



**“No More Surprises: Protecting Patients from Surprise Medical Bills”**

**by**

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**for the**  
**House Energy and Commerce Committee**  
**Subcommittee on Health**

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

We applaud the leaders of the House Energy and Commerce Committee for coming together in a bipartisan way to develop a discussion draft for the "No Surprises Act." This draft bill takes important steps toward ensuring that patients are protected, doctors are paid fairly, health plan networks are supported, and the free market is permitted to work to deliver affordable, high-quality care. AHIP has provided recommendations to the committee on key elements of the discussion draft, and we appreciate your thoughtful consideration of our ideas. This legislation would go a long way to protect American consumers and patients.

We appreciate this opportunity to offer our support for the No Surprises Act and other solutions that alleviate the financial burdens imposed on patients by surprise medical bills. Every American deserves affordable, high-quality coverage and care, as well as control over their health care choices. Surprise medical bills stand in the way of this commitment, which is why health insurance providers have been advocating for federal legislation that will protect all patients from these unexpected and unjustified costs.

Our member health insurance providers have come together with organizations representing American consumers, employers, brokers, and others to offer real solutions to this problem. Together we are calling for an end to arbitrary and inflated surprise medical bills imposed on patients by certain specialty doctors and emergency medical services (EMS) providers.

Our testimony focuses on the following:

- A review of how surprise medical bills occur;
- Data demonstrating the frequency and magnitude of surprise medical bills;
- Recommendations to protect patients from surprise medical bills;

- Information on the relationship between surprise billing protections and health plan networks;
- Our concern that arbitration as the primary mechanism to address surprise medical billing will increase health care costs for everyone and harm consumers; and
- A comparison of three state laws – enacted in California, Texas, and New York – that provide important lessons as we seek federal legislative solutions that will effectively protect the health and financial security of every American.

### **How Surprise Medical Bills Occur**

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

When patients have health care coverage and get care from doctors in their plan’s network, the health insurance provider typically covers all costs beyond required cost-sharing under their health plan at a negotiated, market-based rate. 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 the patient is responsible. This is because, 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. Unlike premiums and benefit designs regulated as health insurance under state and/or federal law, there is no oversight over or obligation to justify these charges, which means that patients may be exposed to enormous financial liability in these situations.

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

## The Frequency and Magnitude of Surprise Medical Bills

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

In February 2019, the USC-Brookings Schaeffer Initiative for Health Policy published a white paper<sup>1</sup> which reported that:

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

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

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

Data clearly show that the frequency of surprise medical billing is increasing at alarming rates. Moreover, the financial burden such bills impose on both individual consumers subject to the surprise bills and all consumers who rely on health insurance to access care is enormous.

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

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

Data from the Health Care Cost Institute (HCCI) show that an increasing percentage of ER visits are being categorized as more complex based on hospital coding. From 2008 to 2017, the percentage of all ER visits categorized as Code 5 increased from 17% to 27%. At the same time, average emergency room prices increased from \$549 to \$1,121 for Code 5 visits, from \$468 to \$1,072 for Code 4 visits, and from \$354 to \$757 for Code 3 visits. Recognizing that ER visits have a high potential for surprise bills and that hospitals are paid more for complex treatments, these findings demonstrate the cost pressures that patients are facing due to rising ER prices.

The likelihood of receiving a surprise medical bill varies greatly from state to state and county to county, largely because specialists and emergency rooms in some parts of the country are markedly less likely to accept private insurance. In some regions, there is growing provider concentration on both the physician and hospital side, leading to monopolistic market power that makes it even more challenging to bring providers into an insurance network at reasonable rates in order to deliver an affordable health plan network to patients and their families. We see this in places like McAllen, Texas, and St. Petersburg, Florida, where patients had an 89% and 62% chance, respectively, of receiving surprise medical bills. Conversely, in more competitive health care markets like Boulder, Colorado, and South Bend, Indiana, researchers found the rate of surprise medical bills to be nearly zero.<sup>3</sup>

Even for consumers who never receive one, surprise medical bills mean higher premiums. A 2015 analysis of out-of-network charges in New Jersey<sup>4</sup> shows that for the largest health insurance provider in the state, out-of-network claims comprised 8% of their total commercial spending in 2013. If the plan had paid these out-of-network claims at 150% of Medicare rates, rather than the billed charges, the insurance provider would have paid 52% less for out-of-network services, amounting to savings of almost half a billion dollars (\$497 million), which could have resulted in a reduction of 4.3% in total commercial claims and consumers paying 9.5% less out-of-pocket.

It is important to note that surprise billing is not an issue seen across all types of providers, however. The problem of surprise medical bills tends to be concentrated among a select number of providers from certain medical specialties often in certain geographic regions that are taking

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<sup>3</sup> Cooper and Morton (2016)

<sup>4</sup> 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](http://avalere-health-production.s3.amazonaws.com/uploads/pdfs/1427291367_AH_Analysis_of_Policy_Options_WP_v3b2.pdf)

advantage of market dynamics where the patient has no choice in selecting the provider. These providers are likely to charge substantially more than similarly trained and qualified peers in other specialties. They are also more likely either to not accept private insurance or to require extraordinarily high reimbursement rates to participate in insurance networks. Studies have found that surprise medical bills are most likely to come from emergency medicine physicians, anesthesiologists, radiologists, and pathologists.<sup>5</sup>

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.<sup>6</sup>

Since patients are subject to the “balance” of these charges in most states, these unreasonably high charges may have a devastating impact on consumers. The bottom line is that surprise medical bills create financial hardship for millions of Americans, whether or not they personally have received one. Federal legislative action is needed to address this problem for everyone, regardless of the kind of coverage they have.

### **Solutions for Protecting Patients From Surprise Medical Bills**

Over the past year, AHIP has been advocating for federal legislation that would protect patients from surprise medical bills. Our recommendations build upon our collaboration with other leading organizations representing consumers, employers, and health insurance providers. Working with these partners, we have endorsed a set of guiding principles for federal legislation and also addressed a letter to congressional leaders, calling for meaningful steps to address surprise medical bills.<sup>7,8</sup>

AHIP applauds Chairman Pallone and Ranking Member Walden for developing a bipartisan discussion draft of the “No Surprises Act” and for inviting feedback and comments from

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<sup>5</sup> Loren Adler, Paul B. Ginsburg, Mark Hall, Erin Trish (September 25, 2018) Analyzing New Bipartisan Federal Legislation Limiting Surprise Medical Bills. Health Affairs.

<https://www.healthaffairs.org/doi/10.1377/hblog20180924.442050/full/>

<sup>6</sup> Bai, G., & Anderson, G. F. (2017). Variation in the Ratio of Physician Charges to Medicare Payments by Specialty and Region. JAMA, 317(3), 315

<sup>7</sup> <https://www.ahip.org/wp-content/uploads/Surprise-Billing-Consensus-Statement-12.10.18.pdf>

<sup>8</sup> <https://www.ahip.org/wp-content/uploads/Hill-Sign-on-Letter-Surprise-Medical-Bills-031819-2.pdf>

consumers, health care organizations, and other interested parties. We have provided recommendations for strengthening this draft legislation, focusing on the importance of addressing surprise billing by ground and air ambulance operators, recognizing median contracted rates as an appropriate, market-based payment benchmark, and applying the median contracted rate approach to self-funded plans regulated under ERISA. We appreciate that the committee has been receptive to our suggestions.

Our recommendations for federal legislation focus on four priorities:

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

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

In addition, the cost-sharing that may be imposed upon an insured patient under these situations should be limited to the amount for which the patient would be responsible for a participating network provider, including for deductibles and calculating out-of-pocket maximums.

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

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

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

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

An independent dispute resolution process, established at the state level, should be available when there is a dispute as to whether a reimbursement was correctly determined according to the market-based methodology we are recommending. Dispute resolution processes should not be the default or primary vehicle instead of the established payment benchmark. In addition, internal appeals processes should be exhausted prior to initiating a dispute resolution process.

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

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

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

### **Surprise Medical Billing Legislation Will Not Weaken Health Plan Networks**

Provider networks are an essential part of health care coverage and the care that people receive. They help ensure that enrollees have access to a robust network of high-quality doctors and health care settings, and that these providers are held accountable to high standards for care quality at reasonable, market-driven rates. It also benefits providers and plans by reducing administrative expenses and streamlining reimbursement.

As a first step to eliminate surprise medical bills, we want providers and hospitals to voluntarily contract with health plans. This benefits everyone – both by advancing value-based payment arrangements and prompt claims payments. Early reports from the implementation of the California law which includes a benchmark is that network participation is increasing, while rates of surprise billing are decreasing. The opposite is true in states like Texas that previously



enacted policies to require payments of billed charges and have proven to undermine network value.<sup>9</sup>

There are several circumstances under which a patient would be unable to choose whether, or from whom, to receive care. Nobody chooses which ER doctor they see when they are taken out of the ambulance, nobody makes an appointment to see their preferred anesthesiologist, or insists that their blood be examined by a particular pathologist. In these instances, the facility chooses the doctor for the patient, rather than the patient choosing the doctor. There is a clear incentive for some providers to stay out of network for financial gain, leading to surprise billing. Federal action is needed to correct this perverse incentive that leads to higher costs for all consumers.

One of the most essential roles of a health insurance provider is to offer enrollees an array of health care providers who are conveniently located, meet the needs of the patient, are affordable, and are practicing the highest quality medicine. Indeed, this is the core of the service our members provide to more than 200 million Americans. Our members and health insurance providers across this country work to ensure that when patients need to see a doctor, they can see a high quality doctor of their choosing. When an enrollee needs a primary care physician, a gastroenterologist, a dermatologist, or take their child to a pediatrician, quality provider networks make that possible. We would not and could not support any legislation or other actions that make it more difficult for quality health care providers to join networks.

While network participation is an important element of this discussion, it is important to impress upon the committee that the reason surprise medical bills are a problem is not a lack of network adequacy that some may suggest. Surprise medical bills are a challenge solely because a small subset of medical specialists have sufficient market power that they lack the financial incentives to participate in health plan networks since their patient volume is not driven by network inclusion unlike most other provider types. They will continue to lack an incentive to join these networks, unless legislation is enacted to truly correct this underlying market failure.

We support federal legislation that creates a competitive market environment where health insurance providers and doctors can continue to actively collaborate on offering affordable, high quality care that puts patients first. If we effectively lower costs and incentivize greater network

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<sup>9</sup> Texas Association of Health Plans Out of Network Claims Survey, February 2019. Available at: [https://cdn.ymaws.com/www.tahp.org/resource/collection/16E3C8B1-6C50-4F6D-8C23-EA29F4AE4818/Texas\\_Findings\\_OOn\\_Claims\\_Final\\_2-15-19-compressed.pdf](https://cdn.ymaws.com/www.tahp.org/resource/collection/16E3C8B1-6C50-4F6D-8C23-EA29F4AE4818/Texas_Findings_OOn_Claims_Final_2-15-19-compressed.pdf)

participation by ancillary physicians, Americans will find health care more affordable and have better access to the care they need from the other providers in their health plan's network.

### **Arbitration Would Increase Administrative Burdens and Health Care Costs**

We have serious concerns about any proposal that would use arbitration to determine payments to out-of-network providers. We appreciate that the Administration and the “No Surprises Act” have rejected arbitration in favor of a market-based approach to protecting the American people from surprise medical bills.

The fundamental problem with arbitration is that it imposes administrative burdens on the entire health care system, including employers that offer self-funded coverage. For the 110 million Americans who receive coverage in self-funded plans, a federally-imposed arbitration process would force employers to hire staff or outside consultants to manage a complex process. Health insurance providers would need to make similar investments.

The experience of Texas, which we discuss below, shows how arbitration can slow down the claims process, increase administrative burden, exacerbate patient aggravation, and limit payment certainty. When Texas established an arbitration system to resolve surprise medical bill disputes, the number of complaints increased dramatically. In 2013, the Texas Department of Insurance received 43 requests for mediation. A year later that figure had increased to more than 600, with at least 8,000 complaints expected this year. By the fall of 2018, there was a backlog of more than 4,000 cases.<sup>10</sup> The administrative burdens associated with these proceedings – for all parties involved – take away resources that could be better focused on our shared goal of advancing high-quality, patient-centered health care for all Americans.

Another major concern with arbitration is that this approach fails to address the root cause of surprise medical bills: exorbitant bills from certain specialty doctors and EMS providers. Accepting their egregiously high prices as a starting point will not help to lower health care costs for Americans.

Billed charges from these specialists represent a form of price gouging. As long as the inputs into the process give credence and weight to price gouging, the end result will be payments that are

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<sup>10</sup> Root & Najmabadi. *Thousands of Texans Were Shocked by Surprise Medical Bills – Their Requests for Help Overwhelmed the State*. The Texas Tribune. February 12, 2019. <https://www.texastribune.org/2019/02/12/texas-mediation-balance-billing-faces-massive-backlog/>

excessively high – which in turn will increase premiums. And if health plans must continue paying these exorbitant bills – even if slightly reduced – everyone who buys health insurance will shoulder the burdensome costs resulting from this price gouging. Arbitration will not succeed in correcting this market failure.

### **Lessons to be Learned From State Legislation**

As Congress explores legislative options for eliminating the problem of surprise medical bills, it is important to look at state laws in this area. Below we review the impact of laws enacted in California, Texas, and New York.

In California, a state law passed in 2018 provides surprise medical billing protections and establishes reimbursement requirements for *non-emergency* services received from non-contracting providers at contracting facilities. This law applies to both health care service plans and health insurance providers.<sup>11</sup>

The new California law is not based on provider charges. Instead, it requires health insurance providers to reimburse non-contracting providers the greater of the average contracted rate or 125% of Medicare fee-for-service reimbursement for the same or similar services in the general geographic area. The methodology for determining the average contracted rate went into effect January 1, 2019. If either the non-participating provider or the payor disputes whether the payment of the specified rate is appropriate, the regulator – either the Department of Managed Health Care or the California Department of Insurance – can authorize a Dispute Resolution Process. Both parties in dispute must participate, and the decision of the independent organization is binding. This significantly narrows when this approach is used.

This approach determines the reimbursement methodology based on market rates defined as what similar providers routinely accept as payment in-full for their services. As a result, it does not increase health care spending. Instead, it encourages health insurance providers and health care providers to enter into mutually beneficial contracts. If Congress chooses to implement this type of methodology to address the issue of surprise medical bills, it will allow health insurance providers to continue to manage costs through contracting with health care providers while

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<sup>11</sup> Health care service plans are those entities regulated by the California Department of Managed Health Care and include all HMO plans, plus some PPO and EPO plans. Health insurers are those entities regulated by the California Department of Insurance and include some PPO and EPO plans.

maintaining existing incentives for contracting providers and negotiating with new providers to join networks.

By banning surprise medical billing, protecting provider networks, and not adding new costs to the system, California represents the best current approach to protecting patients. Contrary to some public reports from provider organizations, we are not aware of health insurance providers refusing to contract with doctors or dramatically reducing reimbursement rates since the law took effect. In fact, we understand that some health plan networks have increased as a result of this law and that the state is looking at how similar protections can be expanded to emergency rooms, which are not currently covered.

By contrast, existing Texas state law ties reimbursement for non-contracting providers to billed charges by requiring carriers to pay the provider's usual and customary charges. To understand the impact of this approach, we note that in Texas billed charges at the 80th percentile of FAIR Health data (usual and customary rates) for a high severity emergency department visit total \$1,902. This represents a payment of 3.94 times the average negotiated rate (allowed amounts by health plans) of \$483. This outcome demonstrates that linking payments for out-of-network services to unjustified provider-set charges will lead to significantly greater out-of-network charges meaning higher costs for consumers. In Texas, 65% of ER physician spending is out of network, substantially higher than all other physician specialties.<sup>12</sup>

Not only has this system led to higher costs, it has also done nothing to tamp down on surprise billing. In fact, Texas currently has the highest rates of surprise medical billing in the country and some of the lowest network participation by ancillary providers despite robust and stringent network adequacy requirements for plans. Put simply, the perverse incentives to remain out of network were exacerbated by the Texas surprise billing law.

Recognizing the dire need to address the market failure in the state, the Texas legislature has approved legislation to standardize consumer protections across state-regulated health plans and remove patients from billing disputes. This bill, which was signed into law on June 4 and takes effect immediately, would prohibit surprise medical billing by providers of emergency services and certain facility-based services, require carriers to reimburse providers the usual and customary rate, and transform the existing mediation system into an arbitration program between the provider and insurer only. While we appreciate that patients will be taken out of the middle,

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<sup>12</sup> TAHP, Out of Network Claims Survey, IBID.

the new law will do nothing to address the perverse provider incentives to remain out of network or to lower costs for consumers.

In New York, state law provides for a “baseball style” dispute resolution process whereby providers submit a rate for consideration and health insurance providers submit their own reimbursement rate. Whichever submission the mediator finds more reasonable is determined to be the reimbursement amount for the disputed claim. The New York State system relies on a practicing physician to serve as mediator, which adds an inherent level of bias into the process. Additionally, unjustified provider-set charges are required to be a consideration in the arbiter’s determination.

Costs in the New York dispute resolution system can be significant, with standard claims disputes filing fees costing plans, anecdotally, between \$500-800 to resolve. For many arbitration systems, the filing fee in a two-party dispute is \$1,500 per party, as identified by JAMS, a leading third-party mediation and arbitration firm, which represents a typical market rate for such services.<sup>13</sup> These fees do not include additional in-house or outside counsel or other costs involved in arbitration. Plans are required to factor these administrative costs into premiums, which has a direct impact on consumers and their ability to access affordable coverage.

While evidence suggests that the current system in New York reduced costs once enacted, that cost reduction is relative to an unreasonably high standard, which is what prompted the legislation in the first place. New York’s previous system, like Texas, required the payment of provider-set billed charges. As a result, costs were unsustainably high.<sup>14</sup>

Based on the impact an arbitration system like New York’s has on both market incentives and administrative costs, AHIP believes that New York’s system does not deliver optimal outcomes and, if implemented nationally, would not effectively reduce costs.

Looking at the different approaches taken in these states, we urge the committee to pursue a California-style solution that protects patients and consumers with common sense rules that do

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<sup>13</sup> *Arbitration Schedule of Fees and Costs*. JAMS. <https://www.jamsadr.com/arbitration-fees>

<sup>14</sup> An Unwelcome Surprise, How New Yorkers Are Getting Stuck with Unexpected Medical Bills from Out-of-Network Providers, March 7, 2012, [http://www.statecoverage.org/files/NY-Unexpected\\_Medical\\_Bills-march\\_7\\_2012.pdf](http://www.statecoverage.org/files/NY-Unexpected_Medical_Bills-march_7_2012.pdf)

not undermine networks, do not lead to higher cost-sharing or premiums, and help increase access to affordable coverage options.

## **Conclusion**

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