TESTIMONY OF

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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

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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

[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.

[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.

[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.

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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 <u>non-governmental witness</u>, 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.*

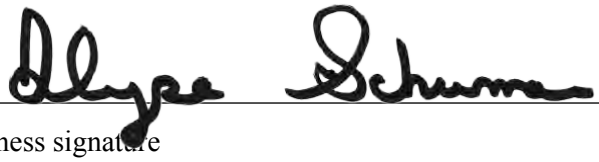
N/A

If you are a <u>non-governmental witness</u>, 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.