House Ways & Means Committee
Protecting Patients from Surprise Medical Bills
May 21, 2019
3:00 pm, Longworth 1100

Purpose
To discuss proposals for addressing surprise billing.

Members Present
Chairman Doggett, Ranking Member Nunes, Representatives Thomas, Buchanan, Kind, Smith, Blumenauer, Marchant, Sewell, Chu, Evans, Kelly, Schneider, Gomez, Horsford

Witnesses
PANEL 1
The Honorable Katie Porter, Representing the 45th District of California
The Honorable Cathy McMorris Rodgers, Representing the 5th District of Washington
PANEL 2
Mr. James Patrick Gelfand, Senior Vice President, Health Policy, ERISA Industry Committee
Mr. Tom Nickels, Executive Vice President, Government Relations and Public Policy, American Hospital Association
Ms. Jeanette Thornton, Senior Vice President, Product, Employer, and Commercial Policy, America's Health Insurance Plans
Mr. Bobby Mukkamala, Board of Trustees, American Medical Association

Opening Statements
Chairman Doggett said one in seven patients has received a surprise bill for a hospital that is in-network. There is even a TV series by Jaie Avila called "Show Me Your Bill", but the public cannot rely on media exposure to control surprise billing. States are enacting protections, but federal action is essential, since in Texas, for example, 40% of ensured individuals are ensured under ERISA plans. The End Surprise Billing Act is designed to protect individuals. Under the legislation, patients would only be charged in-network rates for emergency situations and only be charged out-of-network rates in non-emergency situations when informed of the rates. There is still conflict over how to resolve insurer-provider disputes despite the various surprise billing proposals floating around. This hearing was organized on a bipartisan basis. It is unclear which proposal Trump supports but his support is critical. **Chairman Doggett** supports any proposal that can get enough votes and get Trump's signature.

Ranking Member Nunes said he is interested in hearing common sense, targeted solutions, not a food fight. Policies should help consumers make informed decisions about their healthcare. Patients should hear about their cost-sharing obligations before receiving treatment and be notified about whether their providers are in-network. Hospitals should be held responsible for issues between doctors and insurers, not patients. The

organizations represented on the second panel have the responsibility to solve the problems for patients.

Testimony

Panel 1

Ms. Porter said she has had to fight her own battle with surprise billing after she went to the ER for an appendectomy. She chose a further away hospital because it was in-network. Her insurer claimed the surgeon was out-of-network so she received a bill for $3,000. The so-called EOBs and surgeon's handout explained that he was treated as out-of-network provider despite working at an in-network hospital. Her insurer put profits over patients. The benefits manager at Anthem BlueCross kept coaching her to blame her surgeon. She then learned that her employer, UCI, pays a medical doctor to help employees navigate insurer. Thousands of Americans have fewer resources than her and are surprised by bills far more devastating. This cannot be the status quo. Any solution must not rely on the patient's ability to go to war with the insurer or provider.

Ms. McMorris Rodgers said one of her constituents received her bill of $227,000 after heart surgery. She was eventually able to get help with a complicated medical charity waiver but it took six months and countless collections call. It should not be this way. Nobody told her that she could have been transferred to an in-network hospital, which could have saved tens of thousands. The solution is more transparency, to make it easier to be an informed patient. This Congress needs to move in a bipartisan fashion.

Panel 2

Mr. Mukkamala said the American Medical Association (AMA) has long been concerned about gaps in out-of-network coverage. The best solutions have several common principles. First, protection for patients. Patients should be kept out of the middle of payment negotiation. Payment should count toward deductibles. Second, network adequacy must be regulated and increased. Third, fair payment should be established for providers to ensure that appropriate market incentives remain in place. Mechanisms could include a minimum payment standard based on physician rates or billing arbitration process that considers many factors. Third, transparency in many forms. Patients who choose to obtain out-of-network physicians should be informed about their anticipated costs. For network adequacy, physicians want to be offered fair contracts in-networks. For physicians in small practices and for highly concentrated markets, physicians are in a week position relative to commercial health insurers. Insurers need to offer fair contracts to physicians, and Congress can facilitate this through regulating provider networks. To protect patients, network adequacy standards should include measurable requirements on the front end before insurance products are brought to market, maximum wait times, and maximum patient provider ratios. The AMA urges Congress to avoid any solutions that set minimum payment standards for out-of-network care at noncompetitive rates. In-network rates cannot be used as the benchmark for out-of-network rates. Additionally, payment

benchmarks should not be based on a percentage of Medicare rates, which simply do not reflect the cost of providing care. Medicare physician payment rates have declined 19 percent over the past 17 years. Finally, it is critical that any benchmark comes from sources independent of interested parties, with historical manipulation of data by the insurance companies.

Ms. Thornton said that surprise medical bills should be ended so patients have peace of mind. Federal legislation should focus on four things. First, balance billing should be banned when patients are involuntarily treated by an out-of-network provider, including emergency services, ambulance transportation. Second, health insurance providers should be required to reimburse out-of-network providers in appropriate and reasonable amount in those scenarios. Third, states should establish an independent dispute process that works in tandem with the established processes. Fourth, hospitals or providers should be required to provide advance notice of patients' providers' network status. AHIP supports Chairman Doggett's bill. Proposals that use arbitration to determine payments to out-of-network providers should be rejected. They do not address the root cause of surprise bills--exorbitant bills from specialists, which are price gouging. Some proposals and the Administration have rejected arbitration in favor of a market approach, which is appreciated. California and Texas have enacted laws that take different approaches. California's approach does not increase healthcare spending and encourages plans and providers to enter into mutually beneficial contracts. Texas ties reimbursement for noncontracting providers to the 80th percentile of provider charges, which has led to inflated payments and one of the highest rates of surprise billing in the country.

Mr. Nickels said the AHA supports federal legislation. Congress must help the people who have employer-funded plans under ERISA and those who do not live in states with comprehensive protections. Patients should not be subject to balance bills when they have acted in good faith to obtain in-network care and should not be denied care. First, Congress should explicitly prohibit balance billing in previously described scenarios and make sure patients are kept out of processes to determine reimbursement. Second, Congress should ensure adequate oversight of networks. Third, Congress should allow providers and payers to determine payment, rejecting a national benchmark even if geographically adjusted. A reimbursement rate set by law would disincentivize employers from ensuring adequate provider networks. A baseball style of arbitration similar to what New York has enacted seems to be efficient and places the responsibility on the provider or insurer, not the patient. There has not been a noticeable impact on insurance rate. These state-level solutions do not affect the employees covered under ERISA, but they could be successfully deployed at the federal level with some modification. The AHA disagrees with bundling. While voluntary bundled payment models are fine, it would be difficult to apply to ED services due to the diversity of patient needs. The complexity of what and whom to bundle would not prevent the issuance of surprise bills. This would also place hospitals in the role of what insurers should do. Congress should allow providers and hospitals to work towards this goal of providing estimated costs of patient care without including it as a

component in the surprise billing package. Finally, patients must receive increased help with navigating the healthcare system.

Mr. Gelfand said 181 million Americans get insurance through their job, and they frequently do everything right, but they still receive enormous surprise bills. The vast majority of providers do not generate surprise bills—it is in a certain subset of scenarios. ERIC proposes three policy changes. First, an in-network matching rate guarantee. Second, an emergency last resort benchmark backstop. When plans and providers can't agree on rates, set a benchmark that could be based on a percentage of Medicare rates. Third, require informed consent. When a transfer or handoff takes place, offer an alternative if possible. Congress can also crack down on abusive behavior by outsourced medical staffing firms and banning certain kickback agreements. The first snipe hunt is a call for mandatory binding arbitration, a dodge to deflect tough decisions but would raise patient costs. Next, transparency alone will not solve a de facto monopoly. The current system is not balanced and the losers are patients. Lastly, some have advocated deferring to the states, but few have enacted solutions.

Questions and Answers

Chairman Doggett asked Dr. Mukkamala if an in-network matching guarantee is sufficient. **Dr. Mukkamala** said that it sounds easy to implement, but the reality is that physicians deserve unique fees for unique services and geographies. It's an easy way out but it's not fair. **Chairman Doggett** asked whether there is justification for charging different Medicare rates for in- vs out-of-network. **Dr. Mukkamala** said there is a benefit for working with an in-network provider, so they earn the discount. **Chairman Doggett** asked why the New York arbitration system works well. **Mr. Gelfand** said that arbitration raises cost and rearranges the deck chairs on the Titanic. In New York, the system discourages arbitration. **Ms. Thornton** said that AHIP's plans have been working in New York for many years and found that it has not worked to the fullest extent possible, so it would not be the best national model. **Chairman Doggett** asked why bundling won't solve the problem. **Mr. Nickels** said that bundling doesn't directly help the patient. It puts hospitals and the government into the position of what the insurer should be doing.

Ranking Member Nunes said that he hopes on the patient tool of a website that provides costs for services performed in a physician office. He asked Mr. Nickels whether transparency could be expanded online. **Mr. Nickels** said yes. It is important for consumers to understand there is a reason why prices are higher at a hospital outpatient department compared to an ASC or physician office. Emergency departments have additional costs and burdens, which must be built into rates. EMTALA is not reimbursable. **Ranking Member Nunes** asked which of the Greatest of Three rule payment rates is typically highest and what the dollar delta is between the rate and what the physician eventually receives. **Dr. Mukkamala** said that the Medicare is the foundation. Blue Cross Blue Shield of Michigan is 115 percent of Medicare rates. The out-of-network rate for a new insurance company that does not contract with him should be negotiated. **Ms. Thornton** said the Greatest of Three methodology only applies to emergency services. The usual and customary rate is the highest generally. A lot of the situations are not emergencies and thus not covered by the Greatest of Three. **Ranking Member Nunes** asked if hospitals

determine the usual and customary and reasonable amount. **Mr. Nickels** said hospitals do not support rate-setting in any capacity.

Rep. Thompson said one of his staffers got two separate bills from physicians he never saw and never asked to see. The bills were larger than the bill for his total ER visit. **Rep. Thompson** asked Mr. Nickels why a fixed rate approach might lead to smaller, more inclusive networks. **Mr. Nickels** said AHA is concerned with network shrinkage, and default rates would exacerbate that. **Rep. Thompson** asked Mr. Nickels if networks tightened in California. **Rep. Thompson** said the data is not in yet to determine that. **Dr. Mukkamala** said there are multiple cases documented of insurance companies shrinking in California because of uncompetitive rates. **Rep. Thompson** asked Ms. Thornton why an arbitration system would lead to higher premiums. **Ms. Thornton** said the arbitrator faces random guidelines for making a decision, so it's likely they will take the provider's price. It does not address the root cause of high rates. **Rep. Thompson** asked if premiums increased in New York. **Ms. Thornton** said premiums have come down since the baseball system.

Rep. Buchanan said the lack of transparency and the exorbitant bills are a big concern. He asked what Congress can do. **Dr. Mukkamala** said his office has two full time people just to navigate medical billing. Transparency requirements will come from Congress. So much gets written off to accommodate the physician fee schedule. **Mr. Nickles** said Medicare requires physicians to charge the same amount, which gets negotiated with insurers. MedPAC talks about how poor the payments. It should be so patients only pay the in-network amount. **Ms. Thornton** agrees. Patients should be taken out from the negotiation. During emergencies, transparency will not help because patients are not in a position to make a choice.

Rep. Kind asked how extensive surprise billing is. **Ms. Thornton** said one in five ER visits results in a surprise bill and it's even higher in ground and air ambulances. 15 percent of hospitals nationwide are causing this issue. **Rep. Kind** asked how transparency will work in emergency situations. **Mr. Gelfand** said it's not reasonable to expect the patient to ask those questions as they're in an ambulance. Pathology, emergency, anesthesiology and radiology are the specialists that are generating the surprise bills because patients are stuck with them. **Rep. Kind** asked whether a federal standard is needed. **Mr. Gelfand** said yes. **Mr. Nickels** said yes, as states can't help the people under ERISA. It's not the hospitals that are out-of-network but the physicians. The issue is with the physicians. **Rep. Kind** asked if there are Stark or Anti-Kickback Statute problems. **Mr. Nickels** said yes, that is part of the issue relating to hospital-physician arrangements. **Ms. Thornton** said yes, a federal floor is important.

Rep. Smith said there can't be unintended consequences of federal action that impact the critical access hospitals. **Rep. Smith** asked what challenges rural areas face. **Dr. Mukkamala** said physicians working alone overnight in a rural hospital should have every opportunity to negotiate contracts with insurers. **Mr. Nickels** agrees. A national rate or benchmark would not work for rural America; it would result in fewer rural physicians. **Ms. Thornton** said health plans are highly regulated on adequacy in rural America. Surprise billing is not related to network adequacy. **Mr. Gelfand** said rural patients need the most protection for surprise billing.

Rep. Blumenauer said that Oregon recently banned surprise billing. He asked the witnesses for their perception of the Oregon approach. **Dr. Mukkamala** said the Oregon proposal does a great job of protecting patients. **Ms. Thornton** said AHIP supports Oregon's approach. **Mr. Nickels** said that the Oregon legislation should be extended federally. **Mr. Gelfand** said that eventually someone will have to pay the bill, so if the underlying issue isn't addressed, prices will just be spread throughout the premium, leaving every enrollee to pay for the surprise bill.

Rep. Sewell submitted to the record an article detailing patients struggling to afford medical debt. **Rep. Sewell** asked Mr. Nickels how rural hospitals can be assisted with bad debt so they don't have to go after patients in order to keep their doors open. **Mr. Nickels** said Medicaid expansion. The federal and state government need to acknowledge that they underpay. Private insurers pay more than cost and the government pays less. The government must take responsibility. **Rep. Sewell** asked Ms. Thornton how important Medicaid DSH and low-volume payments are for helping hospitals make up for inadequate reimbursements. **Ms. Thornton** said very important. **Mr. Nickels** said there are Medicaid DSH cuts in October, which will undercut hospitals' ability to provide services.

Rep. Marchant said there has been a general complaint that Medicare has an artificially low reimbursement rate. Congress must be cautious not to add more government regulation. He asked if Medicare should be involved in this discussion. **Dr. Mukkamala** said 93 percent of physicians participate in Medicare. **Rep. Marchant** asked if patients are told their physician is nonparticipating. **Dr. Mukkamala** said yes, but it only works for elective appointments. Surprise situations are the issue. **Mr. Nickels** said it is not a good idea for government to set benchmarks for public or private insurance.

Rep. Chu submitted to the record a Vox article detailing surprise billing at the Zuckerberg San Francisco General Hospital, which does not participate in any private insurance. **Rep. Chu** asked Ms. Thornton and Mr. Nickels how common practices like Zuckerberg San Francisco General Hospital's are, and how that is even legal in the first place. **Mr. Nickels** said no other hospital in America is out-of-network for every insurer in that area. It is inexcusable. **Ms. Thornton** agrees. This is why federal legislation needs to step in. **Rep. Chu** asked what would happen if a federal law was passed that differs from state laws operating, and how it would impact patients and providers. **Mr. Gelfand** said it would be important for there to be one standard that applies to all beneficiaries, but that is only for the self-insured large plans. For a fully insured plans it would make sense for state law to govern. **Mr. Nickels** said there must be maximum flexibility for state law to continue. There needs to be a standard for ERISA folks. Federal statute should apply for states with no law. **Ms. Thornton** said states should primarily regulate their state law.

Rep. Evans asked Mr. Gelfand where the highest balanced bills are. **Mr. Gelfand** said it's largely ancillary services, like air ambulance and anesthesiologists. **Rep. Evans** asked Ms. Thornton to explain narrow networks. **Ms. Thornton** said surprise billing occurs whether the network is big or small. These are often providers that someone doesn't choose. **Rep. Evans** asked how patients are treated by out-of-network doctors that they don't select in the first place. **Ms. Thornton** said that hospitals can have out-of-network doctors despite being in-network. **Rep. Evans** asked Mr. Nickels how hospitals can have providers that patients don't choose

themselves. **Mr. Nickels** said that patients in emergency situations need to get taken care of regardless of who's there to treat them.

Rep. Kelly asked how fair prices are determined for procedures. **Dr. Mukkamala** said prices are negotiated based on physician skill and availability. **Rep. Kelly** asked how geographic differences can be adjusted for. **Dr. Mukkamala** said it is important for insurers to account for the needs of their beneficiaries and establish network adequacy before selling their product. **Rep. Kelly** said it must be more expensive to run a big hospital in Philadelphia than a small hospital in rural Pennsylvania. **Mr. Nickels** said half the payments are dictated by government. The rural issue is a perfect example of physician paucity.

Rep. Schneider said two-thirds of Americans are worried about receiving an unexpected medical bill. Using the example of an out-of-state ski accident, **Rep. Schneider** asked what the most likely source of a surprise bill would be. **Dr. Mukkamala** said contracting can't prevent the problem of out-of-network billing if the patient is in an out-of-network state. **Rep. Schneider** asked if someone is making a windfall. **Mr. Gelfand** said hospitals will outsource their emergency room to a Wall Street company, which is definitely making money due to their relationship with the in-network hospital and out-of-network emergency room. **Ms. Thornton** said premiums cannot be raised.

Rep. Gomez asked what the shortfalls of the California law are and how well it's working. **Dr. Mukkamala** said that it solves one problem and creates a massive other problem of network shrinkage. Contracts don't get renewed because it's cheaper for insurers to not give hospitals in-network status. **Ms. Thornton** said AHIP supports it and consumers are protected while not raising healthcare costs. **Mr. Nickels** said that the benchmark doesn't affect hospitals. AHA fears that insurers will lean on a Medicare-based rate. **Mr. Gelfand** said that there has not been a mass migration of physicians outside of California. People are not losing access to care while surprise bills are being stopped.

Rep. Horsford said that the solution cannot involve simply shifting responsibility or cost. Out-of-network providers are charging an average of 150 percent more than in-network providers and that is a serious problem. Last week Nevada signed into law a compromise bill that protects patients by requiring them to only pay the copay, coinsurance or deductible at the in-network level for emergency care. **Rep. Horsford** asked Mr. Nickels and Dr. Mukkamala how patients can be protected further. **Mr. Nickels** said he agrees with the Nevada law since it takes the patient out of the middle of it. It allows the provider and insurer to negotiate.