7909.

Sincerely,



Mark Schoeberl
Executive Vice President for Advocacy

Cc:

The Honorable Chuck Grassley
The Honorable Ron Wyden

The Honorable Lamar Alexander
The Honorable Patty Murray

The Honorable Frank Pallone
The Honorable Greg Walden

The Honorable Richard Neal
The Honorable Kevin Brady

American Hospital Association™
Advancing Health in America

AMA AMERICAN MEDICAL ASSOCIATION

Federation of American Hospitals®

April 2, 2019

The Honorable Robert Scott
Chairman
Committee on Education and Labor
United States House of Representatives
2176 Rayburn House Office Building
Washington, DC 20515

The Honorable Virginia Foxx
Ranking Member
Committee on Education and Labor
United States House of Representatives
2101 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Scott and Ranking Member Foxx:

America's physicians, hospitals and health systems are fully committed to protecting patients from surprise medical bills. No patient should have the added stress and financial burden of receiving a bill for out-of-network emergency care that they could not avoid or out-of-network care that they reasonably could have expected to be in-network. Our organizations support a federal legislative solution to protect patients in these scenarios that limits patients' cost-sharing obligations to the in-network amount, and prohibits balance billing when the opportunity for health plans and providers to arrive at a fair payment rate is ensured.

The simplicity of the solution outlined above is in stark contrast to the complexity of another, untested idea that has been raised as part of the important dialogue about solving this issue: hospital bundled billing. This concept may seem simple and straightforward in theory; in reality however, this approach would be administratively complex, fundamentally change the relationship between hospitals and their physician partners, and alone, does nothing to protect patients from surprise bills. We strongly oppose such a model.

Bundled billing is not appropriate for many types of medical services. For example, the unique nature of emergency care – namely uncertainty and the potential for high variation – makes it a poor candidate for bundled payments. Several variations of bundled payments for episodes of care have been implemented over the past decade with mixed success. Developing such an arrangement involves a complex array of clinicians, statisticians, lawyers and others to define the services and duration of the bundle, to appropriately price it, and to ensure that any financial relationships between the various providers adhere to state and federal law, including the Stark law and the Anti-Kickback Statute. To-date, bundling has been tested by the Center for Medicare & Medicaid Innovation and some commercial payers in limited circumstances and, in general, early results indicate it could work for services for which the clinical care pathway is well defined and little variation is expected, such as for certain planned joint replacements. Even so, for the vast majority of these bundles, physicians and hospitals continue to negotiate their own rates with insurers. Any individual visit to an emergency department can involve countless possible services – from initial diagnosis and confirmatory tests to complicated trauma and surgical procedures involving multiple physicians and other providers, depending on an array of factors. Simply put: bundled payments are not appropriate for emergency care and have not been sufficiently tested for widespread adoption for other types of care.

Surprise bills are a direct result of a lack of negotiated contract between the patient's insurer and the hospital and/or physicians that provided their care. We support solutions that focus on arriving at a fair

payment from an insurer to a provider while protecting patients from the consequences that can arise when an insurer lacks adequate contracted providers. In contrast, bundling facility and physician payments in these situations simply allows insurers to transfer to hospitals their responsibility for establishing comprehensive physician networks and managing the associated financial risk.

We should remain focused on taking patients out of the middle of standard negotiations between insurers and providers and protecting them from "surprise bills" when they have not had the opportunity to choose who provides their care, while rejecting unproven proposals that would up-end the foundation of relationships that hold the health care system together.

Sincerely,

American Hospital Association
American Medical Association
Federation of American Hospitals

[Additional submissions by Mr. Morelle follow:]

April 2, 2019

The Honorable Joseph Morelle
U.S. House of Representatives
1317 Longworth House Office Building
Washington, D.C. 20515

Dear Congressman Morelle:

The Healthcare Association of New York State, on behalf of our member nonprofit and public hospitals, nursing homes, home health agencies and other healthcare providers, is pleased to have the opportunity to comment on the success of the Out-of-Network Consumer Protection Law in New York state.

As HANYS and our members worked with lawmakers in New York to address the challenge of surprise billing, HANYS remained committed to one core principle: protect patients and insulate them from any negotiation between insurers and providers. This principle was a key to the successful passage and implementation of New York's groundbreaking Out-of-Network Consumer Protection Law, which took effect on March 31, 2015.

The Out-of-Network Consumer Protection Law protects New Yorkers from financial exposure from surprise bills and emergency services. It requires hospitals, clinics and other practitioners to post information relating to plan participation and fees, and it mandates that managed care organizations and other network plans disclose details of their networks and out-of-network payment policies. The law applies to all New York state-regulated insurance products, including health maintenance organizations, preferred provider organizations, exclusive provider organizations, municipal health benefit plans, student health plans and Medicaid managed care plans. However, it does not apply to Employee Retirement Income Security Act preempted, Medicare Advantage and self-insured health plans.

Among the provisions of the law that have been successfully implemented in New York is an independent dispute resolution process for charges for services that would be considered a surprise bill under the law, and for emergency services.

During the debate on the Out-of-Network Consumer Protection Law, HANYS supported a dispute resolution process rather than setting a flat rate for services for several reasons. Among the concerns with setting a rate for payment in these circumstances is that it would encourage the expansion of narrow networks throughout the state and would strip the hospital of any ability to negotiate contracts with insurers in the long term. In a sense, it puts The Honorable Joseph all control of payment back in the hands of private insurance companies, at the expense of New York's nonprofit hospitals.

The result of this policy has been that very few cases of surprise bills and emergency bills even get to the arbitration stage. According to the New York State Department of Finance, in 2017, only 645 claims for emergency services were arbitrated by an Independent Dispute Resolution

Entity. Of those 645 cases, 203 disputed claims were ruled in favor of the health plan, 61 were ruled in favor of the provider, 102 were a split decision and 170 were considered ineligible. In the case of non-emergency surprise bills, only 451 claims were considered by an Independent Dispute Resolution Entity. Of those claims, 141 were ruled in favor of the provider, 49 for the health plan, 75 were a split decision and 119 claims were ineligible.

The data demonstrate that the dispute resolution process is rarely used and more importantly, that New Yorkers are not burdened with overwhelming out-of-network surprise bills. As Congress looks to curb the financial and emotional stress caused by surprise bills at the national level, HANYS urges lawmakers to reject any proposal that would set base payments as a means to resolve payment disputes between insurers and providers. Based on the New York experience, it is clear that this policy is not necessary and that it could only lead to severe unintended consequences.

HANYS also urges Congress to ensure that any national framework does not impede the great strides made in New York.

Sincerely,

Marie B. Grause, RN, JD
President

HANYS®
Always There for Healthcare

Marie B. Grause, RN, JD • President

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April 2, 2019

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U.S. House of Representatives
1317 Longworth House Office Building
Washington, D.C. 20515

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HANYS also urges Congress to ensure that any national framework does not impede the great strides made in New York.

Sincerely,

Marie B. Grause

Marie B. Grause, RN, JD
President

[Additional submissions by Mr. Scott follow:]

American College of Emergency Physicians
ADVANCING EMERGENCY CARE

ACEP 50 YEARS
Making Every Moment Count

April 1, 2019

The Honorable Frederica S. Wilson
Chairwoman
Subcommittee on Health, Education, Labor, and Pensions
House Committee on Education and Labor
Washington, D.C. 20515

The Honorable Tim Walberg
Ranking Member
Subcommittee on Health, Education, Labor, and Pensions
House Committee on Education and Labor
Washington, D.C. 20515

Dear Chairwoman Wilson and Ranking Member Walberg:

On behalf of the American College of Emergency Physicians (ACEP) and our 38,000 members, thank you for your efforts to protect patients and their families from unexpected high medical bills. ACEP remains committed to the goal of improving price transparency for our patients in a constructive and substantive manner, and we appreciate your leadership in holding this timely hearing.

Patients cannot choose where or when they will need emergency care, and they should not be punished financially for having emergencies. ACEP strongly agrees that patients must truly be taken out of the middle of billing issues that can arise around insurance coverage of emergency care.

As you examine this important issue, we urge you to keep in mind the particular factors that are unique to emergency medicine. In the emergency department, minutes and seconds matter and emergency physicians are often required to exercise their best clinical judgement quickly. Additionally, emergency physicians and their practice of medicine are subject to the Emergency Medical Treatment and Labor Act (EMTALA) that guarantees access to emergency medical care for everyone, regardless of insurance status or ability to pay. This law – an important consumer protection – has had the effect of disincentivizing health plans from entering into fair and reasonable contracts to provide services at appropriate in-network rates.

Because emergency physicians are required to screen and stabilize any patient who comes into the emergency department (under EMTALA), insurance companies are ensured their policyholders are always able to access emergency care. Therefore, they have no real incentive beyond what are often poorly defined and enforced state requirements to maintain an adequate number of emergency physicians in their networks. They are further incentivized to keep their networks narrow since if a policyholder's emergency care happens to be out of network, the patient's deductible is likely significantly higher (as permitted under section 2719A of the Affordable Care Act), which then shifts the majority (if not the entirety) of the cost of the encounter to be paid out of the patient's pocket, rather than the insurer's.

Many of the so-called "surprise bills" that patients face following an emergency encounter actually turn out to simply be due to a surprise lack of coverage – where patients discover that the costly insurance premiums they have dutifully paid each month have in actuality provided them with little to no protection against the cost of care due to high deductibles and other opaque or complicated health plan designs.

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As Congress begins developing potential legislative solutions to take the patient out of the middle and eliminate balance billing practices, we believe there are successful, comprehensive policy solutions already in effect in certain states that would be informative to any federal approach. In particular, we believe the examples of New York and Connecticut provide a solid foundation for federal legislation. Brief summaries of these laws are provided in the following pages.

We agree strongly that more must be done to protect patients and their families from unexpected high medical bills and provide greater stability and transparency in these encounters. To this end, earlier this year ACEP released a proposed framework of policy solutions to protect emergency patients. Our detailed framework is also included in the following pages, but there are six key provisions:

1) **Balance billing is prohibited** — When a patient receives out-of-network emergency care, the emergency services provider cannot make any demand for such payment from the patient.

2) **Streamline the process to ensure patients only have a single point of contact for emergency medical billing and payment** — Under ACEP's proposal, insurers will directly pay any coinsurance, copay, and deductible for emergency care to the provider, and can then collect back these amounts from the patient. This will put an end to patients receiving and having to reconcile the multiple, confusing bills and explanations of benefits that result from the many providers who often need to be involved in a single emergency episode.

3) **Ensure the patient responsibility portion for out-of-network emergency care is no higher than it would be in-network** — When facing an emergency, patients or their family members do not have time to try and figure out where their care will be in-network, so they should not be punished financially for being unable to do so. Under current law, while copays and coinsurance must be the same for emergency patients whether they are in- or out-of-network, deductibles can be much higher—often double.

4) **Require insurers to more clearly convey beneficiary plan details** — This would include printing the deductible on each insurance card. While a simple step, it can help patients better understand the limits of their insurance coverage and reduce the surprise when they later get a bill.

5) **Require insurers to more clearly explain their rights related to emergency care** — Policyholders deserve to have this in plain, easy-to-understand clear language.

6) **Take the Patient Out of Insurer-Provider Billing Disputes** — ACEP wants to prevent provider/insurer billing disputes. To expedite and simplify this process, ACEP is calling for the creation of an arbitration process to settle network issues, similar to that used in New York (as described in the following pages).

ACEP believes these core principles are necessary first and foremost to protect patients seeking emergency medical care. Additionally, they provide an outline for a policy solution we believe that is not overly burdensome or costly to implement at the federal level, is based on models that have already proven successful at the state level and have not led to inflated costs in those states, and would establish a system that ensures fair and equitable negotiation between providers and insurers.

We also note our strong concerns with proposals that would either provide a single bundled payment from a hospital for emergency services or would set a benchmark payment at a certain level of Medicare rates. A bundled payment would not actually address the underlying cost issues, but instead merely shift the venue for negotiation under the assumption that hospitals would somehow be able to better negotiate with physicians than insurers. With regard to proposals based on a percentage of Medicare rates, this approach is flawed in that 1) Medicare rates were never intended to reflect market rates and have not kept pace with inflation; 2) according to CMS' own actuaries, Medicare rates are not expected to keep pace with the average rate of physician cost increases[1]; 3) Medicare rates were never designed for the general population but rather an age-specific group (e.g., does not include pediatrics or obstetrics); and, 4) Medicare is shifting toward a value-based payment approach, and it is unclear how it could even be used as a basis for determining a benchmark rate in future years.

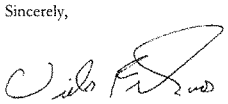
Once again, ACEP thanks you for your leadership on this effort to protect patients from unexpected medical bills. We appreciate the opportunity to provide these comments, and we stand ready to work with you to develop meaningful reforms.

---

[1] 2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2018.pdf

Should you have any questions, please do not hesitate to contact Laura Wooster, ACEP's Associate Executive Director of Public Affairs, at lwooster@acep.org.

Sincerely,



Vidor Friedman, MD, FACEP
ACEP President

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Framework for Protecting Patients When Emergency Care is Out-of-Network

Background

By oath and by law, emergency physicians will treat any patient, regardless of their ability to pay. Federal law under the Emergency Medicine Treatment and Labor Act (EMTALA) forbids emergency care providers from discussing with the patient any potential costs of care or details of their particular insurance coverage until they are screened and stabilized. Patients can't choose where and when they will need emergency care – so they should not be punished financially for having emergencies.

Expanded Patient Protections that Truly Take the Patient Out of the Middle

- When a patient receives out-of-network emergency care, the emergency services provider cannot make any demand for payment from the patient -- balance billing is prohibited;
- The patient won't pay any more out-of-pocket (i.e. coinsurance, copay, **and** deductible) than they would have paid if their emergency care were in-network (currently such protection only applies to coinsurance and co-pays);
- Insurers will directly pay any coinsurance, copay, and deductible for emergency care to the provider.
  - Insurers can then collect back these amounts from the patient. This ensures patients only have **a single point of contact** for emergency medical billing and payment, and will no longer receive and have to reconcile multiple, confusing bills and EOBs that result from the many providers that are often involved in a single emergency episode.
- To ensure policyholders better understand the limits of their insurance coverage and *all* potential out-of-pocket costs when seeking care, insurers will be required to display the patient's deductible amount on policyholders' insurance cards.
- Insurers must provide their policyholders with clear, concise and meaningful explanations of their plans' emergency services benefits, an up-to-date list of in- and out-of-network providers, and beneficiary rights under EMTALA.

Take the Patient Out of Insurer-Provider Billing Disputes

- The insurer will pay directly to the emergency care provider within 30 days the amount of the deductible and cost-sharing (plus an additional amount as determined below). When provider-insurer disputes arise over reimbursement for out-of-network emergency services, the following will be used to resolve them:
  - The payment amount will be determined under any state law that takes a comparable approach to this proposal.;
  - For claims under $750 (amount to be adjusted for inflation), the balance will be paid in full. For inflation-adjusted amounts over $750, the insurer will pay an interim payment directly to the provider.
- Required payments will be made within 30 days of claim submission. Failure to do so will trigger civil monetary penalties (CMPs) of $500 per day.
- Either party may trigger the alternative dispute resolution (ADR) process described below within 30 days of the provider receiving the interim payment.

Alternative Dispute Resolution (ADR)

- HHS will maintain a database of ADR entities that meet certain qualifications (e.g. freedom from conflicts of interest, reasonable fees) to resolve disputes. Costs related to this will be offset by any collected CMPs, as referenced above. HHS may delegate responsibility of the database to a third party such as the American Arbitration Association or to any state that already undertakes a similar function.
- The emergency care provider and insurer will submit to the arbitrator the amount that was charged or billed for the emergency medical services, and the interim amount paid, respectively. Either party may consolidate multiple disputed claims between them into a single adjudication.
- The arbitrator will select one of these two amounts as the payment amount, and in doing so consider the following:
  - The provider's level of skill, education and training,
  - The nature of the services provided,
  - The circumstances and complexity of the case,
  - 80th percentile of charges for comparable services in the same geographical area, as determined by a transparent and wholly independent Medical Claims Database (such as FAIR Health),
  - 150% of the average in-network rate for comparable services in the same geographical area as determined by a transparent and wholly independent Medical Claims Database (such as FAIR Health)
- Arbitration will be completed within 30 calendar days of either party commencing the ADR process. Any payment owed by one party to the other must be made within 15 calendar days of a determination. The costs of the ADR shall be borne by the non-prevailing party.

Commission on Access to Quality and Affordable Emergency Care.

HHS will establish a Commission on Access to Quality and Affordable Emergency Care with diverse, cross-sector representation to study and provide recommendations to Congress within three years of bill enactment on specified matters including:

- Adequacy of patient protections, including network adequacy standards and clarity of enrollee notification language from insurers
- If the bill's new processes surrounding out-of-network emergency care are providing sufficient provider protections to ensure continued access to high-quality emergency care for patients;
- The merits of establishing supplemental funding for uncompensated care by incurred by emergency physicians pursuant to their practice of medicine under the requirements of EMTALA.

State Models: New York

In 2015, New York implemented a law that banned balanced billing and established an arbitration process for out-of-network emergency services.

Not all claims are included in the independent dispute resolution (IDR) process. Smaller claims for emergency services that that are currently less than $683.22 (annually adjusted for inflation) and do not exceed 120 percent of "usual and customary cost" (UCR) are automatically exempted. UCR is defined as the 80th percentile of all charges for a health service rendered by a provider in the same or similar specialty and provided in the same geographic region as reported by a benchmarking database maintained by a nonprofit organization. New York identifies the FAIR Health charge database as an independent entity that can calculate UCR.

Under the established IDR process, the arbitrator picks either the charge set by the provider or the allowed amount offered by the insurer, without modification. The party whose amount is not chosen must pay for the cost of arbitration (estimated by the State of NY to range from $225 to $325 per appeal), as well as any outstanding amounts as a result of the decision.

This "loser pays" baseball-style arbitration process has proven to be an effective way of incentivizing providers to charge reasonable rates, while at the same time encouraging insurers to pay appropriate and reasonable amounts. Since both parties have this powerful incentive to act fairly, most claims do not even need to go into the IDR process. As seen in the chart below, out of the millions of visits to the emergency department in 2018, only 849 emergency claims went to arbitration (out of an estimated 7-8 million emergency visits statewide). As well, the decisions rendered on these were evenly split, further demonstrating that the system is working.

Emergency Services

Total received	849
Not eligible	162
Still in process	139
Decision rendered	548
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The New York law has preserved access to emergency care and has not led to significant increases in insurance premiums. In fact, the Kaiser Family Foundation has shown that premiums in New York have grown more slowly than rates for the rest of the nation over the last five years.[2] Similarly, studies have shown that the law has lowered the rate of out-of-network bills by 34 percent and lowered in-network emergency physician payments by 9 percent.

[2] Kaiser Family Foundation (2015-2019): "Marketplace Average Benchmark Premiums," https://www.kff.org/e4f94bd/

State Models: Connecticut

The Connecticut law, passed in 2016, bans balanced billing and sets a minimum benefit standard for out-of-network emergency services based on the greatest of three payment amounts: 1) the in-network amount; 2) the usual, customary, and reasonable (UCR) rate; and 3) the Medicare amount. The UCR is defined in law as the 80th percentile of all charges for the particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported in a benchmarking database.[3] Like New York, Connecticut has identified FAIR Health as the independent entity that should be used to determine UCR. FAIR Health data illustrate that provider charges in CT have not increased beyond the rate of inflation since the law was implemented. And similarly to the experience in New York, data shows that premiums grew more slowly in Connecticut than the rest of the nation.

Also included in Connecticut's law are greater out-of-pocket protections for consumers. As previously noted in this response, under federal law, cost-sharing for out-of-network emergency services cannot be greater than cost-sharing for in-network emergency services but is defined as only the co-payment and co-insurance. Connecticut includes deductibles in the definition, along with co-payments and co-insurance. **ACEP supports a change in federal law that would level deductibles for out-of-network and in-network emergency services**.

[3] Public Act No. 15-146, "An Act Concerning Hospitals, Insurers and Health Care Consumers,"

April 02, 2019

The Honorable Frederica S. Wilson
Chair
Subcommittee on Health, Employment,
Labor and Pensions
Washington, DC 20515

The Honorable Tim Walberg
Ranking Member
Subcommittee on Health, Employment,
Labor and Pensions
Washington, DC 20515

Dear Chair Wilson and Ranking Member Walberg:

We applaud you for holding a hearing examining surprise billing. Reflecting the goal of employers to protect patients from surprise medical bills without undermining network participation or resulting in higher health care costs for all consumers, we urge Congress to pass legislation consistent with the following provisions:

Protect Patients from Surprise Medical Bills

- The goal of any federal surprise balance billing legislative solution is to protect patients in situations in which they lack a choice of providers. It is vitally important, however, that any legislative solutions not discourage network participation or result in higher health care costs for all consumers. Patients often lack any meaningful choice of provider when they obtain care in out-of-network emergency rooms, and when a patient receives services in in-network facilities from out-of-network professionals, particularly with respect to a small number of provider specialties.
- To protect consumers and families, federal legislation must ensure that patient cost-sharing is limited to in-network amounts for emergency services performed at an out-of-network facility or for treatment by out-of-network facility-based physicians performed at in-network facilities, and prohibit providers from imposing additional "surprise" balance bills in these circumstances.
- Congress should implement this change through an amendment to section 2719A of the Public Health Service Act ("PHSA"), which applies to both group and individual commercial insurance, and which would apply to insured and self-funded group health plans through section 715 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

Disclosure and Transparency

- For surprise balance billing that occurs at an in-network facility and follow-up care from emergency treatment at an out-of-network facility, federal legislation must require disclosure of out-of-network professional costs at the time of scheduling. This disclosure will help ensure that patients can make an informed decision and schedule procedures when an in-network professional is available.
- Facilities such as hospitals should also be required to list prominently on their websites, whether they lack available providers who participate in networks which the facility participates in – including what those specialties are, and the likelihood that a patient may thus be seen by an out-of-network provider.

- Much of the surprise over unexpected balance billing can be eliminated by providing this disclosure.
- Congress could implement this disclosure requirement directly on hospitals (through Medicare's minimum requirements for hospitals under 42 USC § 1395x(e)(1)-(8)), or through an amendment to section 2718(e) of the PHSA, which requires hospitals to disclose standard charges for items and services provided by the hospitals.

Required Reimbursement

- Out-of-network providers frequently bill well in excess of negotiated rates and Medicare reimbursement for these services, as opposed to the actual value of the service provided. A study by Ge Bai and Gerard F. Anderson, published in JAMA in 2017 comparing physician charge-to-Medicare payment ratio across specialties found that anesthesiology had the highest median (5.8), followed by interventional radiology (4.5), emergency medicine (4.0), and pathology (4.0).
- To ensure equitable payment for the services provided without discouraging network participation or resulting in higher costs for all consumers, legislation must set a reasonable federal reimbursement structure that (1) establishes a federal cap for emergency services at an out-of-network facility at 125 percent of the Medicare rate, and (2) requires all providers at an in-network facility to accept in-network rates.
- Conversely, without reasonable limitations on the reimbursement rates, out-of-network providers in surprise balance billing situations will have an incentive to bill even higher rates in order to achieve maximum payment through any binding arbitration mechanism. Binding arbitration is an inefficient and ineffective approach to addressing surprise billing and should not be included as a legislative solution. The experience of the mediation process in Texas is instructive. According to a recent report, the Texas Department of Insurance received just 43 requests from consumers for mediation in 2013. In 2014, the number of requests grew to more than 600 and have climbed steeply ever since. There were 4,519 requests in 2018, creating a significant backlog,
- Requiring facilities to bundle medical services for covered procedures into a single payment also could help address this problem if structured properly. In the case of bundled services performed by out-of-network providers, the costs of those services within the bundle cannot exceed either the allowable in-network rate or 125% of Medicare. But, care must be taken to ensure that the contracted bundled payment is final and not merely a progress point toward further negotiation.
- Congress should implement this change through an amendment to section 2719A of the PHSA, which applies to both group and individual commercial insurance, and which would apply to insured and self-funded group health plans through section 715 of ERISA.

Ambulance and Outsourced Emergency Departments

- A significant concern to both patients and plans are the massive costs associated with non-participating ambulance, air ambulance, and emergency department services.

- According to GAO's analysis of the most complete data identified for air ambulance transports of privately-insured patients, 69 percent of about 20,700 transports in the data set were out-of-network in 2017.
- Ambulance, air ambulance, and emergency services are essential to ensure that patients receive the care they need in the most urgent of situations. Subjecting patients in the most dire of circumstances to balance billing exposes patients to material liabilities in order to receive the care they need.
- Any legislative solution for surprise balance billing should also specify that ambulances and air ambulance services are considered emergency services for purposes of the statutory limitations on balance billing and reimbursement rates.
- Further, Congress should include provisions to eliminate problematic incentives in which an in-network facility could profit by allowing or encouraging an outsourced out-of-network emergency department to surprise bill in-network patients.
- Congress should implement this change through an amendment to section 2719A of the PHSA, which applies to both group and individual commercial insurance, and which would apply to insured and self-funded group health plans through section 715 of ERISA.

We look forward to working with you to address the burden of surprise medical billing.

Sincerely,

American Benefits Council
Associated Builders and Contractors, Inc.
Associated General Contractors
Auto Care Association
Colorado Business Group on Health
Council for Affordable Health Coverage
Economic Alliance for Michigan
Florida Health Care Coalition
Food Marketing Institute
Greater Philadelphia Business Coalition on Health
HealthCare 21 Business Coalition
Houston Business Coalition on Health
Louisiana Business Group on Health
Midwest Business Group on Health
National Alliance of Healthcare Purchaser Coalitions
National Association of Health Underwriters
National Association of Wholesaler-Distributors
National Business Group on Health
National Restaurant Association
National Retail Federation
Pacific Business Group on Health
Partnership for Employer-Sponsored Coverage
Retail Industry Leaders Association
Retailers Association of Massachusetts
Rhode Island Business Group on Health

Self-Insurance Institute of America, Inc.
Silicon Valley Employers Forum
Small Business & Entrepreneurship Council
Society of Professional Benefit Administrators
St. Louis Area Business Health Coalition
The Council of Insurance Agents & Brokers
The ERISA Industry Committee
Wyoming Business Coalition on Health



Statement for the Record

of the

American Medical Association

for the record

U.S. House of Representatives Committee on Education and Labor
Subcommittee on Health, Employment, Labor and Pensions

Re: Examining Surprise Billing: Protecting Patients from Financial Pain

April 2, 2019

Division of Legislative Counsel
(202) 789-7426

STATEMENT

of the

American Medical Association

to the

U.S. House of Representatives Committee on Education and Labor
Subcommittee on Health, Employment, Labor and Pensions

Re: Examining Surprise Billing: Protecting Patients from Financial Pain

April 2, 2019

The American Medical Association (AMA) appreciates the opportunity to present our views to the U.S. House of Representatives Committee on Education and Labor, Subcommittee on Health, Employment, Labor and Pensions concerning unanticipated medical bills. As health insurance plans increasingly rely on narrow and often inadequate networks of contracted physicians, hospitals and pharmacies to control costs, even patients who are diligent about seeking care from in-network physicians may face unanticipated medical bills from out-of-network providers that participate in their care. Physicians are limited in their ability to help patients avoid these unanticipated costs because like patients, they may not know in advance who will be involved in an episode of care, let alone other providers' contract status with all the insurance plans in their communities. Health insurers must be incentivized to negotiate fair contracts with physicians to ensure that networks are sufficiently robust.

The problem of unanticipated out-of-network bills is complex and requires a balanced approach to resolve. The AMA agrees that any solution must keep patients out of the middle of payment rate negotiations and ensure that when patients seek emergency care or otherwise do not have the opportunity to select their provider, they should not be responsible for cost sharing beyond what they would face if they had seen an in-network provider. Any proposed solutions should also require both providers and insurers to be transparent about anticipated charges and the amount of those charges that insurance will cover. We also agree that if balance billing is banned, there must be a process in place to ensure that providers receive fair reimbursement for their services.

The AMA encourages Congress to look to states that have already acted to address unanticipated medical bills, specifically those state laws that have functioned well such as New York and Connecticut. The AMA is committed to working with Congress to find a workable solution for all stakeholders that protects patients from unanticipated out-of-network bills.

Key Principles in Addressing Unanticipated Medical Bills

There are several key principles that must be a part of any solution proposed to address unanticipated out-of-network medical bills. First, oversight and enforcement of network adequacy is needed. Robust network adequacy standards include, but are not limited to, an adequate

ratio of emergency physicians, hospital-based physicians, and on-call specialists and subspecialists to patients, as well as geographic and driving distance standards and maximum wait times. Provider directories must also be accurate and updated regularly to be useful to patients seeking care from in-network providers. In addition, insurers should be held to complying with the prudent layperson standard in existing law for determining coverage for emergency care, so that insured patients are not liable for unexpected costs simply because they were unable to accurately self-diagnose ahead of time whether their symptoms were, in fact, due to an emergency medical condition.

Any solution to address unanticipated medical bills must also require transparency so that all patients who choose in advance to obtain scheduled care from out-of-network physicians, hospitals or other providers are informed prior to receiving care about their anticipated out-of-pocket costs. When scheduling services for patients, providers should be transparent about their own anticipated charges, and insurers should be transparent about the amount of those charges they will cover.

In general, the AMA urges Congress to avoid any solutions that arbitrarily cap payment for physicians treating out-of-network patients. If pursued, guidelines on what out-of-network providers are paid should reflect actual charge data for the same service in the same geographic area and should not be based on a percentage of Medicare rates, which have become increasingly inadequate in covering overhead costs or be based on in-network rates, as either standard would eliminate the need for insurers to negotiate contracts in good faith.

The AMA could support a legislative solution that provides for a mediation or sequential alternative dispute resolution (ADR) process for those circumstances where the minimum payment standard is insufficient due to factors such as the complexity of the patient's medical condition, the special expertise required, comorbidities, and other extraordinary factors. Arbiters should not be required to consult in-network or Medicare rates when making final determinations regarding appropriate reimbursements.

Finally, as noted previously, the AMA strongly supports solutions that keep patients out of the middle of payment rate negotiations. Patients should only be responsible for in-network cost-sharing amounts when experiencing unanticipated medical bills.

Successful State Models

Many states have acted to address unanticipated out-of-network billing and there are several existing state models that have worked well to protect patients from surprise medical billing. The AMA points to New York's balance billing law as a well-functioning model for several reasons including:

- The law protects patients from unanticipated out-of-network bills.
- The law emphasizes the role of network adequacy in solving the "surprise" billing problem and puts in place new requirements to regulate networks and affords patients the right to an independent external appeal to be treated by a non-network provider if the network is inadequate.
- The law establishes a strong independent dispute resolution (IDR) process made by a reviewer with training and experience in health care billing, reimbursement, and usual and customary charges in consultation with a licensed physician in active practice in the same or similar specialty as the physician providing the service that is the subject of the dispute.

- The IDR process requires consideration of factors, including the rate that non-participating physicians charge for the service in the area based on independent data, usual and customary charge for the service based on independent data, the complexity of the case, and the physician's experience, training and education.
- There are no data that we know of that suggest that the law has resulted in either premium increases or a dramatic narrowing of networks.

The AMA also views the Connecticut law on unanticipated out-of-network care for emergency services as a potential model for all unanticipated out-of-network care situations because:

- The law protects patients from unanticipated out-of-network bills for care received at an in-network hospital.
- The law creates a solution by establishing a payment standard that incorporates charge data from an independent data source.
- There is no evidence that we know of that suggest law has resulted in premium increases, dramatic narrowing of networks, or higher rates of out-of-network physicians.

Facilitating In-Network Contracting

It is important to recognize that most physicians want to be included in payers' networks, if fair contracts are offered. However many physicians are in a weak bargaining position relative to commercial health insurers. Therefore, Congress must incentivize insurers to come to the negotiating table with physicians and offer fair contracts. The most promising way for policymakers to facilitate contracting between providers and health plans is to ensure regulation of provider networks. Strong network adequacy requirements create a more balanced environment for all stakeholders where: insurers are incented to maintain meaningful access to in-network providers by offering providers competitive contracts; providers are incented to come to the table knowing that it will be a fairer process; and patients will have access to in-network care and get greater value for their premiums paid.

While there has been a great deal of discussion about the growth of narrower provider networks, relatively little has been done to create or enforce network adequacy requirements, especially as they relate to hospital-based providers. Ensuring that, at a minimum, in-network providers are available at in-network hospitals should be the first step for legislators and regulators in addressing unanticipated out-of-network care at in-network hospitals. Moreover, ensuring that patients have appropriate access to primary and specialty care will go a long way in preventing emergency department visits and other hospitalizations that may lead to unanticipated out-of-network bills.

The basis of network adequacy standards should be quantitative, measurable requirements on the front-end, before insurance products are brought to market. The quantitative standards should include minimum time and distance requirements, maximum patients-to-provider ratios, and maximum wait times. In addition, and specific for hospital-based specialties, it is critical that standards also measure access to in-network physicians at in-network hospitals.

Meaningful regulation of provider networks must also be ongoing. Consistent monitoring of the network's ability to provide in-network hospital-based care is particularly important, given that patients may not evaluate access to these providers simply through a directory or other tool, as is normally the case when choosing a provider.

Finally, it is important to recognize the connection between accurate provider directories and meaningful access to in-network providers for patients. The AMA encourages greater oversight of provider directories and stronger requirements that they be transparent and up-to-date. Patients need access to robust, up-to-date provider directories to enable them to determine which providers are in-network as they purchase their plans, and which providers continue to be in-network as their medical needs change. Additionally, providers need accurate information from health plans to allow for in-network referrals when further treatment is needed.

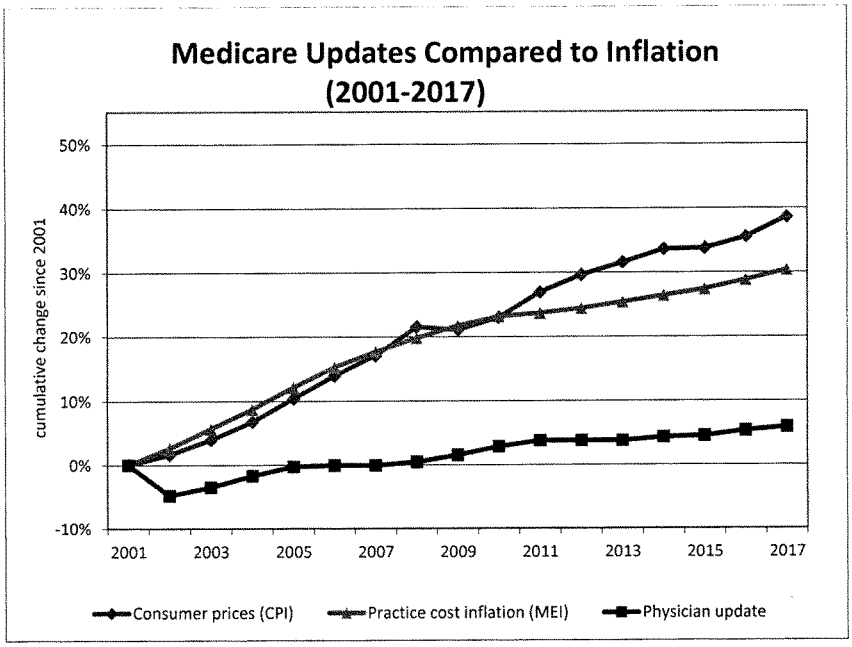
Payment Standards

As AMA has repeatedly pointed out, Medicare payment rates do not reflect the costs of providing care, especially in the commercial market where the population varies greatly. Medicare uses the resource-based relative value scale (RBRVS) system to establish physician payments, determined by the resource costs associated with the total amount of physician resources required to provide a specific service. However, before Medicare rates are finalized, they go through adjustment and conversion processes to meet federal budgetary requirements. Adjustments are done in a budget neutral manner, meaning that if an adjustment increases the payment for one service, it must account for this increase by decreasing payment in another. This establishes artificial decreases in payment for many physician services ever year. And before the final Medicare payment is set, geographically adjusted values are multiplied by a conversion factor - a monetary payment determined by Medicare each year that changes based on the Medicare economic index, adjustments pertaining to budget neutrality and other adjustments stipulated by legislation. After everything is complete, the resulting payment rates are not reflective of markets rates for physician services.

As illustrated by the chart below, Medicare physician payments have not kept up with inflation over the past decade. According to data from the Medicare Trustees, Medicare physician payment rates have barely changed over the last decade and a half, increasing just six percent from 2001 to 2017, or just 0.4 percent per year on average. And, under the Medicare Access and CHIP Reauthorization Act (MACRA), physician payment rates will be frozen for calendars years 2020 through 2025.

In comparison:

- The cost of running a medical practice has increased 30 percent between 2001 and 2017, or 1.7 percent per year. Inflation in the cost of running a medical practice, including increases in physician office rent, employee wages, and professional liability insurance premiums, is measured by the Medicare Economic Index, or MEI.
- Economy-wide inflation, as measured by the Consumer Price Index, has increased 39 percent over this time period (or 2.1 percent per year, on average).



Sources: Federal Register, Medicare Trustees' Reports and U.S. Bureau of Labor Statistics

Over time, the adequacy of Medicare physician payment rates has eroded significantly. Adjusted for inflation in practice costs, Medicare physician payment rates have declined 19 percent from 2001 to 2017, or by 1.3 percent per year on average. As such, the AMA opposes efforts to cap or benchmark out-of-network physician payments on a percentage of Medicare. Linking out-of-network rates to Medicare would eliminate any incentive for insurers to build adequate networks or offer physicians fair contracts.

Thank you for the opportunity to offer our input. We look forward to working with you and your colleagues to help determine the best way to protect patients from costly surprise medical bills.

Statement for the Record
to the
House Committee on Education and Labor

Surprise Billing

Garry Brydges, DNP, MBA, ACNP-BC, CRNA ,
FAAN,
President, American Association of Nurse Anesthetists

1 April 2019

Introduction

Chairman Scott and Ranking Member Foxx, thank you for the opportunity to offer this statement for the record. The American Association of Nurse Anesthetists (AANA) is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists, with membership that includes more than 53,000 CRNAs and student nurse anesthetists representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 45 million anesthetics to patients each year in the United States. CRNAs provide acute, chronic, and interventional pain management services. In some states, CRNAs are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.

Address the Underlying Causes of Surprise Billing by Directing CMS to Issue a Proposed Rule on Provider Non-Discrimination Provision and by Promoting Adequate Provider Networks in Medicare Advantage Plans and Health Plans Inside the Marketplace

The AANA appreciates the Committee's concern regarding patients being surprised by out-of-network bills. The economic burden of receiving care out-of-network can be substantial for patients. Furthermore, knowing which providers and services are in-network and out-of-network is a huge burden for the patient as well as the provider and the facility. The Committee can address this issue best by addressing the underlying causes, such as inadequate networks offered by insurance plans and plans engaging in discrimination against providers based on their licensure or certification. While this is not an issue under Medicare Part B, as Medicare recognizes CRNAs as qualified providers and CRNAs must accept assignment as a condition for payment,[1] this is an issue with private health plans, thus potentially affecting the private payer market and Medicare Advantage plans.

Therefore, it is important to highlight the harms of discrimination CRNAs currently face in the selection criteria that certain health plans develop, which determines the selection of providers that participate in their networks. CRNAs, acting within the scope of their license or certification under applicable state law or regulation, have experienced discrimination with respect to participation in qualified health plans, thus forcing them to become an out-of-network provider. Such discrimination may exacerbate surprise billing, impair consumer choice, reduce competition, and affect healthcare costs.

We recommend that the Committee direct CMS to use its authority to further implement the federal provider nondiscrimination law by issuing a proposed rule. In 2010, Congress passed this provision in the Patient Protection and Affordable Care Act (Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706(a), "Non- Discrimination in Health Care, 42 USC §300gg-5),[2] which prohibits health plans from discriminating against qualified licensed

[1] See 42 §414.60 (c).

[2] Patient Protection and Affordable Care Act, Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706(a), Non-Discrimination in Healthcare (42 U.S.C. §.300gg-5). The statutory provision reads as follows: "(a) Providers.--A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any healthcare

healthcare professionals, such as CRNAs, solely on the basis of their licensure. This law promotes access to healthcare and consumer choice of healthcare professionals and helps reduce healthcare costs through competition. It prohibits discrimination based on provider licensure that keeps patients from getting the care they need.

To promote patient access to high quality healthcare, market competition and cost efficiency, all qualified health plans must all avoid discrimination against qualified, licensed healthcare professionals, such as CRNAs, solely on the basis of licensure or certification. Proper implementation of the provider nondiscrimination provision is crucial because health plans have wide latitude to determine the quantity, type, and geographic location of healthcare professionals they include in their networks, based on the needs of their enrollees. However, when health plans organize their healthcare delivery in such a way that discriminate against whole classes of qualified licensed healthcare professionals by licensure or certification, for example, by prohibiting reimbursement for anesthesia and pain management services provided by CRNAs, patient access to care is impaired, consumer choice suffers, and healthcare costs climb for lack of competition. Additionally, such discrimination provides incentives for the use of higher-cost providers without improving quality or access to care. Promoting nondiscrimination encourages the use of qualified, licensed, and certified healthcare professionals such as CRNAs who perform the same services to the same high level of quality as other qualified providers.

While we recognize that CMS has developed network adequacy standards in Medicare Advantage plans and in the Marketplace, the Committee should direct CMS to do more to ensure that health carriers maintain networks that are sufficient in numbers and types of providers to assure that all services to covered persons will be accessible to them without unreasonable delay. The AANA believes that patients benefit the greatest from a healthcare system where they receive easily accessible care from an appropriate choice of safe, high quality and cost-effective providers, such as CRNAs. Therefore, we request that CRNAs be included in all health carrier network plans, which will help ensure network adequacy, access and affordability to consumers.

AANA Comment: Direct HHS to Work with Stakeholders in Developing Guidance to Educate Consumers on Questions to Ask Their Insurance Companies

We also recommend that the Committee direct the Department of Health and Human Services to work with healthcare stakeholders, such as CRNAs, in developing consumer guidance documents on surprise billing and out-of-network coverage and resources for assistance. For instance, this guidance could provide consumers with the education needed to know what questions to ask their insurance plans prior to procedures and where to go for help. We are happy to assist in the development of these patient tools.

Conclusion

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provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any healthcare provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures."

In conclusion, addressing some of the underlying causes of surprise billing, such as inadequate networks offered by insurance plans and plans engaging in discrimination against providers based on their licensure or certification, along with patient education would help reduce the sticker shock associated with needed medical services and would promote patient access to a range of beneficial, safe and cost-efficient healthcare professionals, consistent with public interests in quality, access and cost-effectiveness. The AANA and its members look forward to collaborating with the Committee on this very important issue.



Statement for the Record to the
House Committee on Education and Labor
Subcommittee on Health, Employment, Labor, and Pensions
Subcommittee Hearing
"Examining Surprise Billing: Protecting Patients from Financial Pain"
April 2, 2019

On behalf of the AAFP, representing 131,400 family physicians and medical students, thank you for the opportunity to submit this statement for the record to the U.S. House Committee on Education and Labor concerning the hearing, *Examining Surprise Billing: Protecting Patients from Financial Pain.*

The AAFP appreciates the Committee's interest in protecting patients and their families from unanticipated medical bills. We share your concerns that such bills drive up patient out-of-pocket costs and threaten to damage the patient-physician relationship. As the nation's largest medical association of primary care physicians, we are committed to the strategic goal of ensuring health care coverage for all – a goal based on AAFP policy which recognizes that health is a basic human right for every person. The right to health includes universal access to timely, acceptable and affordable health care of appropriate quality. This goal requires health care system reforms that aim to serve all Americans, be foundational in primary care, and work to and reduce barriers such as price and accessibility that limit people from obtaining health care coverage.

Unfortunately, health insurance plans too often restrict patients' access to physicians by adopting narrow networks of contracted physicians, hospitals, pharmacies, and other providers. Even patients who strive to seek care from in-network physicians and hospitals can find themselves with unanticipated out-of-network bills from providers who are not in their insurance plan's network.

The AAFP joined more than 100 state and national medical organizations on a February 7 letter to House Ways and Means Committee Chairman Richard Neal (D-MA) and Ranking Member Kevin Brady (R-TX) urging them to protect Americans from unexpected medical costs. The letter is available at: https://www.aafp.org/dam/AAFP/documents/advocacy/legal/administrative/LT-WaysMeans-SurpriseBilling-020719.pdf

The AAFP and co-signatories urged consideration of several policies, including:

- Insurer accountability: Narrow networks contribute to surprise billing. Strong oversight and enforcement of network adequacy is needed from both federal and state governments.
- Limits on patient responsibility: Patients should only be responsible for in-network cost-sharing rates when experiencing unanticipated medical bills.
- Transparency for scheduled health care: When scheduling services for patients, providers should be transparent about their own anticipated charges, and insurers should be transparent about the amount of those charges they will cover.
- Benchmark payments: In general, caps on payment for physicians treating out-of-network patients should be avoided. If pursued, guidelines or limits on what out-of-network providers

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are paid should reflect actual charge data for the same service in the same geographic area from a statistically significant and wholly independent database. These should not be based on increasingly inadequate Medicare rates or on in-network rates, which would hinder good-faith contract negotiation from insurers.

- Keeping patients from being middlemen: Payment rate negotiations should be between insurers and those who provide medical care. To ensure that patients aren't stuck doing that work, "physicians should be provided with direct payment/assignment of benefits from the insurer."

The AAFP appreciates the opportunity to share these comments and welcomes the opportunity to work with policy makers to achieve positive outcomes on these and other policies. For more information, please contact Teresa Baker, Senior Government Relations Representative, at 202-232-9033 or tbaker@aafp.org.

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Advancing Health in America

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Statement
of the
American Hospital Association
for the
Committee on Education and Labor
Subcommittee on Health, Employment, Labor and Pensions
of the
U.S. House of Representatives
"Examining Surprise Billing: Protecting Patients from Financial Pain"
April 2, 2019

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to submit for the record our comments on surprise medical billing.

We believe the last thing a patient should worry about while receiving health care services is an unanticipated medical bill that impacts their out-of-pocket costs and undermines the trust and confidence that patients have in their caregivers. Hospitals and health systems are deeply concerned about the impact of such bills and are committed to finding a solution that first and foremost protects patients.

The AHA Board of Trustees believes addressing surprise medical bills to protect patients is a top priority for our members. Following are the AHA board-approved principles.

GUIDING PRINCIPLES

America's hospitals and health systems are committed to protecting patients from surprise bills and support a federal legislative solution to do so.

Surprise billing typically occurs when a patient receives an unexpected bill for care they thought was covered by their health plan, or when they receive a bill for out-of-network emergency services. Some forms of coverage, including Medicare and Medicaid, have strong patient protections against surprise billing. However, other types of coverage, most notably self-funded, employer-sponsored plans regulated through the Employee Retirement Income Security Act of 1974 (ERISA), do not contain the same protections. While many state governments have attempted to address this issue, only a few have passed comprehensive protections, and states have limited regulatory oversight of ERISA plans.

The three most typical scenarios for when a patient receives an unexpected bill occur when: (1) a patient accesses emergency services outside of their insurance network, including from providers while they are away from home; (2) a patient has acted in good faith to obtain care within their network but unintentionally receives care from an out-of-network physician providing services in an in-network hospital; or (3) a health plan denies coverage for emergency services saying they were unnecessary. In all of these situations, we believe it is critical to protect patients from surprise bills.

We have developed the following principles to help inform the debate regarding surprise medical billing in the scenarios outlined above. In the event a patient chooses to go out-of-network for non-emergency care, these principles should not apply. In February of this year, the AHA and five other national hospital associations sent a joint letter to Congress outlining our position using these principles as a guide (see attachment 1).

PROTECT THE PATIENT. Any public policy solution should protect patients and remove them from payment negotiations between insurers and providers.

Patients, regardless of the type of health care coverage they have, should be protected from gaps in insurance coverage that result in surprise bills. Patients should have certainty regarding their cost-sharing obligations, which should be based on an in network amount. Patients should not be "balance billed" in the situations described above, meaning they should not receive a bill from the provider beyond their cost-sharing obligations. Patients should not have to bear the burden of serving as an intermediary between health plans and providers, rather health plans should be responsible for paying providers directly.

ENSURE PATIENTS HAVE ACCESS TO EMERGENCY CARE. Any public policy solution should ensure that patients have access to and coverage of emergency care.

This requires that health plans adhere to the "prudent layperson standard" and not deny payment for emergency care that, in retrospect, the health plan claimed was not an emergency. Recent actions by some health plans to deny coverage of emergency services puts patients' physical, mental and financial health at risk.

PRESERVE THE ROLE OF PRIVATE NEGOTIATION. Any public policy solution should ensure providers are able to continue to negotiate appropriate payment rates with health plans.

The government should not establish a fixed payment amount for out-of-network services. Health plans and providers take into account a number of factors when negotiating rates. Any rate or methodology sufficiently simple for national use would not be able to capture these factors. In addition, a fixed payment rate could undermine patients' ability to access in-network clinicians by giving health plans less of an incentive to enlist physicians and facilities to join their networks because they can rely on a default out-of-network payment rate. Providers and health plans should be able to develop networks that meet consumers' needs, and not be compelled to enter into contracts that could thwart the development of more affordable coverage options that support coordinated care.

EDUCATE PATIENTS. Any public policy solution should include an educational component to help patients understand the scope of their health care coverage and how to access their benefits.

All stakeholders – health plans, employers, providers and others – should undertake efforts to improve patients' health care literacy and support them in navigating their health coverage and the health care system.

ENSURE ADEQUATE PROVIDER NETWORKS AND GREATER HEALTH PLAN TRANSPARENCY. Any public policy solution should include greater oversight of health plan provider networks and the role health plans play in helping patients access in-network care.

Patients should have access to easily understandable provider network information to ensure they can make informed health care decisions, including accurate listings for hospital-based physicians in health plan directories and websites. Patients also should have adequate access to in-network providers, including hospital-based specialists at in-network facilities, rather than simply a minimum number of physicians and hospitals. Federal and state regulators should ensure both the adequacy of health plan provider networks and the accuracy of provider directories. Health plans should be responsible for an efficient and timely credentialing process to minimize the amount of time a physician is "out-of-network."

SUPPORT STATE LAWS THAT WORK. Any public policy solution should take into account the interaction between federal and state laws.

Many states have undertaken efforts to protect patients from surprise billing, but federal action is necessary to protect patients in self-insured employer-sponsored plans regulated under the Employee Retirement Income Security Act, which cover the majority of privately insured individuals. Any federal solution should provide a default to state laws that meet the federal minimum for consumer protections.

ADDRESSING OTHER ISSUES

Notice and Disclosure. Many stakeholders see a role for hospitals in notifying patients of the potential for out-of-network care in non-emergency settings, and most hospitals have some form of notice-and-disclosure protocols in place. Some existing notice requirements at the state level include that hospitals:

- notify patients that they may be provided care from physicians not in the patient's network;
- post the health plans they participate in, as well as their contracted physician groups;
- inform patients before scheduling non-emergency services as to network status of care providers; and
- provide patients with the medical codes and estimated fees for any potential out-of-network care.

While we believe that providing the patient such network status information is important, it is not in and of itself a solution to surprise medical bills. The nature of emergencies, and the legal requirements regarding how and when coverage may be discussed, make providing notice in some of these instances difficult. Notice may not be particularly effective in other scenarios as well. Additional paperwork can often be confusing for patients, especially in instances where they may not have another timely alternative for care.

Network Adequacy and Patient Education. Today, hospitals work with patients and their insurers to help them navigate the health care system, including scheduling follow-up care with in-network providers. These efforts have grown commensurate with the growth in high-deductible health plans and narrow insurance networks. Patients enrolled in these newer health plan products often lack an understanding of their out-of-pocket obligations before their plan coverage starts, or that their plan's narrow network limits their access to hospitals and providers. Ensuring adequate networks and patient education regarding the health insurance products they purchase is critical to addressing surprise medical bills.

Bundling of Emergency Department Services. Some stakeholders are promoting the use of "bundling" of hospital and physician services as a way to reduce the incidence of surprise medical billing. While full details on the approach are not yet available, the model, as currently explained, would have insurers negotiate and contract with hospitals for a single rate for emergency care. Hospitals, presumably, would then be responsible for negotiating and contracting with physicians for their services. This concept may seem simple and straightforward in theory; in reality, however, this approach would be administratively complex, fundamentally change the relationship between hospitals and their physician partners, and, alone, do nothing to protect patients from surprise bills. We strongly oppose such a model.

The unique nature of emergency care – namely the uncertainty and potential for high variation – makes it a poor candidate for bundled payments. Several variations of bundled payments for episodes of care have been implemented over the past decade with mixed success. Developing such an arrangement involves a complex array of clinicians, statisticians, lawyers and others to define the services and duration of the bundle, to appropriately price it, and to ensure that any financial relationships between the various providers adhere to state and federal law, including the Stark law and Anti-kickback Statute. To date, the greatest success in bundling has been for services for which the clinical care is well defined and little variation is expected, such as for certain planned joint replacements. For the vast majority of these bundles, physicians and hospitals continue to negotiate their own rates with insurers. Any individual visit to an emergency department can involve countless possible services – from initial diagnosis and confirmatory tests to trauma and complicated surgical procedures involving multiple physicians and other providers, depending on an array of factors. Simply put: Bundled payments are not appropriate for emergency care.

Bundled payments alone also do nothing to stop patients from receiving surprise bills and may put patient access to care at risk. In fact, the proponents of this model note that it must be coupled with a state or federal law that specifically bans balance billing. This ban is the solution to surprise bills, and one that we support. Bundling, therefore, appears to meet some other objective, including allowing insurers to transfer to hospitals their responsibility for establishing comprehensive physician networks and managing the associated financial risk. Hospitals are not set up to manage this type of risk, and patient access to care in their communities could be threatened if they are unsuccessful.

Reference Pricing. We urge committee members to reject legislative proposals specifying a national reimbursement rate for out-of-network services. Health plans and hospitals have a longstanding history of resolving out-of-network emergency service claims, and this process should not be disrupted. We are particularly concerned that any attempt at setting a reimbursement standard in law will have significant consequences, including the creation of a disincentive for insurers to maintain adequate provider networks. Growth in the use of no-network, reference-based pricing models in the commercial market suggests this is already a growing strategy, and one that would accelerate if the insurer could simply default to a government-established, out-of-network rate or methodology.

The process of rate negotiation is a core function of managing a health plan. The process takes into account a number of factors that could not be accounted for in a government rate or methodology. For example, health plans and providers often consider their entire lines of business, volume, quality, partnerships on special programs or initiatives, and other factors when setting rates. Any rate or methodology sufficiently simple for national use would not be able to capture the many factors that health plans and providers consider in individual markets, and health plans should not be absolved of the core function of establishing provider networks, including negotiating rates with providers.

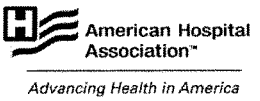
Air Ambulances. Some of our hospital and health system members have raised concerns about the increase in surprise billing for air ambulance services and the need for federal engagement on this issue. The Federal Aviation Administration (FAA) regulates air ambulances, and federal law pre-empts states from regulating rates, routes and services of air carriers, which has limited state governments' ability to address air ambulance balance billing issues.

The Government Accountability Office recently released a report on air ambulance surprise bills that found that, between 2010 and 2014, the median prices charged by air ambulance providers for helicopter transports approximately doubled, and the number of air ambulance helicopters grew by more than 10 percent.[1] In addition, the agency found that, in 2017, about two-thirds of air ambulance transports for privately insured patients were out of network, insurers typically paid only a portion of the out-of-network services, and almost all of the consumer complaints involved balance bills of over $10,000. As required by the FAA Reauthorization Act of 2018, the Secretary of Transportation has formed an advisory committee on air ambulance patient billing. The advisory committee is directed to recommend ways to protect consumers from surprise air ambulance bills. While this issue is not in the jurisdiction of the committee, we would ask you to consider air ambulance service issues while developing legislation solutions related to surprise medical billing.

CONCLUSION

We thank you for the opportunity to share the hospital and health system field's principles and concerns as they relate to surprise billing. We appreciate that this issue is a priority for Congress, as it is for our field and our patients. We have outlined a solution to the issue of surprise billing, and urge Congress to enact legislation.

[1] GAO-19-292 Air ambulance www.gao.gov/assets/700/697683.pdf













February 20, 2019

Dear Congressional and Committee Leadership:

On behalf of our member hospitals, health systems and other health care organizations, we are fully committed to protecting patients from "surprise bills" that result from unexpected gaps in coverage or medical emergencies. We appreciate your leadership on this issue and look forward to continuing to work with you on a federal legislative solution.

Surprise bills can cause patients stress and financial burden at a time of particular vulnerability: when they are in need of medical care. Patients are at risk of incurring such bills during emergencies, as well as when they schedule care at an in-network facility without knowing the network status of all of the providers who may be involved in their care. **We must work together to protect patients from surprise bills.**

As you debate a legislative solution, we believe it is critical to:

- **Define "surprise bills."** Surprise bills may occur when a patient receives care from an out-of-network provider or when their health plan fails to pay for covered services. The three most typical scenarios are when: (1) a patient accesses emergency services outside of their insurance network, including from providers while they are away from home; (2) a patient receives care from an out-of-network physician providing services in an in-network hospital; or (3) a health plan denies coverage for emergency services saying they were unnecessary.

- **Protect the patient financially.** Patients should have certainty regarding their cost-sharing obligations, which should be based on an in-network amount. Providers should not balance bill, meaning they should not send a patient a bill beyond their cost-sharing obligations.

- **Ensure patient access to emergency care.** Patients should be assured of access to and coverage of emergency care. This requires that health plans adhere to the "prudent layperson standard" and not deny payment for emergency care that, in retrospect, the health plan determined was not an emergency.

- **Preserve the role of private negotiation.** Health plans and providers should retain the ability to negotiate appropriate payment rates. The government should not establish a fixed payment amount or reimbursement methodology for out-of-network services, which could create unintended consequences for patients by disrupting incentives for health plans to create comprehensive networks.

- **Remove the patient from health plan/provider negotiations.** Patients should not be placed in the middle of negotiations between insurers and providers. Health plans must work directly with providers on reimbursement, and the patient should not be responsible for transmitting any payment between the plan and the provider.

- **Educate patients about their health care coverage.** We urge you to include an educational component to help patients understand the scope of their health care coverage and how to access their benefits. All stakeholders – health plans, employers, providers and others – should undertake efforts to improve patients' health care literacy and support them in navigating the health care system and their coverage.

- **Ensure patients have access to comprehensive provider networks and accurate network information.** Patients should have access to a comprehensive network of providers, including in-network physicians and specialists at in-network facilities. Health plans should provide easily-understandable information about their provider network, including accurate listings for hospital-based physicians, so that patients can make informed health care decisions. Federal and state regulators should ensure both the adequacy of health plan provider networks and the accuracy of provider directories.

- **Support state laws that work.** Any public policy should take into account the interaction between federal and state laws. Many states have undertaken efforts to protect patients from surprise billing. Any federal solution should provide a default to state laws that meet the federal minimum for consumer protections.

We look forward to opportunities to discuss these solutions and work together to achieve them.

Sincerely,

American Hospital Association
America's Essential Hospitals
Association of American Medical Colleges
Catholic Health Association of the United States
Children's Hospital Association
Federation of American Hospitals

COLLEGE of AMERICAN PATHOLOGISTS

Statement for the Record
United States Senate Committee on Education and Labor
Subcommittee on Health, Education, Labor, and Pensions
Examining Surprise Billing: Protecting Patients from Financial Pain

April 2, 2019

Statement by
College of American Pathologists

The College of American Pathologists (CAP) appreciates the opportunity to share our comments in response to the Committee's hearing on the issue of unexpected out-of-network medical bills for patients. We appreciate the discussion of this important issue so that all stakeholders can work together and formulate financial protections for patients who need care that requires out-of-network physicians at in-network facilities. The CAP has been constructively engaged on this issue for many years. It has always been our position that patients should not be financially penalized for the failure of health insurance plans to provide in-network access to hospital-based physician specialties.

As the world's largest organization of board-certified pathologists and leading provider of laboratory accreditation and proficiency testing programs, the CAP serves patients, pathologists, and the public by fostering and advocating excellence in the practice of pathology and laboratory medicine worldwide. The CAP believes that to protect patients from gaps in their health insurance coverage, insurers and providers should settle all payments without the patient's involvement, even if an independent arbitrator settles disputes. Network adequacy standards for health plans should be set, and at a minimum there should be network standards for ensuring that an appropriate number of specialty physicians are available to provide medically necessary services at "in-network" facilities. Additionally, we think it critically important that out-of-network payment mechanisms not, in any way, deter, displace or discourage equitable health plan contracting for physician services, as we believe such contracting is critical to maintaining the private commercial marketplace that consumers wish to avail. Finally, any reimbursement for out of network services should be based on data compiled by independent, non-affiliated organizations, like FAIR Health Inc., or a state's all-payor claims database (APCD). For these reasons, we urge a fully deliberative and engaged physician specialty stakeholder process as has occurred to date in multiple states to produce an optimal legislative outcome that protects patients and preserves the non-governmental health care marketplace.

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Remove burden of surprise bills from patients

Limiting patient cost sharing is an essential part of any Congressional action. Through no fault of their own, patients are caught off guard when an insurer doesn't cover certain physician services. Patients do not need additional financial stress when they are at their most vulnerable. Congress should create a system whereby insurers and providers can come to agreement independent of the patient, who should only pay for care at an in-network rate. Alternative dispute resolution (ADR) can help address this problem. If there is a dispute on payment between an insurer and provider, an independent arbitrator can step in, consider factors pertaining to the case (complexity, duration, etc.), as well as geographically-based charges by providers and payments from insurers in order to determine the fair market value of the physician service.

We can look to the states to find examples of what is working well. Several states have policies that protect patients from out-of-network bills resulting from gaps in health insurance plan contracting. States with laws that are reasonable and that appropriately protect patients include: Arizona, New Jersey, Maryland, Massachusetts, Illinois, Minnesota, Florida, Colorado, and New Hampshire.

In our view, the optimal state law protecting patients from surprise medical billing is the law enacted by New York State. Not only is there mediation/arbitration between insurers and providers, but the payment methodology upon which the "usual and customary rate" (UCR) is calculated is based upon the 80th percentile of FAIR health database charges, so as to reflect the market value of physician services. In New York, patients are financially saved harmless and there is a way for disputes between providers and plan payers to be resolved, and it relies on a payment rate that is acceptable to the provider community.

Enact network adequacy standards

Inadequate networks are the root cause of surprise bills. Without adequate networks of contracted physicians, a patient cannot be properly guarded from out of network health care at an in-network facility. If there are fewer out of network providers to begin with, there will be fewer patients receiving their bills. Furthermore, transparency cannot solve the problem for patients as many physician services are unexpected and cannot be anticipated by the patient. For example, written estimates of pathology services in advance of providing the service cannot provide reliable or useful information for patients. The need for, or type of pathology services needed in a procedure cannot be reliably predicted. Moreover, patients under anesthesia during a procedure cannot exercise choice or control over pathology or laboratory referrals. Thus, creating regulatory standards that require health insurance plans contract with the requisite

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number of providers capable of the full array of physician care, including pathology and laboratory services, in an in-network facility is paramount to reducing surprise bills.

It is important to recognize that the vast majority of providers, including pathologists, wish to contract with health plans. Health plans have deliberately and systematically denied network participation to, or ejected pathologists and clinical laboratories from network participation, and states are starting to take notice. In December of 2017, the Washington State insurance commissioner fined a health insurer $1.5 million and detailed steps it must take to fix its provider networks. Most recently, in Texas, the Center for Public Policy Priorities reported in 2014 that one health plan in the state had no pathologist providers at 20% of their in-network hospitals. Then, in October 2018, this particular health plan was fined $700,000 by the Texas Department of Insurance for failure to contract with a hospital-based physician specialty in multiple counties.

The CAP supports federal enactment of network adequacy requirements similar to the law of Louisiana (Network Adequacy Act 22§1019.1 et seq,) that expressly requires health insurance plans to "maintain a network of providers that includes but is not limited to providers that specialize in mental health and substance abuse services, facility-based physicians, and providers that are essential community providers." Facility-based physicians are defined in the Louisiana Act to include: "anesthesiologist, hospitalist, intensivist, neonatologist, pathologist, radiologist, emergency room physician, or other on-call physician, who is required by the base health care facility to provide covered health care." Such requirements should be subject to regulatory oversight and enforcement to ensure that enrollees (patients) have reasonable and timely access to in-network physician specialists at in-network hospitals and facilities. California (Code of Regulations (CCR) Title 10, Section 2240.5 (d) (14)) and New Hampshire (RSA 420.J:7 II(e)are two other states with specific hospital-based physician network adequacy requirements. However, at present, the vast majority of states have no such hospital-based physician network adequacy requirement and thus should be compelled under federal law to adopt such requirements.

Fair reimbursement for out-of-network services

In order to encourage health plans to contract for physician services, and to ensure that the health care delivery system is financially viable, a fair market rate should be paid for physician services. In general, caps on payment for physicians treating out-of-network patients should be avoided. If pursued, guidelines or limits on what out-of-network providers are paid should reflect actual charge data for the same service in the same geographic area from a statistically significant and wholly independent database.

They should not be based on a percentage of Medicare rates, which have become increasingly inadequate in covering overhead costs, nor should they be based on in-network rates, which would eliminate the need for insurers to negotiate contracts in good faith. Any prohibition, whether state or federal, on billing from out-of-network providers

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not chosen by the patient should be paired with a corresponding payment process that is keyed to the market value of physician services.

Summary

As the committee moves to address this issue, it's of paramount importance to strike a compromise that holds patients harmless if they are treated by a physician who is out-of-network, but also allows providers and insurers to come to agreement on outstanding bills. The CAP would be supportive of any legislative proposal that includes:

1.) Language that holds patients harmless and enacts a process, like ADR, that would allow insurers and providers to settle any billing disputes without involving the patient.
2.) Inclusion of network adequacy standards that ensure a proper number of physicians can provide services at in-network facilities.
3.) If a payment benchmark is proposed, that Medicare is not used. Instead there is a balance of geographic rates from an independent database to inform either an arbitrator in an ADR process, or a general rate for services provided from an out-of-network provider.

Thank you for your consideration of this important issue and we look forward to working with your committee to come up with the best solution for ensuring patients have in-network access to physician services or are otherwise protected from out-of-network charges that result from health plan inadequacies. If you would like to meet, or have any questions, please contact Michael Hurlbut, Assistant Director, Legislation and Political Action, at mhurlbu@cap.org or 202-354-7112.

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April 9, 2019

U.S. House of Representatives
Committee on Education & Labor
Subcommittee on Health, Employment, Labor, and Pensions

Re: Hearing on "Examining Surprise Billing: Protecting Patients from Financial Pain"

Chairwoman Wilson, Ranking Member Walberg, members of the subcommittee:

Community Catalyst is a national, non-profit health care advocacy organization dedicated to quality affordable health care for all. We respectfully submit the following statement on the issue of surprise medical bills discussed at the hearing on April 4, 2019.

We appreciate the opportunity to weigh in on this important issue that is a top health concern for many individuals and families in this country.[1] Evidence shows over fifty percent of privately insured patients have been surprised by a medical bill they thought would be covered, and twenty percent of those bills were the result of a doctor not being a part of a patient's insurance network.[2] These surprise medical bills are often excessively high, which can result in hundreds and thousands of dollars in medical debt or even bankruptcy.[3]

Although at least 25 states have taken initial steps to protect their residents from surprise medical bills, only Congress can fully close the gaps and loopholes that leave patients vulnerable to severe financial distress. Congress is in a better position to protect more consumers due to ERISA preemption that excludes consumers in self-funded plans from benefiting from state protections.

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[1] Ashley Kirzinger, Bryan Wu, Cailey Muñana, and Mollyann Brodie. Kaiser Health Tracking Poll – Late Summer 2018: The Election, Pre-Existing Conditions, and Surprises on Medical Bills. *The Kaiser Family Foundation*, September 05, 2018. https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-late-summer-2018-the-election-pre-existing-conditions-and-surprises-on-medical-bills/ Accessed April 5, 2019

[2] NORC at the University of Chicago. Press Release: New Survey Reveals 57% of Americans Have Been Surprised by a Medical bills. August 30, 2018. http://www.norc.org/NewsEventsPublications/PressReleases/Pages/new-survey-reveals-57-percent-of-americans-have-been-surprised-by-a-medical-bill.aspx. Accessed April 5, 2019

[3] Liz Hamel, Mira Norton, Karen Pollitz, Larry Levitt, Gary Claxton, and Mollyann Brodie. The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey. The Kaiser Family Foundation, January 05, 2016. https://www.kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey. Accessed April 5, 2019

We commend the Committee for holding their hearing on the 4th and the witnesses for the excellence they presented. We would like to reinforce and expand on several points that were made at the hearing.

In general, we strongly urge the Committee to adopt strong consumer protections that hold consumer harmless from surprise medical bills in all situations where they cannot reasonably be expected to ensure they are receiving in-network care. At the same time, it is critical to put in place policies that curb provider monopoly power on pricing and ensure quality networks. Since it is difficult for Congress to assess competitive conditions in every market, you might want to consider an approach that would set both a floor to prevent insurers from forcing providers to accept unreasonably low rates, but also a ceiling to keep providers from pushing the rates too high.

Finally, federal policies on surprise medical bills should apply to all states as minimum requirements. However, states should be allowed to go beyond the federal floor to create additional consumer protections and further lower health care costs. We also urge the Committee to put in place a mechanism for oversight, enforcement and evaluation.

Detailed Policy Recommendations

We strongly believe that if done correctly, ending surprise balance billing is one way to not only protect people from excessive bills and the risk of medical debt, but also to work to lower health care costs overall. We encourage the Committee to adopt a comprehensive approach, which should include the following policy elements:

Prohibit surprise medical bills.[4] As noted by Madam Chairwoman Wilson in her opening statement, *"the victims of surprise medical billing often have no control over whether their medical provider is in- or out-of-network."* Therefore, to hold consumers harmless from surprise medical bills, Congress should explicitly prohibit providers from balance billing patients in *all* situations where they cannot reasonably be expected to ensure they are receiving in-network care. Those situations include, but are not limited to:

- *Emergency care, including ground and air ambulance transportation.* In many cases, emergency physicians and the hospitals where they work do not contract with the same insurers. As a result, despite going to an in-network hospital for emergency care, a patient might be treated by an out-of-network physician. Nationwide, one in five in-patient emergency admissions leads to a surprise medical bill, and more than half of these cases involved ambulance transportation.[5]

[4] For additional consumer protections, please see our recent policy report: Ending Surprise Balance Billing: Steps to Protect Patients and Reduce Excessive Health Care Costs. February 2019. https://www.communitycatalyst.org/resources/publications/document/2019/balance-billing/CC-BalancedBilling-Report-FINAL.pdf

[5] Christopher Garmon and Benjamin Chartock. One In Five Inpatient Emergency Department Cases May Lead To Surprise Bills. Health Affairs, Vol. 36, No. 1. https://doi.org/10.1377/hlthaff.2016.0970. Accessed April 5, 2019

In regards to air ambulance services, the recent report conducted by the U.S. Government Accountability found that in 2017 two-thirds of air ambulance transports for patients with private insurance were out-of-network. Almost all of the consumer complaints about balance bills, reviewed for the report, were over $10,000.[6] Some states have attempted to collect information from patients in the effort to raise awareness of balance bills related to air ambulance.[7] However, due to the Airline Deregulation Act of 1978 (ADA) that explicitly precludes states from regulating air transportation, including air ambulances, states are unable to put in place policies that can protect their residents from exorbitant out-of-network charges from for-profit air ambulance companies. This particularly affects patients living in many rural parts of the country, who sometimes rely on air ambulance services to access emergency care. Federal policymakers alone have the power to regulate air ambulances by amending the ADA.

- *Unexpectedly receiving care from out-of-network providers (including ancillary providers and specialty providers) at an in-network facility.* Similar to emergency physicians, providers such as anesthesiologists, pathologists, radiologists, neonatologists, or assistant surgeons might be out-of-network even though they work at an in-network facility. For example, a patient could arrange for a hip replacement with an in-network surgeon at an in-network facility, but the assistant surgeon helping with the surgery and the radiologist performing the MRI could be out-of-network. In these situations, patients have no means to check if any out-of-network providers are part of their care team.

- *Inadvertently receiving care from out-of-network providers due to inaccurate provider directories.* A patient could do everything right to make sure they receive care from providers that have contracted with their health plan, but if they unknowingly rely on an inaccurate provider directory, they could end up inadvertently receiving care from an out-of-network provider.

Require transparency and disclosure of provider network status and estimated out-of-network charges. Consumers should be informed when care is out-of-network and their potential financial obligations. However, Congress should be cautious of the use of consumer notifications. As explained above, there are many situations in which a normally prudent person cannot be expected to manage the process of ensuring that every provider is in-network. Therefore, *it is critical that consumer protections should not be tied to notices or triggered by notice failure.* Disclosure and transparency requirements *should not* be a substitute for consumer protections from surprise medical bills; they should be a complement.

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[6] United States Government Accountability Office. Air Ambulance: Available Data Show Privately-Insured Patients Are At Financial Risk. Report to Congressional Committees. March 2019. https://www.gao.gov/assets/700/697684.pdf. Accessed October 18, 2018.

[7] In the effort to raise awareness of this problem, state officials from Montana and Michigan reviewed 58 cases of balance billing resulting from air ambulances since 2013 and found that patients were balance billed an average of $31,000. (Sources: Consumers Union (March 2017). Health Policy Report: Up in the Air: Inadequate Regulation for Emergency Air Ambulance Transportation. https://consumersunion.org/wp-content/uploads/2017/04/Up-In-The-Air-Inadequate-Regulation-for-Emergency-Air-Ambulance-Transportation.pdf; and United States Government Accountability Office (July 2017). Air Ambulance: Data Collection and Transparency Needed to Enhance DOT Oversight. Report to the Committee on Transportation and Infrastructure, House of Representatives. https://www.gao.gov/assets/690/686167.pdf)

Establish a process to resolve payment disputes between insurers and out-of-network providers that includes provider payment standards in surprise scenarios. Consumers should not bear the burden of resolving surprise medical bills. At the same time, it is necessary to have a system that puts downward pressure on monopoly prices while ensuring that provider payments are adequate. To accomplish these goals, it is important to establish a payment resolution process that (a) encourages insurers and providers to settle their disagreements between themselves; (b) does not put upward pressure on premiums; and (c) does not provide financial incentives for providers to remain out-of-network. A number of approaches, if designed carefully, are consistent with these goals:

- One option would be for Congress to establish a "baseball" arbitration process as a fallback option if these two parties are unable to reach a resolution on their own—where each party submits their "best and final" offer. An arbitrator would then choose one or the other. However, where there is an arbitration involved, it is crucial that provider charges should not be used as a benchmark for resolving disputes as charges, especially for specialty services, most often resulting in surprise bills are often excessively high. For example, a 2017 study published in the Journal of the American Medical Association (JAMA) found that the average anesthesiologist, radiologist and pathologist charge is four times more for their services than what Medicare pays for similar services while for general practice the charge is only 1.6 times higher than the Medicare rate.[8]

- Another approach is to enhance the negotiating leverage of payers by following the example of Medicare Advantage (MA) and setting a ceiling on out-of-network prices. The ceiling on out-of-network charges has allowed MA plans to negotiate payment rates that are equivalent to, or sometimes even lower than Medicare. Under Medicare rules, out-of-network providers cannot charge MA beneficiaries more than Medicare FFS rates—a cap that also has had the effect of constraining rates for in-network providers.[9] A study conducted by Berenson et. al. found that MA plans "nominally pay only 100-105 percent of traditional Medicare rates" citing the statutory and regulatory requirements that maintain parity in pricing for hospital services.[10] As with the arbitration approach, it is important that any rate ceiling not cause premiums to increase or give providers a financial incentive to remain out-of-network.

Oversight, evaluation and enforcement. To ensure that consumers are effectively protected from surprise medical bills, Congress should consider requiring mechanisms to oversee, evaluate and enforce these protections. HHS and other relevant agencies should track the prevalence of and resolutions to out-of-network billing disputes and ensure that patients are not erroneously billed. Oversight evaluation and enforcement will help ensure that both the consumer protections and

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[8] Ge Bai and Gerard F. Anderson. "Variation in the Ratio of Physician Charges to Medicare Payments by Specialty and Region." JAMA. 2017; 317(3):315-318. doi:10.1001/jama.2016.16230. Accessed April 5, 2019.

[9] Murray R. Hospital Charges And The Need For A Maximum Price Obligation Rule For Emergency Department & Out-Of-Network Care. Health Affairs. https://www.healthaffairs.org/do/10.1377/hblog20130516.031255/full/. Published May 16, 2013. Accessed April 5, 2019.

[10] Berenson RA, Sunshine JH, Helms D, Lawton E. Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices. Health Affairs. 2015;34(8):1289-1295. doi:10.1377/hlthaff.2014.1427. Accessed April 5, 2019

payment resolution process are working as intended and can identify the need for further improvements or corrections.

Thank you again for the opportunity to provide comments on this important issue. As individuals and families struggle to pay for health care services, it is clear that what people want is for policymakers to find a way to make their health insurance premiums and out-of-pocket cost sharing more affordable. We urge the Committee to take bold actions to protect consumers and control overall health care costs.

Respectfully submitted,



Michael Miller
Director, Strategic Policy

[Additional submission by Mr. Walberg follows:]

April 02, 2019

The Honorable Frederica S. Wilson
Chair
Subcommittee on Health, Employment,
Labor and Pensions
Washington, DC 20515

The Honorable Tim Walberg
Ranking Member
Subcommittee on Health, Employment,
Labor and Pensions
Washington, DC 20515

Dear Chair Wilson and Ranking Member Walberg:

We applaud you for holding a hearing examining surprise billing. Reflecting the goal of employers to protect patients from surprise medical bills without undermining network participation or resulting in higher health care costs for all consumers, we urge Congress to pass legislation consistent with the following provisions:

Protect Patients from Surprise Medical Bills

- The goal of any federal surprise balance billing legislative solution is to protect patients in situations in which they lack a choice of providers. It is vitally important, however, that any legislative solutions not discourage network participation or result in higher health care costs for all consumers. Patients often lack any meaningful choice of provider when they obtain care in out-of-network emergency rooms, and when a patient receives services in in-network facilities from out-of-network professionals, particularly with respect to a small number of provider specialties.
- To protect consumers and families, federal legislation must ensure that patient cost-sharing is limited to in-network amounts for emergency services performed at an out-of-network facility or for treatment by out-of-network facility-based physicians performed at in-network facilities, and prohibit providers from imposing additional "surprise" balance bills in these circumstances.
- Congress should implement this change through an amendment to section 2719A of the Public Health Service Act ("PHSA"), which applies to both group and individual commercial insurance, and which would apply to insured and self-funded group health plans through section 715 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

Disclosure and Transparency

- For surprise balance billing that occurs at an in-network facility and follow-up care from emergency treatment at an out-of-network facility, federal legislation must require disclosure of out-of-network professional costs at the time of scheduling. This disclosure will help ensure that patients can make an informed decision and schedule procedures when an in-network professional is available.
- Facilities such as hospitals should also be required to list prominently on their websites, whether they lack available providers who participate in networks which the facility participates in – including what those specialties are, and the likelihood that a patient may thus be seen by an out-of-network provider.

- Much of the surprise over unexpected balance billing can be eliminated by providing this disclosure.
- Congress could implement this disclosure requirement directly on hospitals (through Medicare's minimum requirements for hospitals under 42 USC § 1395x(e)(1)-(8)), or through an amendment to section 2718(e) of the PHSA, which requires hospitals to disclose standard charges for items and services provided by the hospitals.

Required Reimbursement

- Out-of-network providers frequently bill well in excess of negotiated rates and Medicare reimbursement for these services, as opposed to the actual value of the service provided. A study by Ge Bai and Gerard F. Anderson, published in JAMA in 2017 comparing physician charge-to-Medicare payment ratio across specialties found that anesthesiology had the highest median (5.8), followed by interventional radiology (4.5), emergency medicine (4.0), and pathology (4.0).
- To ensure equitable payment for the services provided without discouraging network participation or resulting in higher costs for all consumers, legislation must set a reasonable federal reimbursement structure that (1) establishes a federal cap for emergency services at an out-of-network facility at 125 percent of the Medicare rate, and (2) requires all providers at an in-network facility to accept in-network rates.
- Conversely, without reasonable limitations on the reimbursement rates, out-of-network providers in surprise balance billing situations will have an incentive to bill even higher rates in order to achieve maximum payment through any binding arbitration mechanism. Binding arbitration is an inefficient and ineffective approach to addressing surprise billing and should not be included as a legislative solution. The experience of the mediation process in Texas is instructive. According to a recent report, the Texas Department of Insurance received just 43 requests from consumers for mediation in 2013. In 2014, the number of requests grew to more than 600 and have climbed steeply ever since. There were 4,519 requests in 2018, creating a significant backlog,
- Requiring facilities to bundle medical services for covered procedures into a single payment also could help address this problem if structured properly. In the case of bundled services performed by out-of-network providers, the costs of those services within the bundle cannot exceed either the allowable in-network rate or 125% of Medicare. But, care must be taken to ensure that the contracted bundled payment is final and not merely a progress point toward further negotiation.
- Congress should implement this change through an amendment to section 2719A of the PHSA, which applies to both group and individual commercial insurance, and which would apply to insured and self-funded group health plans through section 715 of ERISA.

Ambulance and Outsourced Emergency Departments

- A significant concern to both patients and plans are the massive costs associated with non-participating ambulance, air ambulance, and emergency department services.

- According to GAO's analysis of the most complete data identified for air ambulance transports of privately-insured patients, 69 percent of about 20,700 transports in the data set were out-of-network in 2017.
- Ambulance, air ambulance, and emergency services are essential to ensure that patients receive the care they need in the most urgent of situations. Subjecting patients in the most dire of circumstances to balance billing exposes patients to material liabilities in order to receive the care they need.
- Any legislative solution for surprise balance billing should also specify that ambulances and air ambulance services are considered emergency services for purposes of the statutory limitations on balance billing and reimbursement rates.
- Further, Congress should include provisions to eliminate problematic incentives in which an in-network facility could profit by allowing or encouraging an outsourced out-of-network emergency department to surprise bill in-network patients.
- Congress should implement this change through an amendment to section 2719A of the PHSA, which applies to both group and individual commercial insurance, and which would apply to insured and self-funded group health plans through section 715 of ERISA.

We look forward to working with you to address the burden of surprise medical billing.

Sincerely,

American Benefits Council
Associated Builders and Contractors, Inc.
Associated General Contractors
Auto Care Association
Colorado Business Group on Health
Corporate Health Care Coalition
Council for Affordable Health Coverage
Economic Alliance for Michigan
Florida Health Care Coalition
Food Marketing Institute
Greater Philadelphia Business Coalition on Health
HealthCare 21 Business Coalition
Houston Business Coalition on Health
Louisiana Business Group on Health
Midwest Business Group on Health
National Alliance of Healthcare Purchaser Coalitions
National Association of Health Underwriters
National Association of Wholesaler-Distributors
National Business Group on Health
National Restaurant Association
National Retail Federation
Pacific Business Group on Health
Partnership for Employer-Sponsored Coverage
Retail Industry Leaders Association
Retailers Association of Massachusetts

Rhode Island Business Group on Health
Self-Insurance Institute of America, Inc.
Silicon Valley Employers Forum
Small Business & Entrepreneurship Council
Society of Professional Benefit Administrators
St. Louis Area Business Health Coalition
The Council of Insurance Agents & Brokers
The ERISA Industry Committee
Wyoming Business Coalition on Health

[Questions submitted for the record and their responses follow:]

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DUSTY JOHNSON, SOUTH DAKOTA

April 12, 2019

Mr. Frederick Isasi, J.D., MPH
Executive Director
Families USA
1225 New York Avenue, NW, Suite 800
Washington, D.C. 20005

Dear Mr. Isasi:

I would like to thank you for testifying at the April 2, 2019, Subcommittee on Health, Education, Labor, and Pensions hearing on "Examining Surprise Billing: Protecting Patients from Financial Pain."

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later Wednesday, April 24, 2019, for inclusion in the official hearing record. Your responses should be sent to Daniel Foster of the Committee staff. He can be contacted at the main number 202-225-3725 should you have any questions.

We appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman

Enclosure

Health, Employment, Labor, and Pensions Subcommittee Hearing
"Examining Surprise Billing: Protecting Patients from Financial Pain"
Tuesday, April 2nd, 2019
10:15am

REPRESENTATIVE HALEY M. STEVENS (MI)

Surprise medical bills lead to devastating consequences for consumers throughout the country.

1. Is there a way to determine just how large these expenses are for consumers?

2. How prepared are Americans for these unexpected expenses?

REPRESENTATIVE DAVID P. ROE (TN)

1. Insurers typically do not disclose the type of plan that covers a claim. So, patients and providers cannot determine which federal protections apply to the visit. For instance, patients don't know if certain annual and lifetime limits apply to their required contribution. And providers don't know whether the federal minimum payment standard for emergency care applies. Patients and providers may need to expend a great deal of time, energy and money to gather this simple, yet essential, plan information. Given that, do you think federal legislation should require health care insurance policy numbers to designate the type of plan? For instance, if policy numbers included a "-E" at the end when it is an ERISA plan, this would clear up a lot of confusion. What are your thoughts on this approach?

2. While emergency physicians account for only four percent of physicians, they provide 67 percent of all care to uninsured patients and 50 percent of all care given to Medicaid and CHIP patients. Further, in emergency medicine, only commercially-insured claims are profitable. Uninsured, Medicare, and Medicaid claims all have negative profit margins. Even when a claim is covered by commercial insurance, emergency physicians collect only an estimated 30 to 40 percent of patient cost-sharing. In light of this, federal and state laws treat emergency care differently in order to protect access to the nation's health care safety net. The emergency physician is mandated by federal law to provide both in-network and out-of-network care. Do you think federal legislation should mandate that commercial insurers provide appropriate coverage for this federally mandated care?

3. It's clear that patients in the same location have 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 their patients? What are the incentives that have led insurance plans to create narrow, inadequate networks?

4. Patients in these networks receive surprise bills because there isn't the provider base to support the care these patients require. How do we reverse the incentives to allow more providers to be in network and taking care of more patients, which is obviously in their interest to do? Have any states tried to create standards for network adequacy and keep track of the plans' performance? What has the result been for patients in those states?

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April 12, 2019

Mr. Jack Hoadley, Ph.D.
Research Professor Emeritus
Georgetown University: Health Policy Institute
McCourt School of Public Policy
4064 Ridgeview Circle
McLean, VA 22101

Dear Professor Hoadley:

I would like to thank you for testifying at the April 2, 2019, Subcommittee on Health, Education, Labor, and Pensions hearing on "Examining Surprise Billing: Protecting Patients from Financial Pain."

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later Wednesday, April 24, 2019, for inclusion in the official hearing record. Your responses should be sent to Daniel Foster of the Committee staff. He can be contacted at the main number 202-225-3725 should you have any questions.

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Chairman

Enclosure

Health, Employment, Labor, and Pensions Subcommittee Hearing
"Examining Surprise Billing: Protecting Patients from Financial Pain"
Tuesday, April 2, 2019
10:15am

REPRESENTATIVE DONALD NORCROSS (NJ)

1. Some states have limited arbitration to either large claims (e.g., Arizona has a $1000 threshold) or to disputes over a certain threshold (i.e., "amount in dispute"). For instance, the New Jersey law states that dispute resolution is available if the "difference between the carrier's and the provider's final offer is not less than $1000." Therefore, for a $1500 bill from an out-of-network provider, if the carrier has agreed to pay $300, but the provider still believes he or she should receive an additional $1200, then the "amount in dispute" is over $1000 and, as such, eligible for arbitration. Given that nuance, which do you believe is a better threshold – total claim amount or amount in dispute – and why?

REPRESENTATIVE DAVID P. ROE (TN)

1. Insurers typically do not disclose the type of plan that covers a claim. So, patients and providers cannot determine which federal protections apply to the visit. For instance, patients don't know if certain annual and lifetime limits apply to their required contribution. And providers don't know whether the federal minimum payment standard for emergency care applies. Patients and providers may need to expend a great deal of time, energy and money to gather this simple, yet essential, plan information. Given that, do you think federal legislation should require health care insurance policy numbers to designate the type of plan? For instance, if policy numbers included a "-E" at the end when it is an ERISA plan, this would clear up a lot of confusion. What are your thoughts on this approach?

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April 12, 2019

Ms. Ilyse Schuman
Senior Vice President, Health Policy
American Benefits Council
1501 M Street, NW, Suite 600
Washington, D.C. 20005

Dear Ms. Schuman:

I would like to thank you for testifying at the April 2, 2019, Subcommittee on Health, Education, Labor, and Pensions hearing on "Examining Surprise Billing: Protecting Patients from Financial Pain."

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later Wednesday, April 24, 2019, for inclusion in the official hearing record. Your responses should be sent to Daniel Foster of the Committee staff. He can be contacted at the main number 202-225-3725 should you have any questions.

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Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman

Enclosure

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REPRESENTATIVE DAVID P. ROE (TN)

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REPRESENTATIVE RUSS FULCHER (ID)

1. In your testimony, you mentioned that while employers seek to ensure employees are aware of the higher costs of out-of-network services, more "assistance" is needed, such as "contracting with other entities" to negotiate the bill. Can you elaborate on that? How can we generate more affordable choices and options for the consumer?

2. What do you see as the main challenges to requiring third-party providers from contracting with the insurance company that services a particular hospital or clinic, so that the consumer can at least know the potential price of the service and help control prices that are charged by the third-party provider?

3. Typically, employees turn to the benefits manager at their job for help with a surprise bill (a charge they didn't know they had to pay because it wasn't covered on their insurance). What can we do to help these employers have more health care insurance and non-insurance options that might lower costs?

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April 12, 2019

Ms. Christen Linke Young, J.D.
Fellow, USC-Brookings Schaeffer Initiative on Health Policy
The Brookings Institution
1775 Massachusetts Avenue, NW
Washington, D.C. 20036

Dear Ms. Young:

I would like to thank you for testifying at the April 2, 2019, Subcommittee on Health, Education, Labor, and Pensions hearing on "Examining Surprise Billing: Protecting Patients from Financial Pain."

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later Wednesday, April 24, 2019, for inclusion in the official hearing record. Your responses should be sent to Daniel Foster of the Committee staff. He can be contacted at the main number 202-225-3725 should you have any questions.

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Tuesday, April 2nd, 2019
10:15am

REPRESENTATIVE HALEY M. STEVENS (MI)

Many experts, including some of your colleagues at the Brookings Institution, have discussed a multi-pronged approach to addressing surprise billing.

1. Can you share your thoughts on developing policies that treat the balance of the bill as an in-network charge, and therefore covered by the patient's insurance?

2. What about prohibiting balance billing altogether?

REPRESENTATIVE DAVID P. ROE (TN)

1. Insurers typically do not disclose the type of plan that covers a claim. So, patients and providers cannot determine which federal protections apply to the visit. For instance, patients don't know if certain annual and lifetime limits apply to their required contribution. And providers don't know whether the federal minimum payment standard for emergency care applies. Patients and providers may need to expend a great deal of time, energy and money to gather this simple, yet essential, plan information. Given that, do you think federal legislation should require health care insurance policy numbers to designate the type of plan? For instance, if policy numbers included a "-E" at the end when it is an ERISA plan, this would clear up a lot of confusion. What are your thoughts on this approach?

2. While emergency physicians account for only four percent of physicians, they provide 67 percent of all care to uninsured patients and 50 percent of all care given to Medicaid and CHIP patients. Further, in emergency medicine, only commercially-insured claims are profitable. Uninsured, Medicare, and Medicaid claims all have negative profit margins. Even when a claim is covered by commercial insurance, emergency physicians collect only an estimated 30 to 40 percent of patient cost-sharing. In light of this, federal and state laws treat emergency care differently in order to protect access to the nation's health care safety net. The emergency physician is mandated by federal law to provide both in-network and out-of-network care. Do you think federal legislation should mandate that commercial insurers provide appropriate coverage for this federally mandated care?

3. It's clear that patients in the same location have 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 their patients? What are the incentives that have led insurance plans to create narrow, inadequate networks?

4. Patients in these networks receive surprise bills because there isn't the provider base to support the care these patients require. How do we reverse the incentives to allow more providers to be in network and taking care of more patients, which is obviously in their interest to do? Have any states tried to create standards for network adequacy and keep track of the plans' performance? What has the result been for patients in those states?

FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

April 24, 2019

The Honorable Bobby Scott, Chairman
House Committee on Education and Labor
U.S. House of Representatives
Washington, DC 20005

Dear Chairman Scott:

On April 2, 2019, the House Education and Labor Subcommittee on Health, Labor, and Pensions convened a hearing on "Examining Surprise Billing: Protecting Patients from Financial Pain," at which I testified on behalf of my organization, Families USA (FUSA). After the hearing, Members of the Committee submitted questions for the record to all witnesses. Below, please find responses to these questions prepared by the FUSA Staff.

Thank you again for the opportunity to testify. If any Committee Members or staff would like to discuss these answers further or need any other support, we would be very happy to provide assistance. Please feel free to reach out to me or Shawn Gremminger, FUSA Senior Director of Federal Relations at SGremminger@familiesusa.org or 202-628-3030.

Sincerely,

Frederick Isasi
Executive Director

FamiliesUSA.org
1225 New York Avenue, NW, Suite 800
Washington, DC 20005
main 202-628-3030 / fax 202-347-2417

Frederick Isasi, Executive Director, Families USA
Answers to Questions for the Record

Health, Employment, Labor, and Pensions Subcommittee Hearing
"Examining Surprise Billing: Protecting Patients from Financial Pain"
Tuesday, April 2nd, 2019
10:15am

REPRESENTATIVE HALEY M. STEVENS (MI)

Surprise medical bills lead to devastating consequences for consumers throughout the country.

1. Is there a way to determine just how large these expenses are for consumers?

Answer: Surprise medical bills can result in hundreds, thousands, and even tens-of-thousands of completely unanticipated out-of-pocket costs for consumers.[1] For example, to learn about the magnitude of surprise bills, the New York Department of Financial Services surveyed insurance plans in the state on whether they received bills from out-of-network emergency providers that were greater than $2,500 and more than 200% of the Medicare rate. All insurers surveyed reported receiving bills that met these criteria. On average, these bills totaled $7,006, of which insurers paid $3,228 and consumers paid *$3,778.*[2] These data from New York are representative of consumer experience throughout the nation.[3]

2. How prepared are Americans for these unexpected expenses?

Answer: Surprise medical bills can be thousands or even tens-of-thousands of dollars[4] and most American families have little to no ability to absorb the cost of surprise medical bills. For example, the Federal Reserve reports that 40 percent of Americans do not have the savings to cover an unexpected $400 expense (i.e., requiring them to either sell a possession or increase their borrowing).[5] We would posit that consumers who do everything they can to prevent unaffordable medical costs by buying insurance and working to properly navigate the complex health care system rightfully expect that they will be protected from egregious out-of-pocket costs.

These unexpected medical costs take a toll on wellbeing and health: A larger percentage of the population actually fear medical bills from a serious illness than the serious illness itself (40 percent vs.

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[1] Cooper, Zack and Fiona Scott Morton. "Out-of-Network Emergency-Physician Bills — An Unwelcome Surprise" New England Journal of Medicine. 2016. https://www.nejm.org/doi/full/10.1056/NEJMp1608571.
[2] New York State Department of Financial Services, "How New Yorkers Are Getting Stuck with Unexpected Medical Bills from Out-of-Network Providers." New York State. 2012. http://www.statecoverage.org/files/NY-Unexpected_Medical_Bills-march_7_2012.pdf.
[3] Cooper, Zack and Fiona Scott Morton, op. cit.
[4] Cooper, Zack and Fiona Scott Morton, op. cit.
[5] Board of Governors of the Federal Reserve System. "Report on the Economic Wellbeing of U.S. Households in 2017." Federal Reserve. 2018. https://www.federalreserve.gov/publications/files/2017-report-economic-well-being-us-households-201805.pdf.

33 percent).[6] What's more, according to the American Psychological Association, the stress associated with medical bill anxiety can actually make people sicker.[7]

With no way to protect themselves against surprise medical bills and insufficient recourse when bills do occur, families need Congress to step up and protect them from this harm.

REPRESENTATIVE DAVID P. ROE (TN)

1. Insurers typically do not disclose the type of plan that covers a claim. So, patients and providers cannot determine which federal protections apply to the visit. For instance, patients don't know if certain annual and lifetime limits apply to their required contribution. And providers don't know whether the federal minimum payment standard for emergency care applies. Patients and providers may need to expend a great deal of time, energy and money to gather this simple, yet essential, plan information. Given that, do you think federal legislation should require health care insurance policy numbers to designate the type of plan? For instance, if policy numbers included a "-E" at the end when it is an ERISA plan, this would clear up a lot of confusion. What are your thoughts on this approach?

Answer: Families USA strongly supports more transparency in health insurance. Clearer descriptions of health plans, including network type and breadth, cost-sharing amounts, excluded services, and other information consumers understand and need would help people navigate the complex health care system. When it comes to surprise medical bills, however, we believe that transparency is helpful, but it is not sufficient to address the problem.

Even if transparency measures are successful in providing consumers a deeper understanding of their health plan, they cannot prevent surprise bills from occurring. Current law, including under ERISA, allows out-of-network providers to balance bill consumers for hundreds, thousands, or even tens-of-thousands of dollars for care that they could not avoid.[8] For example, the surprise, out-of-network claim may have been generated because of an emergency in which the patient had no choice of provider. Or, the claim might have occurred for an out-of-network service attendant to an in-network service (sometimes referred to an "auto-referral"), such as out-of-network anesthesiology services occurring attendant to in-network surgical services.[9]

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[6] NORC at the University of Chicago and West Health Institute. "Americans' Views of Healthcare Costs, Coverage, and Policy." NORC at the University of Chicago.
2018. https://www.westhealth.org/wpcontent/uploads/2018/03/WHI-Healthcare-Costs-Coverage-and-Policy-Issue-Brief.pdf.

[7] American Psychological Association. "Stress in America: Uncertainty about Health Care." APA. 2018. https://www.apa.org/news/press/releases/stress/2017/uncertainty-health-care.pdf.

[8] Cooper, Zack and Fiona Scott Morton, op. cit.

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

While some limited protections are in place to ease the burden out-of-pocket costs for health care consumers, even when they are fully and properly applied, consumers can still receive very large surprise bills.[10] For example, annual out-of-pocket maximums only apply to in-network care, so they cannot decrease the burden of surprise medical bills, which by definition are out-of-network.[11] Even the savviest consumers receive surprise bills, despite buying insurance and doing all they can to properly navigate the health care system, because current law does not provide sufficient protections.[12]

Finally, it's worth noting that health insurance literacy levels vary significantly among America's families.[13] Average consumers, and their health care providers, may not be familiar with federal health care laws such as ERISA. When patients are in need of urgent care, they should not be penalized for failing to know whether federal law is properly applied to their health plan. Instead they should be able to prioritize their recovery and count on the health care system, and U.S. laws, to automatically protect them from egregious charges they incur due to no fault of their own.

2. While emergency physicians account for only four percent of physicians, they provide 67 percent of all care to uninsured patients and 50 percent of all care given to Medicaid and CHIP patients. Further, in emergency medicine, only commercially-insured claims are profitable. Uninsured, Medicare, and Medicaid claims all have negative profit margins. Even when a claim is covered by commercial insurance, emergency physicians collect only an estimated 30 to 40 percent of patient cost-sharing. In light of this, federal and state laws treat emergency care differently in order to protect access to the nation's health care safety net. The emergency physician is mandated by federal law to provide both in-network and out-of-network care. Do you think federal legislation should mandate that commercial insurers provide appropriate coverage for this federally mandated care?

Answer: It is important to note that federal law vis-à-vis EMTALA does not require emergency department (ED) physicians to treat all patients presenting in the ED. Instead it requires that physicians screen and, in the limited instances in which a patient has an emergency medical condition, stabilize (not treat) these patients.[14]

Furthermore, despite the widespread assertion by the provider community, it is not a given that the Medicare and Medicaid programs are not covering costs for hospitals.[15] Experts believe in some

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[10] Adler, Loren, Mark Hall, Caitlin Brandt, Paul B. Ginsburg, and Steven M. Lieberman. "Stopping surprise medical bills: Federal action is needed." The Brookings Institution. 2017. https://www.brookings.edu/opinions/stopping-surprise-medical-bills-federal-action-is-needed/.

[11] Glover, Lacie. "Health Insurance Deductible vs. Out-of-Pocket Maximum." NerdWallet. 2016. https://www.nerdwallet.com/blog/health/whats-difference-deductible-pocket-maximum/.

[12] Adler, Loren, Mark Hall, Caitlin Brandt, Paul B. Ginsburg, and Steven M. Lieberman, op. cit.

[13] Norton, Mira, Liz Hamel and Mollyann Brodie. "Assessing Americans' Familiarity With Health Insurance Terms and Concepts" Kaiser Family Foundation. 2014. https://www.kff.org/health-reform/poll-finding/assessing-americans-familiarity-with-health-insurance-terms-and-concepts/.

[14] Centers for Medicare & Medicaid Services. "Emergency Medical Treatment & Labor Act (EMTALA)." CMS. Retried April 24, 2019. https://www.cms.gov/regulations-and-guidance/legislation/emtala/.

[15] Stensland, Jeffery, Zachary R. Gaumer, and Mark E. Miller. "Contrary To Popular Belief, Medicaid Hospital Admissions Are Often Profitable Because Of Additional Medicare Payments." Health Affairs. 2016. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0599.

instances Medicare and Medicaid payments are more than sufficient to cover costs.[16] Private coverage simply tends to reimburse at higher rates than Medicare and Medicaid. Emergency physician charges are high relative to other physicians, including radiologists, pathologists, cardiologists, and surgeons. Typically, emergency physicians' billed charges are four to five times what Medicare pays for the same service.[17] However, the range of charges among emergency physicians is wide: a study of one large insurer's claims found that out-of-network emergency physicians set charges at an average of almost eight times what Medicare pays.[18] Comparatively, general surgeons typically charge two to three times Medicare rates.[19]

Economic experts argue that high out-of-network rates charged by emergency physicians are attributable less to the actual cost of delivering care and more to the economic incentives created when patients enter emergency departments in need of urgent care and unable to wait for an in-network provider.[20] When consumers are not in a position to refuse out-of-network care, a physician's incentive to enter a contract with an insurer for an in-network rate is reduced. Economic incentives create a situation where emergency physicians can remain out-of-network with some or even all area insurers, charge high rates, and still count on a steady patient volume.[21]

Federal law does require that health plans cover emergency services[22] and these requirements apply to ERISA plans as well as fully insured plans.[23] Specifically, health plans must cover emergency services without prior authorization, even from out-of-network providers and facilities.[24] In addition, if emergency services are provided out-of-network, health plans must not charge consumers more for those services than they would if the services were delivered in-network. However, consumers may be balance billed by out-of-network providers for amounts that the insurer does not reimburse. Additionally, health plans do not have to count the balanced-billed payments or cost-sharing amounts towards consumers' in-network deductible and out-of-pocket maximum (see additional discussion below).[25]

Importantly, federal law and corresponding regulations set a minimum amount that health plans, including ERISA plans, must pay out-of-network providers in emergency situations. Specifically, health plans, including ERISA plans, must pay out-of-network emergency providers *the greatest of:* 1) median in-network rates, 2) usual and customary rates, or 3) the Medicare rate for the service provided.[26]

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[16] Op. Cit.
[17] Adler, Loren, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Christen Linke Young, and Erin L. Duffy, op. cit.
[18] Cooper, Zack and Fiona Scott Morton, op. cit.
[19] Adler, Loren, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Christen Linke Young, and Erin L. Duffy, op. cit.
[20] Ibid.
[21] Ibid.
[22] SEC. 2719A [42 U.S.C. 300gg–19a]- Patient Protections. https://www.hhs.gov/sites/default/files/ppacacon.pdf; 29 CFR § 2590.715-2719A(b) - Patient protections. https://www.law.cornell.edu/cfr/text/29/2590.715-2719A.
[23] 29 CFR § 2590.715-2719A(b) - Patient protections. https://www.law.cornell.edu/cfr/text/29/2590.715-2719A.
[24] 29 CFR § 2590.715-2719A(b)(2)(i). https://www.law.cornell.edu/cfr/text/29/2590.715-2719A.
[25] 29 CFR § 2590.715-2719A(b), op. cit.
[26] 29 CFR § 2590.715-2719A(b)(3)(i). https://www.law.cornell.edu/cfr/text/29/2590.715-2719A.

However, there are no protections in federal law that prevent emergency providers from billing consumers the difference between what an insurer pays for the service and the provider's charge for the service.[27] This amount— the surprise balance bill— can equal hundreds, thousands, or even tens-of-thousands of dollars based on the charge set by an emergency physician.[28] America's families bear the consequences of high out-of-network emergency charges, which are passed down in the form of surprise medical bills. Congress can protect consumers from this financial harm by enacting legislation that applies to all health plans, including ERISA plans. This legislation should ban surprise out-of-network balance billing while also holding down premium costs.

3. It's clear that patients in the same location have 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 their patients? What are the incentives that have led insurance plans to create narrow, inadequate networks?

Answer: Recent studies have examined whether a correlation exists between insurance plan type and likelihood of receiving a surprise bill. These studies have shown that regardless of where consumers get their coverage— whether individual market, small group market or large group market where networks tend to be broader-- the risk of surprise medical bills is nearly the same.[29] For example, in both fully insured and self-insured ERISA plans, roughly one in five emergency department visits involved care from an out-of-network provider that could result in a surprise bill.[30]

Researchers also have examined whether a plan's specific network model is correlated to the rate of out-of-network billing.[31] Health plan provider network models, such as health maintenance organizations (HMOs), point of service (POS) plans, and preferred provider networks (PPOs), are typically distinguished by four factors: 1) whether enrollees are required to designate a primary care provider, 2) whether specialist care requires consumers to obtain primary care referrals, 3) the degree to which the plan provides coverage for out-of-network services,[32] and the breadth of the network.[33] However, in all

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[27] Ibid.

[28] Cooper, Zack and Fiona Scott Morton, op. cit.

[29] Ibid.

[30] Garmon, Christopher and Benjamin Chartock. "One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills." Health Affairs. Vol 36. No. 1. 2017. https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0970; Claxton, Gary, Matthew Rae, Cynthia Cox, and Larry Levitt. "An analysis of out-of-network claims in large employer health plans." Peterson-Kaiser Health System Tracker. 2018. https://www.healthsystemtracker.org/brief/an-analysis-of-out-of-network-claims-in-large-employer-healthplans/#item-start; Cooper, Zack and Fiona Scott Morton, op. cit.

[31] Garmon, Christopher and Benjamin Chartock, op. cit.

[32] Aetna. "HMO, POS, PPO, EPO and HDHP with HSA: What's the difference?" accessed April 22, 2019 at: https://www.aetna.com/health-guide/hmo-pos-ppo-hdhp-whats-the-difference.html; Cigna. "What's the Difference Between an HMO, EPO, and PPO?" accessed April 22, 2019 at: https://www.cigna.com/individuals-families/understanding-insurance/hmo-ppo-epo.

[33] Polsky, Dan and Janet Weiner. "The Skinny on Narrow Networks in Health Insurance Marketplace Plans." University of Pennsylvania Leonard Davis Institute of Health Economics. 2015. https://ldi.upenn.edu/sites/default/files/pdf/the-skinny-on-narrow-networks.pdf. The authors of this study found that although narrow networks are more associated with some network models, such as HMOs, than other

network types, emergency care is generally covered even if provided out-of-network.[34] Despite these distinguishing factors, research has found minimal variation in surprise bill rates. For example, one study that examined surprise bill rates for consumers in HMO, POS, and PPO plans, respectively, found little variation in the rate of out-of-network claims for inpatient care that could lead to surprise bills at in-network facilities.[35]

Research showing similar rates of surprise billing across plan types is not surprising given what is known about the causes of surprise billing and the care settings in which surprise bills most frequently occur. Studies have found that surprise bills occur most frequently in situations where a consumer is not in a position to choose a provider: that is, in emergency situations or facility-based care situations such as during surgeries.[36] In these instances, providers can remain out-of-network and set high charges but are still guaranteed a high volume of patients because consumers have no way out when their need for care is urgent.[37] Due to these perverse incentives, regardless of whether consumers have narrow or broad network plans, they are at risk for surprise medical bills.[38] Network breadth is not a predictor of surprise billing and addressing network adequacy will not protect consumers from surprise medical bills. Consumers need Congress to enact protections that will prevent consumers from experiencing surprise medical bills, regardless of the type of health plan they have.

Although improving network adequacy will not solve the issue of surprise medical billing, Families USA supports these efforts so that consumers can get the care they need, in a timely manner, without having to travel too far.[39] As insurers modify networks to hold down premium costs, including the creation of narrow networks,[40] it is important to ensure that networks can still provide access to all covered services. Federal law and corresponding regulations include protections to ensure that consumers with Affordable Care Act marketplace health plans can access adequate provider networks.[41] However, in recent years the federal government has scaled back network adequacy regulations, deferring more authority to the states. Previously applied quantitative metrics for guaranteeing network adequacy and federal review of networks in commercial plans have been eliminated.[42] Additionally, a federal plan to label networks by their breadth to improve transparency for consumers was never implemented beyond

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models, such as PPOs, narrow networks are prevalent among all network models including HMO, PPO, and POS plans.

[34] Cigna, op. cit.

[35] Garmon, Christopher and Benjamin Chartock, op. cit.

[36] Adler, Loren, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Christen Linke Young, and Erin L. Duffy, op. cit.

[37] Ibid.

[38] Ibid.

[39] Claire McAndrew. "Standards for Health Insurance Provider Networks: Examples from the States." Families USA. 2014. https://familiesusa.org/product/standards-health-insurance-provider-networks-examples-states.

[40] Dafny, Leemore, Igal Hendel, Victoria Marone, and Christopher Ody. "Narrow Networks On The Health Insurance Marketplaces: Prevalence, Pricing, And The Cost Of Network Breadth." Health Affairs. 2017. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1669.

[41] SEC. 1311 [42 U.S.C. 13031] AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS; 45 CFR § 156.230 - Network adequacy standards.

[42] Hall, Mark and Caitlin Brandt. "Network Adequacy Under The Trump Administration." Health Affairs. 2017. https://www.healthaffairs.org/do/10.1377/hblog20170914.061958/full/.

a four-state pilot.[43] Families USA supports Congress taking action to improve policy in these areas in addition to addressing the urgent priority of surprise medical bills.

4. Patients in these networks receive surprise bills because there isn't the provider base to support the care these patients require. How do we reverse the incentives to allow more providers to be in network and taking care of more patients, which is obviously in their interest to do? Have any states tried to create standards for network adequacy and keep track of the plans' performance? What has the result been for patients in those states?

Answer: When it comes to the provider types most associated with surprise billing, such as anesthesiologists, emergency physicians, radiologists, pathologists, and surgeons, commonsense policies to rein in surprise billing also can have the positive impact of bringing more of these physicians in-network. Our current system incentivizes these providers to remain out-of-network. Even if these providers do not contract with any insurers, they can count on a steady stream of patients in the emergency department or in a facility-based care setting, and they can balance bill those patients for any amount an insurance company won't pay. With commonsense prohibitions on balance billing, such providers will be newly incentivized to negotiate with insurers, as practicing only out-of-network will no longer remain a lucrative option.[44]

Importantly, remaining out-of-network is not always a decision made by individual physicians. Hospitals often offload physician staffing for their emergency departments to third-party management companies that have no responsibility to ensure physician staff participate in the same provider networks as the hospital.[45] In fact, two-thirds of hospitals in the U.S. outsource the staffing of their emergency departments to third-party physician management firms.[46] Research shows that out-of-network claims are higher in hospitals that contract with common staffing companies.[47] All too often, these firms use a business model that leverages the higher prices that can be charged with an out-of-network status.[48] Surprise billing legislation can eliminate the perverse incentive to profit from out-of-network care that consumers incur due to no fault of their own.

Although designed to address a somewhat different problem, many states do have laws regarding network adequacy.[49] Over half of states have some type of quantitative standard to measure the

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[43] Dickson, Virgil. "CMS won't expand pilot that checks network adequacy on HealthCare.gov." Modern Healthcare. 2017. https://www.modernhealthcare.com/article/20170614/NEWS/170619951/cms-won-t-expand-pilot-that-checks-network-adequacy-on-healthcare-gov.

[44] Adler, Loren, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Christen Linke Young, and Erin L. Duffy, op. cit.

[45] Cooper, Zack and Fiona Scott Morton, op. cit.

[46] Dalavagas, Iason. "Coverage Initiation: Envision Healthcare Holdings." 2014. Value Line. http://www.valueline.com/Stocks/Highlights/Coverage_Initiation__Envision_Healthcare_Holdings.aspx#.XJWAFVKjlU.

[47] Cooper, Zack, Fiona Scott Morton, and Nathan Shekita. "Surprise! Out-of-Network Billing for Emergency Care in the United States." Yale University. 2017. https://www.nber.org/papers/w23623.pdf.

[48] Cooper, Zack, Fiona Scott Morton, and Nathan Shekita, op. cit.

[49] Claire McAndrew. "Standards for Health Insurance Provider Networks: Examples from the States." Families USA. 2014. https://familiesusa.org/product/standards-health-insurance-provider-networks-examples-states;

adequacy of commercial health plan networks. However, these standards are not comprehensive. For example, less than 20 states have standards to ensure consumers can obtain an appointment with a provider in a timely manner.[50] States that do have network adequacy standards have been able to take action when health plans do not make care available to enrollees without unreasonable delay, including fining insurers and requiring corrective action.[51] If the federal government were to implement similar standards, it would guarantee protection for families in every state, regardless of where they live or what health plan they have.

[50] Giovannelli, Justin, Kevin Lucia, and Sabrina Corlette. "Regulation of Health Plan Provider Networks." Health Affairs. 2016. https://www.healthaffairs.org/do/10.1377/hpb20160728.898461/full/.
[51] Gold, Jenny. "Kaiser Permanente Cited — Again — For Mental Health Access Problems." California Healthline. 2017. https://californiahealthline.org/news/kaiser-permanente-cited-again-for-mental-health-access-problems/.

REPLIES TO MEMBER QUESTIONS

JACK HOADLEY, GEORGETOWN UNIVERSITY

REPRESENTATIVE DONALD NORCROSS (NJ)

QUESTION 1. Some states have limited arbitration to either large claims (e.g., Arizona has a $1000 threshold) or to disputes over a certain threshold (i.e., "amount in dispute"). For instance, the New Jersey law states that dispute resolution is available if the "difference between the carrier's and the provider's final offer is not less than $1000." Therefore, for a $1500 bill from an out-of-network provider, if the carrier has agreed to pay $300, but the provider still believes he or she should receive an additional $1200, then the "amount in dispute" is over $1000 and, as such, eligible for arbitration. Given that nuance, which do you believe is a better threshold – total claim amount or amount in dispute – and why?

RESPONSE: The principle in the most states that use arbitration systems is that they are used to settle differences between the insurer and the out-of-network provider, in conjunction with rules that guarantee that the consumer pays no more than normal cost sharing. Thus, the consumer should be protected regardless of these thresholds. Nevertheless, any dollar threshold can put the consumer at risk if it means providers believe they have not been paid adequately.

This approach contrasts with a few states in which laws place the consumer would be a risk for a balance bill that falls short of the threshold. The reason for a threshold is avoid the cost of arbitration when the amount in question is small. But even a small bill may be too much for a consumer to take on.

I do not see a compelling logic for one threshold definition over the other. The amount in dispute definition would be more restrictive (given the same dollar amount), so it would lead to fewer arbitration cases. In cases where the bill is large, but the parties are close (say $2,000 versus $2,200), it should be easy to reach a private agreement. But the most important consideration is that arbitration is used in conjunction with rules that protect the consumer regardless of the outcome of the arbitration.

REPRESENTATIVE DAVID P. ROE (TN)

QUESTION 1. Insurers typically do not disclose the type of plan that covers a claim. So, patients and providers cannot determine which federal protections apply to the visit. For instance, patients don't know if certain annual and lifetime limits apply to their required contribution. And providers don't know whether the federal minimum payment standard for emergency care applies. Patients and providers may need to expend a great deal of time, energy and money to gather this simple, yet essential, plan information. Given that, do you think federal legislation should require health care insurance policy numbers to designate the type of plan? For instance, if policy numbers included a "-E" at the end when it is an ERISA plan, this would clear up a lot of confusion. What are your thoughts on this approach?

RESPONSE: Yes, the challenge of knowing what type of insurance is in place is a problem for consumers, who are generally unaware of the category to which their insurance applies. There is a basic disclosure requirement in the ACA, applicable to non-grandfathered ACA-covered plans and ERISA plans, that calls

on plans to provide a uniform explanation of coverage which includes limitations such as the absence of annual and lifetime limits. Within ERISA there is a general requirement (section 102) that the content of the summary plan description sent to enrollees includes "the type of administration of the plan," which should mean that it indicates clearly whether it is self-insured or fully insured. Nevertheless, the average consumer is unlikely to be aware of this information or to understand its implications. Furthermore, providers would not have any of this information and probably rely on their patients to provide insurance information. So a requirement to add an indicator on the plan ID and have that indicator appear on the member's insurance could help reduce confusion for consumers and providers. That said, in considering a protection against balance billing, the lack of clarity among consumers about the type of plan they are enrolled makes it more compelling to have a uniform protection at the federal level that prohibits balance billing in all plan types – individual plans, small-group plans, large-group plans, and self-funded plans.

QUESTION 2. While emergency physicians account for only four percent of physicians, they provide 67 percent of all care to uninsured patients and 50 percent of all care given to Medicaid and CHIP patients. Further, in emergency medicine, only commercially-insured claims are profitable. Uninsured, Medicare, and Medicaid claims all have negative profit margins. Even when a claim is covered by commercial insurance, emergency physicians collect only an estimated 30 to 40 percent of patient cost-sharing. In light of this, federal and state laws treat emergency care differently in order to protect access to the nation's health care safety net. The emergency physician is mandated by federal law to provide both in-network and out-of-network care. Do you think federal legislation should mandate that commercial insurers provide appropriate coverage for this federally mandated care?

RESPONSE. Under EMTALA, there is an obligation on a hospital and its on-call physicians to provide care to patients who come to the hospital with an emergency condition. The Affordable Care Act (section 2719A) and its related Department of Labor regulations require that non-grandfathered health plans must make a payment to these providers, regardless of their network status, based on the greatest of three amounts that are specified in the law and regulations. Several of the states with laws addressing surprise medical bills go beyond the ACA requirements in one of two ways. They either (1) set a payment standard on the amount that the insurer must pay the provider of emergency services or (2) create a dispute resolution or arbitration process to establish a payment amount. These requirements are typically combined with protections that guarantee that consumers are only liable for normal cost sharing amounts. The Congress, if enacts legislation that follows one of these approaches, has the opportunity to ensure both that the consumer is protected and that payment to the provider is appropriate.

QUESTION 3. It's clear that patients in the same location have 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 their patients? What are the incentives that have led insurance plans to create narrow, inadequate networks?

RESPONSE: We do not have good research evidence to say which plans are most likely to see surprise medical bills. In general, it seems likely that plans with narrow provider networks create a greater risk

for receiving a surprise bill because more providers are outside the network. But an important consideration is where the network physicians are based. A plan could offer a narrow network as one way to lower premiums, but such a plan could work carefully to ensure its network includes the doctors and other clinicians who practice in the hospitals that are in the plan's network. In this latter example, the risk of surprise billing is reduced even in a narrow-network plan.

The Affordable Care Act requires that plans sold on the exchanges must maintain a provider network that is "sufficient in numbers and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay." But the federal government has deferred to the states in establishing specific standard to implement this provision.

QUESTION 4. Patients in these networks receive surprise bills because there isn't the provider base to support the care these patients require. How do we reverse the incentives to allow more providers to be in network and taking care of more patients, which is obviously in their interest to do? Have any states tried to create standards for network adequacy and keep track of the plans' performance? What has the result been for patients in those states?

RESPONSE: Consumers benefit from plans with narrow networks if they allow coverage to be offered for a lower premium. But for those plans to work for their members, it requires that networks are adequate so that consumers can find network physicians when they need them. And it requires that members have convenient access to accurate provider directories. Consumers benefit from plans with broad networks if they lower the risk of surprise medical bills and make it easier to see the providers they wish to see. It may make sense for both the federal government and state governments to focus more attention on network adequacy. Yet even with a network that could be classified as broad, there will be situations where surprise bills arise. Thus, addressing network adequacy is not a substitute for protecting consumers from balance bills.



AMERICAN BENEFITS COUNCIL

April 24, 2019

Written Responses of Ilyse Schuman, American Benefits Council

to Questions from

Health, Employment, Labor and Pensions Subcommittee Hearing "Examining Surprise Billing: Protecting Patients from Financial Pain"
Tuesday, April 2, 2019, 10:15 a.m.

Below are the written responses of Ilyse Schuman, Senior Vice President, Health Policy, American Benefits Council, to additional questions submitted by Committee members following the hearing.

REPRESENTATIVE DAVID P. ROE, QUESTION NO. 1:

Insurers typically do not disclose the type of plan that covers a claim. So, patients and providers cannot determine which federal protections apply to the visit. For instance, patients don't know if certain annual and lifetime limits apply to their required contribution. And providers don't know whether the federal minimum payment standard for emergency care applies. Patients and providers may need to expend a great deal of time, energy and money to gather this simple, yet essential, plan information. Given that, do you think federal legislation should require health care insurance policy numbers to designate the type of plan? For instance, if policy numbers included a "-E" at the end when it is an ERISA plan, this would clear up a lot of confusion. What are your thoughts on this approach?

ILYSE SCHUMAN, AMERICAN BENEFITS COUNCIL:

The Council supports increased transparency by requiring providers to inform patients, at the time of scheduling, whether a provider is in-network or out-of-network

with respect to a given facility or service. We believe that ERISA's existing disclosure requirements between the plan and plan participants and beneficiaries adequately provide necessary details regarding the benefits and protections available under the plan and under applicable state and federal law. The primary information gap in the surprise balance billing context is whether the provider, over whom the patient has no choice in selecting, is in- or out-of-network. While additional information on insurance and benefits cards might facilitate the provider in understanding what payment obligations the patient might have under federal or state law, it would do little to limit the negative impact of surprise balance billing on patients who are left without a meaningful role in choosing providers.

We note that to the extent the provider is out-of-network, the Affordable Care Act's (ACA's) prohibitions on the use of annual and lifetime limits and limitations on annual cost-sharing do not apply to the services performed by the provider.

REPRESENTATIVE DAVID P. ROE, QUESTION NO. 2:

While emergency physicians account for only four percent of physicians, they provide 67 percent of all care to uninsured patients and 50 percent of all care given to Medicaid and CHIP patients. Further, in emergency medicine, only commercially-insured claims are profitable. Uninsured, Medicare, and Medicaid claims all have negative profit margins. Even when a claim is covered by commercial insurance, emergency physicians collect only an estimated 30 to 40 percent of patient cost-sharing. In light of this, federal and state laws treat emergency care differently in order to protect access to the nation's health care safety net. The emergency physician is mandated by federal law to provide both in-network and out-of-network care. Do you think federal legislation should mandate that commercial insurers provide appropriate coverage for this federally mandated care?

ILYSE SCHUMAN, AMERICAN BENEFITS COUNCIL:

It is certainly essential that all Americans have access to emergency care. That having been said, the problem of surprise balance bills will not be solved by shifting the cost of a balance bill for out-of-network emergency care from patients to commercial payers. Doing so merely masks the underlying driver of these balance bills - a market failure by virtue of the fact the emergency physicians experience what a study cited in my testimony describes as "inelastic demand from patients." Accordingly, these physicians "will not see a reduction in their patient volume if they fail to negotiate contracts with insurers."[1] The same study found that out-of-network emergency physicians charge, on average, 637% of what the Medicare program would pay for identical services, which is 2.4 times higher than in-network payment rates. The spread between Medicare rates,

1 https://www.nber.org/papers/w23623.pdf

in-network rates and out-of-network billing suggests that more than recouping any negative profit margins is at play. An examination of the distribution of out-of-network billing for emergency care in hospitals across the U.S., which found that out-of-network billing is concentrated in a small number of hospitals, further supports such a conclusion. While 50% of hospitals have out-of-network billing rates below two percent, 15% of hospitals have out-of-network billing rates above 80%.

We also note that current federal regulations already impose reimbursement requirements for out-of-network emergency services (the so-called "Greater of Three Rule") that seeks to harmonize plan reimbursement of out-of-network emergency services with in-network reimbursement rates.

When patients face the crisis of a medical emergency, they need the most expeditious stabilizing care, leaving them without a meaningful choice between in-network or out-of-network emergency care. This lack of choice by the patient can serve as a powerful incentive for emergency physicians to remain out-of-network. Federal legislation should protect patients at perhaps their greatest moments of medical need without further fueling the market distortions that have given rise to balance bills for emergency care in the first place.

REPRESENTATIVE DAVID P. ROE, QUESTION NO. 3:

It's clear that patients in the same location have 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 their patients? What are the incentives that have led insurance plans to create narrow, inadequate networks?

ILYSE SCHUMAN, AMERICAN BENEFITS COUNCIL:

Federal policy should facilitate and incent building provider networks that deliver high-quality and high-value health care to consumers. To protect access to high quality and high-value care, providers should be encouraged to participate in such networks. Network adequacy should not be used to deflect attention from the underlining drivers of surprise billing – a choice by certain specialty providers not to participate in networks. Neither should network adequacy be used to prohibit exclusion of poor-performing providers from a network. To be clear, the use of more defined, high-value networks is not the reason we have a surprise balance billing problem.

Provider networks are an important, if not essential, tool in our health care delivery system. They allow participants to access quality care at affordable rates for the plan, as well as reduced premium and cost-sharing for the participants. By way of example, one Council member company with almost 130,000 covered lives estimates that without

networks, premiums would increase by $8,000 - a 45% increase. Plans are continually striving to bring high-value providers into their networks both to foster increased choice and options for enrollees, but also to help manage plan costs (and related premiums) and improve quality.

We believe that hospitals must play a key role in combatting surprise medical billing. The market power that certain hospital-based physician specialties exert certainly drives surprise medical bills. However, the fact remains that hospitals can and must take responsibility for the physicians staffing their hospitals. When a plan contracts with a hospital, it stands to reason that essential services performed at the facility - emergency, anesthesiology, radiology and pathology - would be included in the network.

REPRESENTATIVE DAVID P. ROE, QUESTION NO. 4:

Patients in these networks receive surprise bills because there isn't the provider base to support the care these patients require. How do we reverse the incentives to allow more providers to be in network and taking care of more patients, which is obviously in their interest to do? Have any states tried to create standards for network adequacy and keep track of the plans' performance? What has the result been for patients in those states?

ILYSE SCHUMAN, AMERICAN BENEFITS COUNCIL:

The Council's member companies seek to provide high-quality, affordable coverage to employees and their dependents. Health plan networks are critical to these employer efforts. The Council believes any legislative solution by Congress should address the current incentives that encourage certain hospital-based physician specialties to remain out of network and generate surprise balance bills.

Because they are part of a wider bundle of hospital care and cannot be avoided once the hospital choice is made, emergency physicians (and other specialist physicians like anesthesiologists, pathologists and radiologists) face inelastic demand from patients and will not see a reduction in their patient volume by remaining out-of-network.

Congress should protect patient from surprise balance billing without undermining access to high-value networks or increasing costs for all consumers. Federal legislation should include a reasonable reimbursement structure that (1) establishes a benchmark cap for emergency services at an out-of-network facility at 125 percent of the Medicare Rate and (2) requires all providers at an in-network facility to accept in-network reimbursement rates for all care performed at the facility by all providers associated with the facility. As noted above, network adequacy should not be used to deflect attention from the underlining drivers of surprise billing - a choice by certain specialty providers not to participate in networks. Neither should network adequacy be used to prohibit exclusion of poor-performing providers from a network.

REPRESENTATIVE RUSS FULCHER, QUESTION NO. 1

In your testimony, you mentioned that while employers seek to ensure employees are aware of the higher costs of out-of-network services, more "assistance" is needed, such as "contracting with other entities" to negotiate the bill. Can you elaborate on that? How can we generate more affordable choices and options for the consumer?

ILYSE SCHUMAN, AMERICAN BENEFITS COUNCIL:

Indeed, employers try to limit the incidence of surprise billing to employees in the first place through enhanced communication and awareness. When an employee nonetheless faces a balance bill from an out-of-network provider, employer assistance can take of the form of helping the employ negotiate down the balance bill. A third party retained by the plan, such as a third party administrator, can negotiate with the provider on behalf of the employee to reduce, if not eliminate, the balance bill.

Such assistance, however, does not ban the practice of surprise medical bills nor solve the problem at its root. The best way to generate more affordable choices and options for consumers is to correct a market failure that allows certain specialist for whom patients have no meaningful role in choosing to remain out-of-network and set higher billing rates because patient volume is essentially guaranteed. Federal policy should incentivize building provider networks that deliver high-quality and high-value health care to consumers. Federal legislation to address surprise balance billing should not discourage network participation by guaranteeing reimbursement rates higher than in-network rates or higher than existing applicable ACA requirements. Simply shifting the burden of balance billing from the patient to the plan or employer will no doubt result in higher premiums and increased costs for all consumers. More affordable options for consumers will be generated by eliminating market failures that incentivize providers to remain out of network.

REPRESENTATIVE RUSS FULCHER, QUESTION NO. 2

What do you see as the main challenges to requiring third-party providers from contracting with the insurance company that services a particular hospital or clinic, so that the consumer can at least know the potential price of the service and help control prices that are charged by the third-party provider?

ILYSE SCHUMAN, AMERICAN BENEFITS COUNCIL:

Third-party providers should be required to accept the negotiated in-network rate when providing services at the in-network facility. These facilities could amend their contracts with the providers to condition the provision of services at the facility upon the provider first agreeing to accept the in-network rate negotiated by the facility with the insurance company or third party administrator.

We are not aware of any specific laws that would specifically preclude such an approach. Hospitals must play a key role in combatting surprise medical bills. The market power that certain hospital-based physician specialties exert certainly drives surprise medical bills. However, the fact remains that hospitals can and must take responsibility for the physicians staffing their hospitals. When a plan contracts with a hospital, it stands to reason that essential services performed at the facility - emergency, anesthesiology, radiology and pathology - would be included in the network. Yet, these are the very specialties that, by virtue of their necessity, are unhampered by competitive market forces in setting their rates and electing not to participate in a network.

REPRESENTATIVE RUSS FULCHER, QUESTION NO. 1

Typically, employees turn to the benefits manager at their job for help with a surprise bill (a charge they didn't know they had to pay because it wasn't covered on their insurance). What can we do to help these employers have more health care insurance and noninsurance options that might lower costs?

ILYSE SCHUMAN, AMERICAN BENEFITS COUNCIL:

The benefits manager may well be the first person an employee turns to when they receive a surprise bill from an out-of-network provider. Recognizing the toll that surprise billing can take on working families, many large employers step in to help pick up the balance bill charges even though they are not obligated to do so. As a result, the problem of surprise billing poses an additional financial burden on employers beyond the substantial cost the employers already bear as sponsors of the health plan. Federal legislation should not mandate shifting the cost of balance bills to employers. Federal legislation should, instead, both protect patients from surprise bills and address the competitive market failure that gives rise to unexpected balance bills in the first place.

Hospital-based specialist like anesthesiologist, radiologists, pathologists, and emergency physicians face inelastic demand from patients who have no meaningful role in choosing these providers. Accordingly, these specialists will not have a reduction of patient volume by remaining outside of a health plan's network. A study cited in my testimony on out-of-network billing for emergency care found that physicians charge, on average, 637% of what the Medicare program would pay for identical services, which is

2.4 times higher than in-network payment rates.[2] Another study comparing physician charge-to-Medicare payment ratios across 54 specialties found that "Physician excess charge was higher for specialties in which patients have fewer opportunities to choose a physician or be informed of the physician's network status (e.g. anesthesiology)."[3] Anesthesiologists were found to be charging more than five times as high as the Medicare rate.

High-value networks of providers are the key to employer efforts to lower costs and improve quality. Federal legislation that enshrines the incentives for these providers to remain out-of-network would undermine the considerable effort that employers, with their health plan partners, undertake to negotiate for effective networks of high value providers. To help employers lower costs, Congress should address this market failure. To ensure equitable payment for providers without discouraging network participation, federal legislation should (1) establish a benchmark cap for emergency services at an out-of-network facility at 125% of the Medicare Rate and (2) require all providers at an in-network facility to accept in-network reimbursement rates for all care performed at the facility by all providers associated with the facility. Clearly, billed charges are out-of-sync with costs and "well-above" typical network rates.[4] Federal efforts to assist employers in limiting the impact of surprise balance billing should focus on the root cause.

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2 https://www.nber.org/papers/w23623.pdf

3 https://jamanetwork.com/journals/jama/fullarticle/2598253

4 http://us.milliman.com/uploadedFiles/insight/2018/changing-landscape-oon-reimbursement.pdf

REPRESENTATIVE HALEY M. STEVENS (MI)
Many experts, including some of your colleagues at the Brookings Institution, have discussed a multi-pronged approach to addressing surprise billing.

1. Can you share your thoughts on developing policies that treat the balance of the bill as an in-network charge, and therefore covered by the patient's insurance?

> Answer: There are two important principles in designing a policy solution to prevent surprise out-of-network billing: (1) protect patients from unexpected high costs and (2) avoid increasing health care spending.
>
> In the types of situations that lead to surprise out-of-network bills (i.e. where the patient is seen by an out-of-network provider that she did not choose), requiring the insurer to treat the allowed costs as in-network for purposes of consumer cost-sharing can be an important part of the solution. It protects the patient from facing a higher or separate deductible and higher coinsurance and copays, and it ensures that amounts accumulate towards the annual out-of-pocket maximum on total cost-sharing.
>
> However, insurers should not be required to pay the full "balance billed" amount to the provider. The balance bill will generally be based on the provider's billed charges, which are not market determined and not subject to any negotiation.[1] If insurers were required to pay the balance billed amount in full, providers could charge any amount they wished and know that the insurer would have to pay that amount. This would likely drive up costs significantly. Therefore, a policy like this must also include some mechanism for determining a reasonable price for the service, either directly or through arbitration, rather than requiring insurers to pay the billed amount.

2. What about prohibiting balance billing altogether?

> Answer: Any solution to the problem must prevent providers in these situations from sending balance bills. But if providers are prohibited from balance billing, they are required to accept whatever payment the insurer makes as payment in full. Therefore, a policy like this should also include some mechanism to ensure that the amount paid to the provider is reasonable.

REPRESENTATIVE DAVID P. ROE (TN)
1. Insurers typically do not disclose the type of plan that covers a claim. So, patients and providers cannot determine which federal protections apply to the visit. For instance, patients don't know if certain annual and lifetime limits apply to their required contribution. And providers don't know whether the federal minimum payment standard for emergency care applies. Patients and providers may need to expend a great deal of time, energy and money to gather this simple, yet essential, plan information. Given that, do you think federal legislation should require health care

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[1] Indeed, our analysis at the USC-Brookings Schaeffer Initiative for Health Policy found that providers in the specialties most likely to see patients that did not choose them (anesthesiologists and emergency medicine physicians) have especially high charges, even as compared to other kinds of physician specialties. *See* Loren Adler, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Christen Linke Young & Erin L. Duffy, "State Approaches to Mitigating Surprise Out-of-Network Billing," USC-Brookings Schaeffer Initiative for Health Policy (February 2019), *available at* https://www.brookings.edu/research/state-approaches-to-mitigating-surprise-out-of-network-billing/.

insurance policy numbers to designate the type of plan? For instance, if policy numbers included a "-E" at the end when it is an ERISA plan, this would clear up a lot of confusion. What are your thoughts on this approach?

> Answer: The Administrative Simplification provisions of HIPAA include some attempts to standardize how providers and payers communicate about a patient's cost-sharing,[2] but they leave gaps. Building upon the existing structure can improve patients' and providers' access to information.
>
> Enhanced transparency about cost-sharing can be useful, but I do not believe it will provide a meaningful tool to address surprise out-of-network billing. Surprise out-of-network bills arise when patients are seen by out-of-network providers that they have no role in choosing. Even if providers knew more about the patient's insurance, that would not address the market failure or change the underlying incentives that lead to surprise bills.

2. While emergency physicians account for only four percent of physicians, they provide 67 percent of all care to uninsured patients and 50 percent of all care given to Medicaid and CHIP patients. Further, in emergency medicine, only commercially-insured claims are profitable. Uninsured, Medicare, and Medicaid claims all have negative profit margins. Even when a claim is covered by commercial insurance, emergency physicians collect only an estimated 30 to 40 percent of patient cost-sharing. In light of this, federal and state laws treat emergency care differently in order to protect access to the nation's health care safety net. The emergency physician is mandated by federal law to provide both in-network and out-of-network care. Do you think federal legislation should mandate that commercial insurers provide appropriate coverage for this federally mandated care?

> Answer: In situations where patients receive care from a provider they did not choose (including emergency care) the normal market negotiations between providers and payers cannot be relied on to generate a reasonable rate. Therefore, policy solutions often require some mechanism for establishing a rate, whether establishing the rate directly or through arbitration.

3. It's clear that patients in the same location have 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 their patients? What are the incentives that have led insurance plans to create narrow, inadequate networks?

> Answer: While more study is needed, the available evidence suggests that surprise out-of-network billing is not caused by narrow networks. Situations that can lead to surprise out-of-network bills have roughly the same prevalence in POS, PPO, and HMO plans[3]—even though these kinds of insurance products have different approaches to network size and network restrictions. And surprise out-of-network bills appear only slightly more

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[2] *See* Health Insurance Reform: Standards for Electronic Transactions, 65 Fed. Reg. 50312 (Department of Health and Human Services, August 17, 2000), https://www.federalregister.gov/documents/2000/08/17/00-20820/health-insurance-reform-standards-for-electronic-transactions.

[3] *See* Christopher Garmon & Benjamin Chartock, "One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills," 36 Health Affairs No.1, Appendix Chart A5 (January 2017), *available at* https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0970.

common in the Marketplace compared to the employer market.[4] This empirical evidence is consistent with the nature of the market failure that leads to surprise out-of-network bills. When patients do not have a choice about which specialist they see, the provider does not face a price-volume trade-off for going in-network: she will receive the same number of patients regardless of whether or not she joins an insurer's network.

4. Patients in these networks receive surprise bills because there isn't the provider base to support the care these patients require. How do we reverse the incentives to allow more providers to be in network and taking care of more patients, which is obviously in their interest to do? Have any states tried to create standards for network adequacy and keep track of the plans' performance? What has the result been for patients in those states?

Answer: Network adequacy is an important component of state and federal regulation of insurance products, but it is likely not an adequate tool to prevent surprise out-of-network billing. For providers that patients choose, they are able to select from the available in-network providers, and network adequacy ensures sufficient choices are available. But when patients do not choose their provider, that dynamic is not relevant: it doesn't matter whether your issuer has some anesthesiologists in-network, it only matters whether the specific anesthesiologist on call at the hospital on the morning of your surgery is in-network. This calls for a different set of policy solutions.

[4] Munira Z. Gunja, Sara R. Collins, Michelle M. Doty & Sophie Buetel, "Americans' Experiences with ACA Marketplace Coverage: Affordability and Provider Network Satisfaction," The Commonwealth Fund (July 2016), *available at* https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2016_jul_1883_gunja_americans_experience_aca_marketplace_affordability_v2.pdf.

[Whereupon, at 12:28 p.m., the subcommittee was adjourned.]

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