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

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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]

[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

[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.