Protecting Patients from Surprise Medical Bills

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

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HOUSE COMMITTEE ON WAYS & MEANS
CHAIRMAN RICHARD E. NEAL

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
May 14, 2019
No. HL-2

CONTACT: (202) 225-3625

Chairman Doggett Announces Health Subcommittee Hearing on Protecting Patients from Surprise Medical Bills

House Ways and Means Health Subcommittee Chairman Lloyd Doggett announced today that the Subcommittee will hold a hearing entitled "Hearing on Protecting Patients from Surprise Medical Bills" on Tuesday, May 21, 2019, at 2:00 p.m. in room 1100 of the Longworth House Office Building.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record can do so here: WMDem.Submission@mail.house.gov.

Please ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Tuesday, June 4, 2019**.

For questions, or if you encounter technical problems, please call (202) 225-3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but

reserves the right to format it according to guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

The Committee seeks to make its facilities accessible to persons with disabilities. If you require special accommodations, please call (202) 225-3625 in advance of the event (four business days' notice is requested). Questions regarding special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories are available [here].

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WITNESSES

The Honorable Katie Porter
Director of the Institute for Innovation Law, UC Hastings School of Law
Witness Statement

The Honorable Cathy McMorris Rodgers
Assistant Director of the Program on Regulation, Therapeutics, and Law PORTAL, Harvard Medical School
Witness Statement

James Patrick Gelfand
Co-Director of the Global Health Justice Partnership, Yale Law School
Witness statement

Dr. S. Bobby Mukkamala
President, American Action Forum
Witness statement

Mr. Tom Nickels
Executive Director, Families USA
Witness statement

Jeannette Thornton
President, American Action Forum
Witness statement

PROTECTING PATIENTS FROM SURPRISE MEDICAL BILLS

Tuesday, May 21, 2019

House of Representatives,

Subcommittee on Health,

Committee on Ways and Means,

Washington, D.C.

The Subcommittee met, pursuant to notice, at 3:12 p.m. in Room 1100 Longworth House Office Building, Hon. Lloyd Doggett [Chairman of the Subcommittee] presiding.

*Chairman Doggett. I will ask the room to come to order. And a little late, but we are getting this going after votes. The Health Subcommittee will come to order. We have brief opening statements and then two panels. And I welcome all of you for coming.

This is the third session of Congress in which I have introduced legislation to ban the practice of surprise billing. Today's bipartisan hearing represents an initial effort by this committee to finally offer some relief to patients who have been bearing the brunt of a dispute between their insurers and some of their health care providers.

For patients, you can take all the right steps in attempting to see that your care in-network is covered, but you may still face some really big bills. Indeed, one in seven Americans have received a surprise bill as a part of receiving care at a hospital that is actually within their insurance network.

The problem in San Antonio, one of the communities that I represent, has been so extensive that Jaie Avil at WOAI, has initiated an entire television series called Show Me Your Bill. And I think a quick video clip from that adequately demonstrates the problem, and I will ask that it be shown at this point.

[Video shown.]

*Chairman Doggett. And I know she is relieved, but we can't rely on media exposure to solve these problems. She is also not a typical consumer caught in this situation. She served as executive director of the San Antonio Restaurant Association, and yet she had these kind of difficulties.

Another example is Drew Calver, a public school teacher with health insurance from his school job. He received out-of-network care after a heart attack, and he almost had another heart attack when he got the $100,000-plus bill. Only after his story was reported by Ashley Lopez at KUT Austin for NPR did he get relief, and some other people around the country, as the story got out, got some relief also. And Drew was recently

invited to the White House to tell his story with the President.

With unanimous consent I am entering his statement about his experience into the record.

[The information follows:]

**********COMMITTEE INSERT**********

*Chairman Doggett. But as we move forward we have some protections from the states that are being implemented -- in fact, one that was approved in Texas last evening -- but I think we will hear that federal action is essential, since in Texas, for example, 40 percent of insured individuals are insured under ERISA plans and they can receive no protection from state laws.

To address the gap in protection, the End Surprise Billing Act, which I referred to, is designed to protect insurance patients from being trapped between an insurer and an out-of-network provider. It is the sole focus of the bill. Originally, that concept, when I first introduced it, faced a great deal of opposition. In Texas, for example, the only remedy until this -- until yesterday, in a bill that I think is not finally approved in the legislature -- the only remedy offered was for the patient to negotiate directly with the health care provider in a little-known mediation system that has helped some but omitted many.

Fortunately, there now appears to be a growing consensus -- most recently joined by President Trump -- that holding the patient harmless should form the foundation for any surprise billing proposal. Under the legislation that I advanced, patients would only be charged in-network cost sharing rates in emergency situations. In non-emergency situations, out-of-network charges would be permitted only when the patient has agreed in advance after receiving effective notice regarding any providers and services, together with estimated charges.

No other bill addressing this issue has yet been filed here in the House. But there is a very useful discussion draft proposal that is being circulated on a bipartisan basis by the House Energy and Commerce Committee, and there are several proposals that have service in the Senate. While every proposal currently begins with the basic premise of the End Surprise Billing Act, conflict remains over how to resolve insure or provider disputes, and that is what we will hear about today from those that have the most direct stake in it.

Our Health Subcommittee hearing has been organized on a bipartisan basis to hear what they have to say, to see if we can find ways of resolving that dispute. But my primary concern remains to ensure that nothing stands in the way of federal action to remove the patient from being in the middle of a dispute that the patient can't control.

The leading proposals have pros and cons that we will hear about, and I think that, while condemning surprise billing, President Trump has rejected two principal approaches: one for arbitration and one for rate setting, and it is unclear exactly which proposal he supports. But I think his support is very important to resolving this. The Administration has raised the possibility of bundling payments as a solution, and we will hear comment about that today.

I basically support any solution that can get 218 votes here in the House and protect patients, gain Senate approval, and his signature. And I look forward to the discussion that we will have today to identify points of agreement so that patients no longer bear the brunt of this dispute.

[The statement of Mr. Doggett follows:]

**********COMMITTEE INSERT**********

*Chairman Doggett. And with that I would ask Mr. Nunes for his opening statement.

*Mr. Nunes. Thank you, Mr. Chairman. I appreciate your willingness to work in a bipartisan manner on this important issue, and I want to thank all of you for your attendance here today.

There is going to be a lot of perspectives, and I am very grateful for the Members of Congress that are here today, Ms. Porter and Mrs. McMorris Rodgers. Unfortunately, Ms. Herrera Beutler cannot be here because she is -- for those of you who don't know, she is nine months pregnant. So hopefully everything is going well, and hopefully she doesn't receive any surprise billing.

[Laughter.]

*Mr. Nunes. But I want to be clear. The trade associations testifying as part of today's second panel, and I am disappointed that all the participants that are going to be here that come from critical sectors of our economy could not come to find a way to work together to protect patients from these huge surprise bills. Instead, we are here exploring a potential government solution to the problem.

We have all heard the ridiculous stories: $600 Band-Aids, $60 ibuprofen, a $5,751 ice pack. The patient with the $5,000 ice pack reportedly went to the emergency room after hitting her head and cutting her ear, but she ended up leaving without care because the plastic surgeon who would see her was out-of-network for her insurance plan. She wanted to avoid a big bill, so she left the ice pack and a bandage. Her insurance plan paid the hospital $862, which it deemed a reasonable and appropriate fee for services. The hospital then sent the patient a bill for $4,989.

My state of California already has pretty robust protections against balance billing patients, going so far as to set a required reimbursement scheme, which I am sure some of

you like and some of you do not like. But I am not interested in watching a food fight between everyone. I want to hear about common-sense, targeted solutions that could help solve different aspects of the surprise billing problem. I want to talk about the policies that increase price transparency and help consumers make informed decisions about their health care.

In a non-emergency, scheduled situation, doctors and hospitals should be able to work with the insurance companies they contract with to give patients an estimate of their total cost of care and their total cost-sharing obligation before they get services or treatment, and patients should be notified about whether or not the health care providers who will be involved in their care are in their insurance network. I think that could go a long way with preventing these eye-popping bills.

As you all know, another type of surprise bill occurs when people get care in an in-network hospital, but were unknowingly seen by an out-of-network doctor. Perhaps hospitals which are responsible for those practicing within the four walls should be held responsible for dealing with issues between doctors and insurance companies in such circumstances. This would ensure that when patients are seen by multiple providers, one of them won't surprise the patient later with an out-of-network balance bill.

To me, the organizations represented on our second panel have the power and, I would argue, the responsibility to solve the issue for patients. I think there are a lot of different steps you should voluntarily take to protect your patients and policyholders.

Many states are working on solutions, either improving existing laws or creating new ones. I know both sides of the aisle in Congress are interested in finding a solution that protects patients.

I look forward to all the constructive testimony today, and I hope that we can deliver some solutions.

With that, Mr. Chairman, I yield back.

[The statement of Mr. Nunes follows:]

**********COMMITTEE INSERT**********

*Chairman Doggett. Thank you, and thank you for your helpful statement.

We have two panels today, the first composed of two of our colleagues, Congresswoman Katie Porter and Congresswoman Cathy McMorris Rodgers.

Ms. Porter, if you would, begin.

STATEMENT OF HON. KATIE PORTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

*Ms. Porter. Chairman Doggett and Ranking Member Nunes, thank you for holding this hearing today. I am concerned about surprise billing as someone who has dedicated my life to protecting consumers, but also because I have had to fight my own battle with surprise billing.

On August 3rd last year, when I was on the campaign trail, I started to feel pain in my abdomen. At 1:00 p.m. I could not continue, and I went home. At 4:31 I texted my campaign manager that I needed to go to the emergency room. I couldn't safely drive through the pain, and I remember sitting on my front porch so if I lost consciousness somebody might find me and I wouldn't be home alone. I didn't call an ambulance because I was concerned about the cost. I could not drive and I asked my manager to please take me to Hoag Hospital. I chose that hospital, even though it was farther away from other providers, because I knew Hoag was an in-network facility.

When I got to the hospital I waited six hours alone in the emergency exam room without treatment. When I finally went to surgery, my doctor told me it was nothing to worry about, just a routine appendectomy. I was given anesthesia, and when I awoke the team around me was panicking. They couldn't get my temperature to drop and they couldn't get my blood pressure to rise. My appendix had ruptured hours before, causing an infection that was making my whole body very sick. I spent the next five days in the hospital receiving powerful IV antibiotics.

A few weeks later I received the bill from my insurance company. The idea of an astronomical hospital bill had weighed heavily on me, and I was happy to see that the cost of my emergency room treatment and assessment and hospital charges, and nearly all of my

inpatient services were covered. I remember sitting at my kitchen table and taking a deep breath filled with relief.

But a few days later I received another bill, this one from my surgeon. While the hospital I had gone to was in network, the insurance company now claimed the surgeon was not, even though they had sent me a notification telling me that my surgeon was in network. Enclosed in that bill for nearly $3,000 was a handout from my surgeon detailing the steps I would have to take while recovering in order to fight to have my insurance company cover the care. So many of his patients had been put in this situation that this medical doctor had used his staff to address patient billing problems. That is not what he trained for in medical school.

These so-called explanation of benefits and the surgeon's handout explained that he was being treated as an out-of-network provider, even though he was employed by, and worked at an in-network hospital. As someone in an emergency situation, I had no ability to assess whether he was in or out of network, and in those cases insurers are supposed to cover the costs. But I got that bill because my insurer put profits before patients.

I called my insurance company to request an appeal. The benefits manager kept asking me questions to guide me and coach me toward saying that it was my surgeon's fault, to blame him for overcharging me. She asked me to call the surgeon and attack my doctor for his bill. Apparently, to Anthem Blue Cross, $3,000 was too high a price for saving my life. The tens of thousands in premiums I had paid to that company over the years were not enough to have them -- cause them to cover the lifesaving care.

Nearly five months after I was hospitalized the surgeon simply requested payment. And at that point I reached out to my employer, the University of California Irvine. That is when I learned that UC Irvine has a designated patient advocate, a medical doctor whose sole job is to help university employees get the health insurance that the university and the

employees pay for.

Can we just reflect on that for a moment? The university is paying a medical doctor to do nothing but navigate insurance.

Finally, the patient advocate, invoking the fact that I had been just elected to Congress, was able to get the insurance company to agree to pay my surgeon's bill.

But here is what I learned from getting sick: I am well educated; I had an employer prepared to help me; I have professional experience fighting for consumer rights; but there are thousands of Americans with fewer resources than me who are surprised with bills far more devastating than mine.

I am here today because I refuse to accept this as the status quo. I refuse to stand idly by while families go bankrupt because of surprise medical bills. Any solution to this issue must rely -- must not rely, excuse me, on the patient's ability to go to war with the insurer or with their provider. That is not the solution. It is time we start putting patients first.

Thank you for inviting me here today.

[The statement of Ms. Porter follows:]

**********INSERT 1**********

*Chairman Doggett. Thank you for sharing your experience.

Mrs. McMorris Rodgers?

STATEMENT OF HON. CATHY MCMORRIS RODGERS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

*Mrs. Rodgers. Chairman Doggett, the Ranking Member Nunes, as well as all the members of the committee, thank you for holding this important hearing on protecting patients from surprise medical billings. I am grateful for your leadership to examine this problem so that Congress can work on a bipartisan solution.

You know, there are so many stories out there. I was going to share another story of a lady from Washington State who had a massive heart attack and ended up in a surgery place, hospital, in Oregon which led to all kinds of challenges. And to save her life she had bypass surgery, a valve replacement, and repair. She ended up spending a whole month in the hospital recovering from the surgery, ranging from an infection and needing more powerful antibiotics.

She was discharged and she received her bill. She owed nearly $227,000. So this one was more than a surprise bill, it was massive. It was stressful and it was devastating.

Now, she eventually was able to get help and relief with a complicated medical charity care waiver. But it took six months of uncertainty and countless phone calls from collection agencies. It shouldn't have to be this way, especially when someone is recovering from a heart attack. What makes this story even more painful is that nobody told her that she could have been transferred to an in-network hospital, which could have saved tens of thousands of dollars. As she said, there should be fairness and equality in the system. You shouldn't have to file a complaint. It should be ingrained into the system so that when you have a problem, and you are due relief, you get it. And she is right.

So what is the solution? There must be more transparency. Right now it is too difficult to be an informed patient. If your care is out of network, and you will be charged

for it, you should know. I am grateful that President Trump is making this a priority to end surprise billing. And I agree that this Congress needs to work towards a bipartisan solution.

Chairman Pallone and Ranking Member Walden on the Energy and Commerce Committee is also working on this issue to protect patients and keep health care costs down.

We can end surprise billing and give patients the certainty that they need over their health care. Again, there shouldn't be any surprises. People should be able to trust that they know how much they are going to be billed, especially when they are in some of the most stressful situations of their lives.

So thank you, everyone, all the members here today, for participating in this hearing. I look forward to working with you and the rest of my colleagues on the Energy and Commerce Committee to address this issue, and I will yield back.

[The statement of Mrs. Rodgers follows:]

**********INSERT 2**********

*Chairman Doggett. Thank you both for coming to share your experiences. Consistent with our committee practice, we won't have you stay for questioning, but we do welcome your continued commitment to help us get this problem resolved. Thank you both very much.

And I will ask our second panel to come up at this point.

[Pause.]

*Chairman Doggett. Thank you all for being here. We are pleased to have leadership from four groups that have a great interest in the problem we have been discussing.

First I would like to welcome Dr. Bobby Mukkamala, who is a head and neck surgeon who has served with the American Medical Association Board of Trustees for the last couple of years. He practices in Flint, Michigan, and is a past recipient of the AMA Foundation's Excellence in Medicine Leadership Award.

Doctor, thank you for being here.

And then Ms. Jeanette Thornton will be next. She is a senior vice president and -- for product, employer, and commercial policy for Americans Health Insurance Programs -- Plans, AHIP. Ms. Thornton has previously held positions with both OMB and the Social Security Administration.

Next we will hear from Tom Nickels, who is executive vice president for government relations and public policy for the American Hospital Association. He has previously worked with the American College of Emergency Physicians and the American Nurses Association, and right here on -- in the House previously, as well.

And finally, the committee will hear from Dr. James Gellan -- Gelfand, excuse me, who is senior vice president for health policy for ERISA, the Employment Retirement Income Security Act, Industry Committee, ERIC.

So we appreciate each of you being here. Your statements will be made part of the record. As you know, we ask that you summarize your testimony in five minutes and then we will get underway with the questions.

The light system is there to give you a warning with a yellow. And when you see the red light, if you will, conclude your remarks.

Doctor, would you begin?

STATEMENT OF S. BOBBY MUKKAMALA, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION (AMA)

*Dr. Mukkamala. Good afternoon, Chairman Doggett, Ranking Member Nunes, and members of the subcommittee. Again, my name is Dr. Bobby Mukkamala. I am a board certified otolaryngologist, head and neck surgeon, in private practice in Flint, Michigan, and a member of the American Medical Association's Board of Trustees. On behalf of the AMA, it is an honor to provide testimony on the important issue of unanticipated out-of-network care, often referred to as surprise billing. I very much appreciate your willingness to explore solutions to this problem that has significant consequences for our patients.

The AMA has long been concerned about gaps in the out-of-network coverage, and is committed to working on solutions to protect patients from the financial impact of surprise coverage gaps. The AMA believes that workable solutions can come in many forms, but the best solutions have several common principles at their core.

First, protection for patients. Patients should be kept out of the middle of payment negotiations. In situations where patients do not have the opportunity to select an in-network provider, they should not be charged any more than the in-network amount, and payments should count towards their deductibles.

Second, network adequacy must be regulated. Critical to any surprise billing solution is a focus on increasing the adequacy of provider networks.

Third, we must establish fair payment for providers to ensure that appropriate market incentives remain in place. Any solution must incorporate a mechanism to ensure fair payment to providers. Such mechanisms could include a minimum payment standard based on physicians' rates and/or a billing arbitration process that requires the consideration

of many factors.

Finally, transparency in many forms is important. For example, all patients who knowingly choose to obtain scheduled health care services from out-of-network physicians should be informed about their anticipated out-of-pocket costs.

Regarding network adequacy it is important to recognize that physicians very much want to be included in health plan networks, but they want to be offered fair contracts. However, with nearly 57 percent of physicians and practices of 10 or fewer physicians, and with most health insurance markets highly concentrated, many physicians are in a weak position relative to commercial health insurers. Insurers need to be incentivized to offer fair contracts to physicians, and we recommend that Congress facilitate this through the regulation of provider networks.

To protect patients, network adequacy standards should include measurable requirements on the front end, before insurance products are brought to market, and factor in minimum time and distance requirements, maximum patient-to-provider ratios, and maximum wait times.

Regarding the fair payment of out-of-network services, the AMA urges Congress to avoid any solutions that set minimum payment standards for out-of-network care at non-competitive rates. Any guidelines on out-of-network provider payment should reflect actual charge data for the same service in the same geographic area. Proposals that use in-network rates as a benchmark for provider payments should be avoided.

These rates are negotiated by physicians and plans during the contracting process, and fees are discounted in exchange for contracted benefits. Those companies that don't sit down to negotiate should not benefit from skipping that step. Setting payments at these discounted rates would further disrupt the increasing market imbalance favoring health insurers. It is likely health plans would quickly drop physicians from their networks,

knowing they could use our services for less when we are outside of their network.

Additionally, payment benchmarks should not be based on a percentage of Medicare rates which simply do not reflect the costs of providing care. When you adjust for inflation and practice costs, Medicare physician payment has declined 19 percent over the past 17 years. As such, linking out-of-network rates to Medicare would eliminate any incentive for insurers to build adequate networks or offer physicians fair contracts.

Finally, it is critical that any benchmark come from sources independent of interested parties. Manipulation of insurer-controlled data for these purposes has happened in the recent past, resulting in real harm to patients and physicians.

In conclusion, the AMA looks forward to the opportunity to work with the committee to protect patients from unanticipated gaps in their coverage and to promote greater access to in-network care. Thank you very much.

[The statement of Dr. Mukkamala follows:]

**********INSERT 3**********

*Chairman Doggett. Thank you, Doctor.

Ms. Thornton?

STATEMENT OF JEANETTE THORNTON, SENIOR VICE PRESIDENT, PRODUCT, EMPLOYER, AND COMMERCIAL POLICY, AMERICA'S HEALTH INSURANCE PLANS (AHIP)

*Ms. Thornton. Chairman Doggett and Ranking Member Nunes and members of the subcommittee, I am Jeanette Thornton, senior vice president of product, employer, and commercial policy for America's Health Insurance Plans. I appreciate the opportunity to testify on solutions to protect the American people from surprise medical bills.

We want to end surprise medical bills so that patients have the peace of mind in an emergency that they will not receive inflated bills from doctors they did not seek out for care, and often never knew treated them.

We have all heard personal stories that demonstrate the need for federal legislation to protect patients from surprise medical bills: there is a story of Dr. Khan, whose ride in an ATV resulted in a $56,000 air ambulance ride and a balance bill of $44,000; Stacy Shapiro, a first grade teacher in Austin, who faced a $6,700 bill, after she felt ill following a morning run, that she was unable to pay.

This issue can even hit close to home for someone like myself, who has been studying this issue. While being seen in the ER a few months ago my focus was on getting better. It did not even come across my mind in that time of great stress I should check the network status of all the doctors who entered my room. Luckily, I am okay, and my doctors were in my health plan's network. However, many people haven't been so lucky.

These stories make it clear that surprise medical bills are creating financial hardship for the American people, and that federal legislative action is needed. We ask that federal legislation focus on four things.

First, balance billing should be banned in situations where inpatients are in voluntarily treated by an out-of-network provider. This includes emergency health services at any hospital, any health care services or treatment performed at an in-network facility by an out-of-network provider not selected by the patient, and ambulance transportation in an emergency.

Second, health insurance providers should be required to reimburse out-of-network providers in an appropriate and reasonable amount in those above scenarios.

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

Fourth, hospitals or other health care providers should be required to provide advance notice to patients of their --of the network status of the treating providers. We appreciate that Health Subcommittee Chairman Lloyd Doggett has introduced legislation the End Surprise Billing Act, or H.R. 861, which would establish a role for hospitals in providing such notices, along with banning balance billing. AHIP supports this bill.

As the committee considers legislative options we urge you to reject proposals that would use arbitration to determine payments to out-of-network providers, which would result in excessive payments and increased premiums. Our major concern is that it fails to address the root cause of surprise medical bills: exorbitant bills from certain specialty doctors. This approach gives equal weight to billed charges and negotiated rates, even though billed charges from these specialists do represent a form of price gouging.

We appreciate that some congressional proposals and the Trump Administration have rejected arbitration in favor of a market-based approach to protecting the American people from surprise medical bills.

It is also important to look at the role of state laws addressing surprise medical bills. Two states in particular, California and Texas, have enacted laws that take very different

approaches.

In California a new law provides surprise medical billing protections and determines reimbursement for non-contracting providers based on market rates that similar providers routinely accept as payment in full. This approach does not increase health care spending, and encourages plans and providers to enter into mutually beneficial contracts.

By contrast, the current state law in Texas ties reimbursement for non-contracting providers to the 80th percentile of provider charges. By linking payments for out-of-network services to provider charges, this approach has led to inflated payments with higher costs for consumers and one of the highest rates of surprise billing across the country.

Thank you for this opportunity to testify. AHIP and our member plans stand ready to work with members of the committee to alleviate the financial burdens imposed on the American people by surprise medical bills. Thank you.

[The statement of Ms. Thornton follows:]

**********INSERT 4**********

*Chairman Doggett. Thank you.

Mr. Nickels?

STATEMENT OF TOM NICKELS, EXECUTIVE VICE PRESIDENT, GOVERNMENT RELATIONS AND PUBLIC POLICY, AMERICAN HOSPITAL ASSOCIATION (AHA)

*Mr. Nickels. Thank you very much, Mr. Chairman, Mr. Nunes. My name is Tom Nickels. I appreciate the opportunity to be here today. I am executive vice president for the American Hospital Association, here today to represent our 5,000 hospitals and health systems members.

I know that the subject of today's hearing is very important to you, Mr. Chairman. We applaud your longstanding efforts to deal with this issue.

The bottom line: we must protect patients from surprise medical bills, and the AHA supports federal legislation to do so. Congress must act to help the 60 percent of Americans who have self-funded employer-sponsored plans under ERISA and those who live in states that have not enacted comprehensive protections to address the issue.

Patients should not be subject to balance bills when they have access to emergency services outside their network, or have acted in good faith to obtain in network care. They also shouldn't be surprised by coverage denials from insurers when they access any emergency services in network or out of network.

I would like to outline elements that could be part of a legislative solution to surprise medical billing.

First, Congress should explicitly prohibit balance billing in the scenarios I just described, and make sure that patients are kept out of any process to determine reimbursement between the payer and the provider. Then Congress should help improve standards for networks and ensure adequate oversight to prevent the incidence of out-of-network care.

Once a patient is protected, we encourage Congress to allow providers and payers

to determine fair and appropriate reimbursement.

We reject a national rate or benchmark for out-of-network services, even if geographically adjusted. They would not be able to capture the many factors that specific health plans and providers consider.

We are also concerned that setting a reimbursement standard by law would serve as a disincentive for insurers to maintain adequate provider networks. We have already seen an increase in the use of no-network reference-based pricing models in the commercial market. This could accelerate, should insurers have the option to default to a government-established out-of-network rate.

Health plans should not be absolved of their core function of establishing provider networks, including negotiating rates with providers.

While the HRA believes that hospitals and payers are able to negotiate reimbursement for our network claims without government involvement, there may be a role for a dispute resolution process. The so-called baseball style of arbitration, similar to what New York has implemented, appears to be an efficient process that places the responsibility to initiate the request with the provider or insurer, and not the patient. Studies have shown a 34 percent reduction in out-of-network billing. Decisions have been largely split between the providers and payers. There has not yet been a noticeable impact on premium insurance rates.

The National Association of Insurance Commissioners has also put forward a model act that outlines a mediation process to resolve disputes. Again, these are state-level solutions and do not resolve the surprise bills received by patients covered under ERISA plans. However, they could be successfully deployed at the federal level with some modification.

Some have suggested that bundling of hospital and clinical services would be the

best way to reduce surprise medical bills. We disagree. While the AHA supports voluntary bundled payment models, this concept would be difficult to apply to ED services, where there can be great variation in the types of services a patient may require, as well as when a patient has a scheduled service that may require the input of providers, some of whom are employed by the hospital, some of whom are not.

More importantly, the additional complexity of what and with whom to bundle would present the insurers of -- would prevent -- would not prevent, excuse me, the issuance of surprise medical bills. Congress would still need to prohibit balance billing on all the various providers who contribute to the patient's care.

In certain settings, moreover, this would place hospitals in the role of what insurers should do: negotiate with providers on behalf of their subscribers. This approach significantly over-complicates what should be a straightforward prohibition on balance billing.

Regarding legislative proposals that would require hospitals and other providers to give an estimate of out-of-pocket costs at the time of scheduling care, this is information our members are working towards providing, though challenges exist. In order to generate accurate estimates, providers must obtain information from a patient's health plan in order to understand the patient's cost-sharing responsibilities and where an individual is with respect to his or her deductibles and out-of-pocket minimums. We ask Congress to allow providers and health plans to continue to work toward this goal without including this component in a surprise billing package.

Finally, all the discussions on how to best serve patients must include increased efforts to help them navigate the health care system. Mr. Chairman, we have an opportunity to protect patients from surprise bills, as a consensus does appear to have developed among all parties. We should not risk moving forward by adding other policies

that would put that passage at risk.

I look forward to working with the subcommittee, and I appreciate this opportunity to appear.

[The statement of Mr. Nickels follows:]

**********INSERT 5**********

*Chairman Doggett. Thank you very much.

Mr. Gelfand?

STATEMENT OF JAMES PATRICK GELFAND, SENIOR VICE PRESIDENT, HEALTH POLICY, ERISA INDUSTRY COMMITTEE (ERIC)

*Mr. Gelfand. Chairman Doggett, Ranking Member Nunes, and members of the subcommittee, thank you for this opportunity to testify. I am James Gelfand, senior vice president for health policy at the ERISA Industry Committee, a trade association representing large employer plan sponsors. Our member companies offer comprehensive health benefits and, as self-insured plans, pay around 85 percent of health care costs for our beneficiaries. About 181 million Americans get insurance through their job, and surprise billing fundamentally frustrates the goals of providing quality, affordable employer-sponsored coverage.

Often our employees do everything right. They look up in-network providers, they call ahead, they ask questions. But still they receive enormous unexpected bills. Many beneficiaries are afraid to go to the hospital, even with a platinum plan. They are skipping care. They are worried while they are at work. And this has become a crisis.

Now, the vast majority of providers never generate surprise bills. It is a small subset of the health system that the patient cannot choose, specifically in three scenarios: number one is when a patient receives care at an in-network facility, but is treated by an out-of-network provider; number two, a patient requires emergency care, but the providers, the facility, or the transportation are out of network; number three is when a patient is transferred or handed off without sufficient information or alternatives.

Employers believe that Congress can and should solve this problem, and that the best solutions will be simple, straightforward, and commonsense.

Chairman Doggett, thank you for your leadership on this issue. You introduced the End Surprise Billing Act in 2015, which most importantly would hold the patients

harmless. We believe that ending surprise billing starts with the concepts that you pioneered. ERIC proposes three core policy changes to decisively end the surprise billing crisis.

First, an in-network matching rate guarantee: it is simple. If a patient goes to an in-network facility, every provider they see should be required to accept in-network rates.

Second, an emergency last-resort benchmark backstop. When plans and providers cannot agree on rates for emergency care, set a benchmark. The best solution would be a percentage of Medicare or the average privately-contracted rate.

Third, require informed consent. When a transfer or handoff takes place, inform the patient if the care will be out of network, and offer an alternative when possible.

These three policies would wipe out the vast majority of surprise medical bills.

There is more that Congress should do, including crack down on abusive behavior by outsourced medical staffing firms and banning certain kickback agreements. But this would already be an incredibly effective start. And the Ways and Means Committee can make this happen by making these simple rules a condition to participate in Medicare. No new taxes or spending needed, no complicated insurance rules, just an opt in and let providers vote with their feet.

Now, we know that Congress is under immense pressure from certain providers, hospitals, and Wall Street investors to maintain the status quo. They are sending Congress on a series of snipe hunts designed to derail legislation. For instance, the first snipe hunt is a call for mandatory binding arbitration. Playing on the fear that making changes to the health care system will cause changes, some have urged Congress not to specify how to solve the problem and instead to punt to arbitrators.

Arbitration is a dodge to deflect tough decisions away from Washington, and it will raise costs for patients. When employers determine the premium costs, we will have to

build in costs to pay arbitrators, pay facilities, pay for gamed arbitration thresholds, and pay exorbitant list prices demanded by providers. If providers can make more money by arbitration, rather than by participating in networks, patients will pay a very heavy toll.

Next, transparency alone will not solve this problem. We are dealing with a market failure and de facto monopolies. Informing a patient that they will be seeing the only anesthesiologist on duty, who happens to only accept cash, doesn't actually help the patient. Transparency is important, but it is not enough.

Some have warned Congress that if you legislate on surprise billing, you risk creating winners and losers. To this we respond, "Obviously." The current system is not perfectly balanced, and the current losers are patients. The idea that the deep inequities in the current system can be solved without changing anything is another snipe hunt.

Others say that the free market will solve the problem. It won't, it hasn't, and surprise billing is getting worse and not better.

They say that if Congress creates a benchmark it is big government interfering in a free market. We disagree.

Lastly, some have advocated deferring to the states, but many states have either not acted, have enacted only half measures, or have actually made things worse. Even if every state enacts a comprehensive solution, this still won't help the 100 million Americans in self-insured plans.

In conclusion, thank you for this opportunity to share our views. The ERISA Industry Committee is eager to work with Congress towards a bipartisan, comprehensive solution that protects access to care and ends the surprise billing crisis without driving up health insurance costs.

I am happy to answer any questions.

[The statement of Mr. Gelfand follows:]

**********INSERT 6**********

*Chairman Doggett. Thank you.

Doctor, let me just ask you to respond about his suggestion that we have an in-network matching guarantee. I think you referenced that. If you don't have -- if you have an in-network matching guarantee, isn't that sufficient? And if you permit charges above that, isn't it an incentive to never join the network?

*Dr. Mukkamala. Sure. So yes, I mean, it is -- it sounds easy to implement, and it is. Just call everybody a network, right? But the reality of the situation is if I am the only guy that can sew an ear back on when it gets cut off in a tragic lawn accident, and there is nobody else around for 100 miles, is my fee -- should it not be different than in a place where there is 10 people available to sew that ear back on? Right?

And I don't have any ability to negotiate that in this situation that is unique to my geography. So if in Flint, Michigan I am the only guy that can do that, then I should be able to sit across from the insurer and say, you know what, I know you usually only pay $200 for that, but I am the only guy around that can do this for this -- that I did last Friday for Mr. Jones, and my fee is actually $400. I think we can work this out. But really, $100 is not reasonable for that. And that is why setting everybody in in-network fees and eliminating the ability to sit across from an insurance company and negotiate those fees isn't a solution. It is an easy way out, but it is not a fair solution.

*Chairman Doggett. I have seen at least one study that suggested that emergency physicians were charging three times the Medicare rate if you were in network, and eight times the Medicare rate if you were out of network. Can you see any justification for that kind of action?

*Dr. Mukkamala. So, you know, Medicare is a program that exists to take care of our elderly population and our disabled population. Right? I participate in it out of a sense of responsibility for my community.

*Chairman Doggett. Sure, and I understand the dissatisfaction with Medicare rates, generally. What I am referring to is the difference --

*Dr. Mukkamala. Right.

*Chairman Doggett. -- in charges, and why one price for those who are in network and another for those that are out --

*Dr. Mukkamala. Right, so --

*Chairman Doggett. It is the same --

*Dr. Mukkamala. So there is a benefit for me to be in network with Blue Cross Blue Shield of Michigan, for example. I get something from that. They sit with me, they show me their data. We had -- we work together on incentive programs to sort of curb costs. If there is an insurance company that is in town that does none of that activity to improve the care of the population in my town, but yet wants to benefit from the same rate of compensation to me, they are doing nothing to earn that discount.

Blue Cross sits across from me on a weekly or monthly basis to improve the care of my population. But Golden Rule Insurance that is new in town, for example, doesn't do any of that work, and yet wants to benefit from having the same provider rates. No. I mean I take a discounted rate from Blue Cross because of all this other robust activity. But if you are not offering me anything to participate in your network, then naturally you should be expected to pay more for my services. Right? I get something from Blue Cross. I get nothing from Golden Rule.

*Chairman Doggett. Thank you.

Mr. Gelfand, why won't the New York arbitration system work well?

*Mr. Gelfand. Unfortunately, our belief is that arbitration raises costs and it doesn't eliminate surprise medical bills. What it does is rearrange the deck chairs on the Titanic and send those surprise bills to somebody else to pay.

Inevitably, in New York what happens is when a provider does win the arbitration, the amount that the insurer must pay is the billed charge which, as you saw in the video, no reasonable company would ever agree to pay. My companies right now have the option of participating in certain state programs that would have arbitration. And so far we have not heard from any company that has chosen to do that.

*Chairman Doggett. Ms. Thornton, what has been the experience with your companies in New York State? And does this arbitration model provide a model that could help us resolve this problem?

*Ms. Thornton. I will get good at this in a second. Thank you for the question. So our plans have been working in the State of New York for many years, and have a lot of experience with the arbitration approach.

So, as a starting point, when that law came into place we are really starting from a broken system, where the plans were required to pay the full billed charge amount. And so the arbitration process was better than what they had in place before. But our perspective is that it is really important to first have a payment benchmark that is really based on the amount of payment that similar providers are getting in the state.

The challenge with arbitration is that it is sort of a clunky and costly process. It is very difficult for plans to plan ahead and get that certainty when they are setting their rates. It adds a lot of costs and a lot of burden for consumers to sort of wait and see what is going to happen throughout the process. So we don't think it would work at the national level in all -- as it hasn't worked in New York to the fullest extent possible.

*Chairman Doggett. What is the effect of having uncertainty on premiums?

*Ms. Thornton. So a plan can estimate, sort of when they are setting their rates, "I am going to have a certain number of out-of-network claims." It is really important that they can understand what they will have to pay in those scenarios, so they can accurately

set their rates going forward.

*Chairman Doggett. And finally, Mr. Nickels, at least one of those who were with President Trump at his recent press conference -- I believe a physician from Johns Hopkins -- suggested that bundling should occur, that we go to the hospital for services, why doesn't the hospital send us a single bill for all of the services that are rendered there? Why won't that approach solve this problem?

*Mr. Nickels. Yes, for a couple of reasons, Mr. Chairman.

First of all, I think if we get the patient out of the middle of this, and make sure that they are only paying their in-network cost insurance, that solves the problem.

Going to bundling takes us to the issue of the -- this potential disagreement between provider and insurer. It doesn't help the patient, necessarily. We can help the patient in different ways. The problem with bundling is that it puts us in the position, it puts hospitals in the position of, frankly, what the insurer should be doing, or, in the case of Medicare and Medicaid, what the government should be doing. It makes us the negotiator, the in-between between the payer and whomever is working in the hospital.

Many of these physicians are not employed by us. If they were all employed by us, that would be a much easier situation. But they are not. And it puts us in a situation -- we have to negotiate with them. We could potentially be on the hook, we could be leveraged. And I don't think it is really workable. Let's just take care of the patient.

*Chairman Doggett. Thank you.

Mr. Nunes?

*Mr. Nunes. Thank you, Mr. Chairman.

Americans should know the price of health care service and what they are going to owe out of pocket before they get that service. Today it costs a patient literally double to get chemotherapy in a hospital compared to a physician's office. My bill, which became

law as part of the 21st Century Cures Act, required the creation of a website so patients can compare their estimated out-of-pocket costs for any given procedure in a hospital outpatient department, compared to an ambulatory surgery center. In this Congress, we are hoping to simply build on this patient tool to add services performed in a physician's office.

Mr. Nickels, I assume you are familiar with this, and it would be nice if we could get the commitment from the American Hospital Association to support legislation to expand transparency online with a tool that could include physician rates in order to empower patients with cost-sharing information.

*Mr. Nickels. Mr. Nunes, as you might imagine, I am familiar with that provision. And I think if we are talking about transparency, what you described is reasonable.

I would have to say it is important for consumers to understand that there is a reason why prices are higher at a hospital outpatient department than they are in an ASC, or a physician office. But providing that information to people is certainly appropriate. We have costs that physician offices and the ASCs do not have. We are open 24/7, mandated by this Congress, that we have to be available. We have overhead, we deal with emergencies, we deal with trauma, we deal with disasters, et cetera. There are costs associated with what hospitals have to provide that need to be built into those rates that are not usually reimbursable costs, such as EMTALA.

So no problem with transparency, but it would be best if people understood why those differences exist.

*Mr. Nunes. Thank you, Mr. Nickels.

I am assuming that all of you are familiar with the "greatest of three" policy: the first being the medium amount negotiated with in-network providers for the emergency service; number two, the amount of payments for out-of-network services such as the usual, customary, and reasonable amount; or, number three, the amount that would be paid under

Medicare for the emergency service. But I think most of you have problems with this policy, that you think the payments are too high or too low, depending on where you sit.

So I am going to go first to you, Dr. Mukkamala. Which of these three is typically highest? And what is the dollar delta between that and what doctors eventually collect after the balance of the bill?

*Dr. Mukkamala. Sure. Yes. So given the choices of the three, Medicare is usually sort of the foundation upon which all the other insurance companies tend to set their rates. So when I participate in network, like with Blue Cross Blue Shield of Michigan, it is usually about 110, 115 percent of Medicare rate. So that is one step higher. If I don't participate with Blue Cross Blue Shield of Michigan, then that rate is -- so I can get the assigned rate from them, and then I have a choice about what to do with the balance. And usually in my practice I write that off. I don't balance bill the patient. But Blue Cross Blue Shield sort of sets their rate, and that is it.

My point is that if -- and Blue Cross Blue Shield, I have a great relationship with, we do a lot of constructive work together. But if a new insurance company comes into town and puts up billboards and markets their product and says, "Here, come buy our policy," and then they get 15,000 patients to sign up, but has never come to my door to say, "You know, when they have an ear, nose, and throat problem we would like you to be in network and provide their care," why should they get the benefit of the in-network price that Blue Cross Blue Shield gets?

So my point is that that out-of-network price for this new insurance company that wants me to take care of their patient, but never came to sit down with me to sign a contract, ought to be something that I negotiate with them, not something that is dictated to me.

*Mr. Nunes. Thank you, Dr. Mukkamala. That was very helpful.

*Dr. Mukkamala. Thank you.

*Mr. Nunes. Ms. Thornton, how do you see the issue?

*Ms. Thornton. Gosh, so today the greatest of three methodology only applies to emergency services. And of the three options that you mentioned, typically the usual and customary is the highest rate that applies. And, as you noted, providers still are allowed to balance bill after the health plan provides payment for those services.

I should also note that a lot of the situations that we are talking about today are not emergencies, and thus are not covered by the greatest of three. Say, for example, you have a surgery and your anesthesiologist is out of network and you are at an in-network hospital.

*Mr. Nunes. So somehow we got to try to find common ground here.

Mr. Nickels, do the hospitals and providers determine the usual and customary and reasonable amount?

*Mr. Nickels. Mr. Nunes, I want to take -- if I could answer a little differently, we don't support rate setting. We don't think that that is the proper role of government. Let's take care of the patient, get them out of the middle of this. It should be not based on UCR or anything else, it should be a negotiation between the hospital and the insurer; the physician and the insurer. That is how the system ought to work.

*Mr. Nunes. Thank you. And with that, Mr. Chairman, I am out of time.

*Chairman Doggett. Thank you very much.

Mr. Thompson?

*Mr. Thompson. Thank you, Mr. Chairman. Thank you for holding the hearing. And all the witnesses, thank you very, very much for being here.

And as you know, and as most of my colleagues have already stated, there are a gazillion stories out there that I think reflect this situation.

I had one just recently. A staff person of mine went to the emergency room. He

has insurance. His insurance covered nearly everything, including a CAT scan. But a few weeks later he got two separate bills from physicians he never saw and didn't ask to see. They reviewed some of his test results, and the bill for those two physicians was larger than the bill for his total ER visit.

It is also alarming that, according to one study, 20 percent of hospital visits -- 1 of every 5 of those visits -- begun in the ER resulted in a surprise bill.

So I am glad that we all agree that we need to fix it. That is the easy thing. The hard part is to figure out what it is going to be.

Mr. Nickels, in your testimony you expressed support for private negotiation between insurers and providers. You also mentioned that fixed payment rates could undermine access to in-network providers. Can you talk a little bit about how that might work? Why might a fixed-rate approach lead to smaller, less inclusive networks?

*Mr. Nickels. Yes. I think our concern there -- and, by the way, your situation with your staff is -- I think what we are all suggesting would, hopefully, solve that problem. They would not have gotten, in terms of their obligations, bills from those out-of-network doctors.

I think for us our concern is if you set some sort of a rate, it becomes the default rate. And we are already having concerns about inadequate networks. I think the AMA has been particularly articulate on concerns about that. And networks are shrinking. If we have a default rate, they are going to shrink some more because everybody will know, oh, if I can't get what I want, I am going to get the default rate. That is not good for anybody. We need larger networks, more robust networks.

Again, we have called for federal intervention. NAIC and others have called for state intervention, and making sure that insurers have adequate networks. We think it could do harm to that effort.

*Mr. Thompson. One of you -- I don't remember which -- mentioned that my home state, California, put in place a fixed-payment-rate approach. Mr. Nickels, to your knowledge have you seen networks begin to tighten in California because of that, or do you expect that to happen?

*Mr. Nickels. I believe I am right on this. The California law does not affect hospitals. It affects physicians. And I think it is relatively new, it is in its first year. And I don't believe that the data is in yet to make that determination. But you can see where we are coming from about that fear shrinking the network because they can default to an amount could have that effect.

*Mr. Thompson. Thank you. Did you want to say something, Doc?

*Dr. Mukkamala. Yes, sir. So, in answer to your question, there are multiple already cases documented of insurance companies shrinking their network in California because they can get the same service at that rate with physicians that are out of their network. And so contracts are already not being renewed for physicians that have had contracts for 20 years, and then they go to renew it, and they are dropped from the network.

*Mr. Thompson. Ms. Thornton, you mentioned that arbitration doesn't work, and you argue that the arbitration system enable a form of price gouging by providers. Can you expand on that a little bit? And why would an arbitration system lead to higher premiums?

*Ms. Thornton. Thank you. Sure, happy to expand on the reasons why we don't prefer an arbitration as an approach.

So one of the challenges with arbitration is that you are taking somebody who is sort of looking from the outside, and you are having them to make a decision about what the appropriate payment should be. And a lot of times some of the state laws have very narrow sort of things that the arbitrator can consider when they have to make their decision.

Say, what the sticker price was, or the bill charge was, or what the similar providers would be providing for that service.

And so our concern is that there is a very -- there is a likelihood that they are going to want to take the provider's price, as well as you are really sort of rewarding a provider from coming in with an overall higher price in the first place. So you are not really getting at the root cause, you are not really looking at why are these high rates coming in -- excuse me, charges coming in in the first place, if that makes sense.

*Mr. Thompson. Thank you. New York has implemented a baseball-style arbitration policy. To your knowledge, have you seen premiums go up since that policy was implemented? And do you expect premiums to go up in New York as a result of that law?

*Ms. Thornton. So, to my knowledge, a recent study from Georgetown did show that premiums have come down since that rule was put in place. However, as I mentioned before, there were a lot of other extenuating circumstances with the prior approach that may have led to that decrease.

*Mr. Thompson. Thank you.

*Chairman Doggett. Thank you very much.

Mr. Buchanan?

*Mr. Buchanan. Thank you, Mr. Chairman. I also want to thank all our witnesses.

I am from Florida, but grew up outside of the Flint area, so it is good to see you, Doctor. Let me ask you. In Florida -- I don't know if it is the case in Michigan and other states, but the idea that you see a lot of hospitals and others write off 40 percent of the receivables. So I guess you look at this surprise inflated billing. How do we get there?

And then it seems like the lack of transparency is a big concern. I have done 80

town halls, I enjoy doing them. We all have as Mr. Thompson said, a lot of stories. But those are the two biggest things. They get a bill for 50, Medicare pays 10, they write off 40. Or just a lack of transparency, they have no idea what it is going to cost, and they get a bill later.

So I guess that is my two questions for all the panelists.

But the other thing is how do we change this behavior or this practice because it is especially alarming to me: 62 percent of Americans don't have $1,000 in the bank. So all of a sudden they get a big bill for $3,000 or $4,000. They live paycheck to paycheck. It is a gigantic issue, and costs have gone up so much the last 20 years, not because of Democrats and Republicans. The costs have gone up.

So I guess I ask all of you -- and, Doc, I will start with you, just your thoughts. Why do we have this massive kind of surprise billing, the lack of transparency? And then what do we do to change that?

*Dr. Mukkamala. Yes. I mean -- so, you know, my wife and I share an office. She is an OB-GYN, I am an ENT. We have two full-time people just to navigate medical billing, right? And we are supposed to be experts at it. This is how complicated it is. And what everybody that you heard here already this afternoon is asking for is transparency. Right? And we need to work towards that, and that will come from you, right, the requirement to be transparent.

I mean if you look at the contract language, when I sign up for my own health insurance, I mean, if I -- I would need my lawyer sitting next to me to decipher it, and I am in the business, right? So absolutely, that transparency is necessary.

As far as why that -- so much gets written off, right, so when you go and you get care, and you end up paying $25, and $75 gets written off, I mean, so my wife and I, we contract with probably about 30 insurance companies. When I take a kid's tonsils out, one

insurance company may be $200 -- may pay me $200, one pays me about $450, and everything in between. I can't have a different fee in my fee schedule for each of those. So my fee for tonsillectomy is about $475, so that when I do it I know that the highest paying payer -- I am still -- they are still within that threshold. Right?

Because if I charge $400, they are not going to send me 450, they are going to send me 400. And so this is the nature of the fee schedule --

*Mr. Buchanan. Okay, let me run down -- we have got limited time.

Mr. Nickels, do you want to respond to that, just the idea? I can't -- a hospital or a lot of practices in Florida writing off 40 percent of their accounts receivable -- I have been in business 30 years before being here. If I did that, I would be broke, I would be out of business. But what is the rationale for that? And they charge -- they ask for a big number, and they get what they can. I don't know if it is just the Canadians coming down. If they can get full retail, they take it, I don't know. But what is your thoughts?

*Mr. Nickels. Yes, sir, you are absolutely right. And what happens is -- again, like physicians, we are required to give -- charge people the same amount. It is actually required in the Medicare statute. And what happens is that charge is an amount, and then we negotiate with insurers and we work out some amount. It is usually less, but you do write off some of it.

With Medicare -- you mentioned earlier -- that is a fixed rate, we have no control whatsoever on that amount. And MedPAC and others, independent sources talk about how the payments are way below our costs, not to mention our charges. So that is the reason why that gets written off.

I think, you know, to take care of the patients you referred to earlier we just need to keep -- get them out of the middle of that -- when they see that bill, what those charges are, whatever it says, it doesn't affect them personally. They pay the -- their in-network

amount.

*Mr. Buchanan. Ms. Thornton, you want to add your thoughts to it, please?

*Ms. Thornton. We agree that the patient should be taken out of the middle. None of the stories that you have all mentioned should happen again. If we really take the patient out, they are not receiving these bills, and then it is left between the plan and the provider to work it out.

I wanted to comment on transparency that you mentioned. I think that is important in a lot of the situations. We do think more transparency about what networks a provider accepts is really important at the time of care. But this really only works in sort of elective care or planned surgery. During an emergency, or when you are having that anesthesiologist behind the scenes, transparency isn't going to help you because you are not in a position to make a choice. And I think that is why we also need to think about transparency from that perspective.

*Mr. Buchanan. Thank you, Mr. Chairman. I yield back.

*Chairman Doggett. Thank you.

Mr. Blumenauer? Excuse me, Mr. Kind?

*Mr. Kind. That is all right. Thank you, Mr. Chairman. Thanks for holding the hearing. I want to thank all the witnesses for your testimony today.

Listen, I -- all of us, I think, can come up with our own anecdotal stories of surprise billing in our respective districts and states. For myself, I represent a large rural western Wisconsin district, so emergency ambulance, emergency air service is one that I hear constantly.

But is anyone here -- Ms. Thornton, maybe you could put this in better context for us. How extensive is this problem of surprise billing in the overall medical billing world? You have a percentage on it in a given year?

*Ms. Thornton. So we have heard that one in five emergency room visits results in a surprise medical bill. And when you talk about ambulance care, both ground ambulance and air ambulance, it is even higher. About 51 percent of ambulance rides resulted in an out-of-network bill. And that is even higher for air ambulance. So we definitely think that needs to be part of any discussion on this issue.

*Mr. Kind. I would agree. I have had some legislation in the past to address quality access issues with the ambulance services and that. But this is something that we have to address.

But overall, with the overall medical billing in a given year, what percentage would you say is surprise billing to the patient?

*Ms. Thornton. So it is very interesting, what we have seen when it comes from a hospital perspective. It is maybe only 15 percent of the hospitals nationwide that are causing this issue that result -- you know, 80 percent of the visits is one of the statistics cited a lot that result in a surprise medical bill. So this is not every doctor. This is not every hospital that are resulting in these surprise medical bills. It is really more of a targeted problem.

And that is why we are supporting federal legislation to address --

*Mr. Kind. Mr. Gelfand, let me ask you, because you mentioned the importance of informed consent, too, as one of the possible options. It gets into the world of price transparency. But listen, if you are seriously injured or seriously sick and you got to get to the hospital right away, I don't care how much informed consent there is, or how much price transparency you have. From the patient's perspective, that is not going to work very well, is it?

*Mr. Gelfand. It is also not reasonable to expect the patient to ask those questions as they are on a gurney or in an ambulance.

One of the things that I don't think we have mentioned yet is that almost all of the providers that are generating these balance bills are providers that you don't have a choice of whether or not to see. We use the acronym PEAR, which stands for a Pathology, Emergency, Anesthesiology, and Radiology, and the sidecar is maybe ambulance and air ambulance. But it is not a huge problem that many different kinds of providers are causing. It is really those providers who -- you are stuck, you are going to see this person or you are going to see nobody.

*Mr. Kind. Yes. Now, given the district I represent, again, I have got patients going over to Minnesota, to Iowa, Illinois. Minnesota and Illinois have passed legislation already. Nine states total have done comprehensive, I think sixteen have done partial, 25 haven't done anything. Does that speak to the need of some federal standard, instead of the patchwork that we are seeing out there right now?

*Mr. Gelfand. We absolutely believe a federal standard is needed, if for nothing else because of the 100 million people who cannot be helped by state law.

*Mr. Kind. Is everyone in agreement with that? Mr. Nickels, I saw you nodding your head.

*Mr. Nickels. Yes, sir. I mean, there are some states who have acted. But again, ERISA -- I think it is 60 million people covered under ERISA. States can't help them. They need to be helped here. And also, the people who are in states that haven't done anything, I think there also needs to be action for them.

If I could comment on one of your other questions, if you don't mind. In terms of how much of this is really going on, I think there is a certain level of frustration. I don't know that we all know with certainty. The only federal study that I have seen, that we have seen, is from the Federal Trade Commission, which basically said that -- they studied ambulances going to hospital emergency departments. Ninety nine percent of hospital

emergency departments in that study were in network.

So it is not the hospital itself that is out of network, it is people -- physicians who practice in our institutions. That does not absolve us of responsibility, but I think -- and they are the physicians that were just described, that is where the issue is.

*Mr. Kind. Mr. Nickels, just staying with you for a second, you talked about the need for maybe expanding networks, robust functioning networks and that. Are we going to run in any Stark law or anti-kickback law problems if we go down that path?

*Mr. Nickels. We have all kinds of Stark and anti-kickback problems that could go on forever on. But yes, I think that that is an issue, in terms of our relationships with physicians, our ability to work with them, work together with them, have some sort of, you know, financial arrangements.

I think that is an issue that would certainly help this issue in encouraging physicians to be in network. We cannot require physicians who don't work for us to do that, but it would be -- and it would certainly be an encouragement.

*Mr. Kind. Ms. Thornton, federal action necessary from your perspective?

*Ms. Thornton. Yes, I certainly agree. We do have a patchwork of state protections across the country. Some cover ER, others cover other things in addition to ER. And I think having a federal floor would be very important.

*Mr. Kind. Great, thank you. I yield back.

*Chairman Doggett. Thank you very much.

Mr. Smith?

*Mr. Smith. Thank you, Mr. Chairman. Thank you to all our witnesses here today. I appreciate your unique perspectives, and there are probably even more perspectives out there when you think about how much input is required for health care. And it is certainly challenging, and I admire your pursuits.

In my district, the 3rd district of Nebraska, 75 counties, there are many critical access hospitals, some of which have one doctor. And so we have rural and we have remote and various dynamics associated. And I want to make sure that if and when there is federal action taken, that we don't have unintended consequences.

And just overall, we know this is not a uniform problem across the country, or even from one provider to the next, from one plan to the next, one patient to the next. And so I just hope that we can move cautiously, even though we know that there is a huge problem that we are currently facing. That is the common thing, is that there is the problem of surprise billing.

Can you perhaps touch on what concerns there would be in rural areas? I know, Doctor, you mentioned that pricing would be different, given kind of supply and demand, I think is what I heard you say. What other things should we keep in mind in terms of challenges facing rural areas, where there tends to be probably more out-of-network dynamics in play, and fewer choices for patients? And yet, you know, the mere access to one provider is considered to be positive and -- in many cases.

*Dr. Mukkamala. Absolutely. And so everything that we have talked about is magnified in the situation you are talking about. And for the one physician that is in that community hospital, that is taking care of patients in the middle of the night, you know, they shouldn't be subject to the same sort of negotiation or same contract that would be given to somebody in -- at Creighton, for example, right, where they have multiple physicians that are going to be taking care of the patient.

It is a unique situation. That physician should have every opportunity to sit across the table from the insurer in that area and say, "Look, I am happy to take care of these patients. Let's work out a contract," right? To bypass that and just sort of give them a contract that is based on X percentage of Medicare, and not take into consideration the

uniqueness of that practice environment, goes counter to any sort of negotiation between any parties in any type of contract.

*Mr. Smith. They would have the opportunity, right, to opt into a network, correct the provider?

*Dr. Mukkamala. If given, yes. I mean, so there are lots of examples of -- again, if you are out of network and you are forced to sign this sort of contract, there is no incentive for an insurance company to bring you into network. Right?

So they -- the insurance company is happy to have Dr. Smith in the town you are describing be out of network, because they are getting him for in-network prices. And that is exactly what we want to avoid by putting them at a table together to work out a more appropriate contract.

*Mr. Smith. Okay. Anyone else wishing to respond?

Mr. Nickels?

*Mr. Nickels. Yes, I couldn't agree more with AMA on that one. I do think if you talk about unintended consequences, again, we are all trying to get the patient out of the middle of this. And I think there is a consensus here.

But the notion that some sort of a benchmark, some sort of a national rate, something that is an average would work in rural America, I think, is one of those unintended consequences you were referring to. That physician, that hospital should be negotiating with that insurer, should not be based on some number that somebody comes up with arbitrarily.

I think, as I mentioned earlier, it will actually result in fewer physicians and hospitals being in network, because it can default to that particular rate. So I think that would be a serious unintended consequence we need to avoid.

*Mr. Smith. Okay. Overall, any other unintended consequences we should be

concerned about?

Ms. Thornton?

*Ms. Thornton. The one thing I will say is that health plans are very strictly regulated on network adequacy in rural areas. They would be required to contract with that hospital anyway. So I really think it is more important -- and we see surprise billing happen, either in large networks and in small networks. I really don't think it is a network adequacy issue at play here. It is sort of the other dynamics.

*Mr. Smith. Mr. Gelfand?

*Mr. Gelfand. Mr. Smith, I would just say that the situation you described in which there is very little choice of provider is a recipe for price gouging. And in fact, the patients who are going to be seen by a provider in that environment are probably in need of the most protection from these surprise bills, because there may be no incentive to participate in a network if you are the only game in town.

*Mr. Smith. Okay, I might just add that there is probably a little more community accountability, as well. Where there are a lot of eyes on the billing, and neighbors having to answer to neighbors. So thank you.

I yield back.

*Chairman Doggett. Thank you. And to maintain balance as we traditionally do, I am going to go to two to one and call on Mr. Blumenauer.

*Mr. Blumenauer. Thank you. And Mr. Chairman, I appreciate your focusing on this like a laser, having the hearing so we have an opportunity to weigh the alternatives.

I think it is clear, Mr. Gelfand, you are talking about people who are stuck. The opportunity of people who need protection the most are most at risk. I have no doubt that there are rationales for various approaches.

But I want to -- for us to end up with something that protects those who are at risk,

and that deals with the notion that there is a relatively -- if I understand the problem correctly, there are a relatively small number of providers that are creating most of the problems in terms of significant surprise billings.

In my state we recently passed a law about 15 months ago in Oregon that -- banning out-of-network billing. The law requires that patients who receive care at in-network facilities will only receive bills at in-network rates, while the insurance companies and the health care providers work out the remainder of the reimbursement.

I wonder if I could ask you to comment on your perception of the Oregon approach, and anything you have heard about whether or not it is working. Doctor, so maybe start with you and go down the line.

*Dr. Mukkamala. Sure.

*Mr. Blumenauer. Quickly, because I would like to hear from everybody.

*Dr. Mukkamala. Yes. Thank you, sir. So we couldn't agree more with what you are working -- the proposal that you have come up with in Oregon, where the patient isn't responsible. They had no idea that -- when they went in there with their bleeding finger, that they were going to be taken care of by a surgeon that was out of network. That is not the patient's responsibility.

At that point, Monday morning, the physician should be on the phone with the insurance company saying, "Hey, I took care of one of your subscribers," and that should be negotiated.

*Mr. Blumenauer. Ms. Thornton?

*Ms. Thornton. So I agree that in Oregon consumers did get taken out of the middle. So that is exactly what we are talking about here. No more balance bills. They can have the peace of mind that, if they have an emergency, they are not going to receive those bills. I think that is so important.

As to the benchmark, I understand that they do allow a reasonable payment rate from the plan process, and that is exactly the type of approach that we support.

*Mr. Blumenauer. Mr. Nickels?

*Mr. Nickels. Yes, I agree. I understand the Oregon law. And you do touch on the issue we have been talking mostly about, emergency care, but the issuer -- which Oregon covers -- where the patient comes into an in-network facility knowingly, and intended to do that, but gets billed by an out-of-network physician in that facility, not an emergency, necessarily. And that -- Oregon takes care of that, that patient should pay their in-network coinsurance, and that is what we are, I think, all recommending happen here at the federal level, too.

Again, our view is that it is best that those negotiations for the other part, the difference between what the insurer wants to pay, the provider wants to get, should be worked out between the insurer and the provider.

*Mr. Blumenauer. Mr. Gelfand?

*Mr. Gelfand. We would agree that taking the patient out of the middle is the very first step that absolutely has to be done, as Oregon did. We would just caution that eventually someone does have to pay the bill. And if that bill has to be paid by an insurance company or by an employer sponsoring a plan, then what happens is, if you don't address the underlying issue that is causing the generation of those bills, that the prices will just be spread throughout the premiums. And instead of one person receiving a surprise bill, every enrollee is going to be paying for that surprise bill.

*Mr. Blumenauer. Any other comments?

Thank you very much.

*Chairman Doggett. Thank you, Mr. Blumenauer.

Ms. Sewell?

*Ms. Sewell. Thank you, Chairman Doggett. And thanks to all of you for being here today.

Two-thirds of the bankruptcies in the United States are linked to medical debt, making medical debt the leading cause of bankruptcy in our country. When they are at their sickest, patients and their families are often left with no support. While they fight for their lives, they spend countless hours on the phone, serving as intermediaries between insurance companies and providers. We have all talked about that here today.

I would like to ask for submission -- an article, Mr. Chairman, an NPR article about recent polling in a report entitled "Life in Rural America."

*Chairman Doggett. So ordered.

[The information follows:]

**********COMMITTEE INSERT**********

*Ms. Sewell. The article shows that 40 percent of rural Americans struggle with routine medical bills, food, and housing. Over a quarter of the respondents say that they have not been able to get health care when they need it at some critical point. The article tells the story of a 72-year-old retired caregiver in rural Kentucky. When asked if she could afford an unexpected $1,000 expense, she resoundingly said no.

An urban -- a recent study by the Urban Institute showed that 8 of the 10 states with the highest rate of past-due medical debt are in the south. Alabama is one of them. There are lots of stories like that. And I would guess that my witnesses, all the witnesses here today, would agree with me that a person should never face financial ruin because they can't pay their medical bills.

We must recognize that our reimbursement system, both public and private, has created a scenario in which safety net and rural hospitals have to garnish a sick person's wages or tax returns in order to keep their doors open. When Medicaid reimburses some emergency rooms at 10 percent of cost, and Medicare not much more than that in Alabama, rural hospitals have -- are having to make up for those low reimbursements in every way they can.

I would like to ask Mr. Nickels what more can we do to help hospitals with bad debt so that they don't have to send debt collectors after some of our most vulnerable constituents just keep its doors open?

*Mr. Nickels. Thank you, Ms. Sewell. I agree with everything you said, and I think that the health care crisis in rural America is one that I would hope that the Congress will take a serious look at this year.

I guess my first thing -- and I can't resist -- is perhaps Medicaid expansion.

*Ms. Sewell. Well, some of us aren't fortunate enough to have a state --

*Mr. Nickels. Yes, I understand that.

*Ms. Sewell. -- that expanded Medicaid, and so --

*Mr. Nickels. Yes, but I couldn't resist.

*Ms. Sewell. Yes.

*Mr. Nickels. You know, but I think that would be certainly one place to go.

I mean the Federal Government --

*Ms. Sewell. I would agree with you.

*Mr. Nickels. Yes, I bet. The Federal Government and state government need to acknowledge that they underpay. I mean MedPAC and others acknowledge this. This isn't just industries talking about ourselves. AMA has said the same thing on the physician side. But I think that the Federal Government and state governments have a responsibility to pay more adequately.

The truth of the matter is -- and we haven't even talked about this -- is the cost shift.

*Ms. Sewell. Yes.

*Mr. Nickels. It is that private insurers pay more than costs, and the government pays less. That should end. The government should take --

*Ms. Sewell. It should.

*Mr. Nickels. -- responsibility.

*Ms. Sewell. Ms. Thornton, how important are Medicaid DSH and bad debt and low-volume payments in helping hospitals make up for inadequate reimbursements?

*Ms. Thornton. Well, I am not an expert in Medicaid policy. So unfortunately, I can't get into too many details on that question. Yes, very important.

*Ms. Sewell. Mr. Nickels, I know you know a lot about that.

*Mr. Nickels. Yes, I was trying to coach the witness here.

*Ms. Thornton. Thank you.

*Ms. Sewell. I know. I was trying to spread the love.

*Mr. Nickels. Go for it.

[Laughter.]

*Mr. Nickels. No, very important. And as you know, there are Medicaid DSH cuts on the horizon beginning in October of this year that we have to -- four billion this coming year, eight billion the year after that. Same for bad debt and those other programs. I mean the Medicaid program, notwithstanding my complaining about inadequate payment, along with the Medicare program, do have subsidies for certain kinds of hospitals, DSH being a classic example of it -- very important for our continued ability to provide services.

*Ms. Sewell. But it is not something that we could do to scale. So we really all have to work together, both the practitioners, the hospitals, the insurance companies, and state and local governments.

But when we have states like Alabama that haven't expanded Medicaid, that have the lowest reimbursement rates for Medicaid, that is really problematic for the people that I represent, people of the 7th congressional district that I represent, which is my home district, includes Birmingham, but also my hometown of Selma, Alabama. Everybody knows of it because of the civil rights and voting rights history, but it is a town of 19,000, and it is actually unacceptable that we have so many rural hospitals throughout this nation that are closing, and these are the most vulnerable.

And sometimes the bad debt reimbursements are just as painful for folks who are struggling every day to receive those calls day in and day out. And I just hope that we, as folks who work in this industry, both policymakers and practitioners, will figure out a way that we can do better.

Thank you, Mr. Chairman.

*Chairman Doggett. Thank you.

Mr. Marchant?

*Mr. Marchant. Thank you, Mr. Chairman. I would like to associate myself with the remarks that Mr. Nunes made in the beginning. It is our responsibility to address this surprise billing issue.

I would, however, note that throughout this testimony there has been a general complaint, and I hear it all the time, that Medicare has a very, very artificially low reimbursement rate. So I would just caution us to, in trying to fix this problem, not to add too much more government regulation to the fix. That might end up actually just exasperating the situation.

I have a large Medicare population, and am blessed with a situation where, within 30 miles of my district, Dallas Fort Worth, there are probably 50 different hospitals or clinics that any Medicare patient could go to. A situation where a Medicare patient goes in for a routine colonoscopy, they find out that there is a polyp, the polyp is removed, and then a few weeks later they get this letter that says, "Amount you may owe the provider." That is a dreaded letter usually, and it is the precursor to, usually, a surprise billing. You may get the surprise billing earlier than that.

Should we involve Medicare in this whole discussion? Should we be protecting these Medicare patients from surprise billing? I would like to have your comments about that.

*Dr. Mukkamala. Sure. Yes, thank you for the question. So, you know, 93 percent of physicians in this country participate in Medicare, they accept what Medicare pays. Right? So the question is relevant to a very small percentage of physicians that are participating with Medicare, or that are accepting Medicare patients but not accepting payment. They are sort of non-par with Medicare, but they are still subject to Medicare rates, and then they have the option to balance bill the patient if they would like.

But again, it is a very small fraction that we are talking about that go that route,

right? Ninety-some percent of physicians out there are on the par side of Medicare, meaning they do participate. And so it is not an issue for the majority of the aging population --

*Mr. Marchant. When Medicare patient goes in, are they told that up front, that you are going to be seen by a doctor or in a setting where we are not going to accept the rate?

*Dr. Mukkamala. Yes. So the very small percentage of physicians' offices that aren't on par with Medicare are not in participating status. That is something that the patients are told that up front, when they present with their Medicare card, and their ID, and they are filling out the paperwork, that, you know, we don't participate. We will courtesy bill Medicare on your behalf, but there may be a balance afterwards.

And that is -- you know, that works in the situation where there is an elective procedure, or elective appointment. But what we are talking about in this room today is the surprise situation where, you know, the patient is being taken care of by somebody that is non-par with Medicare, and it is a surprise situation. That is the issue that needs to be resolved here in this room today.

And I think the point is that that should be a negotiation between the payer and the physician to figure out where that payment is going to land.

*Mr. Marchant. Mr. Nickels?

*Mr. Nickels. If I could first associate myself with your comment about unintended consequences and government intrusion, again I think we have figured out a way that we can help the patient and we are very wary of government setting rates, having benchmarks, having numbers, whether they are associated with Medicare or whether associated with the private sector. We think that is the wrong way to go. That would really create unintended consequences that we need to avoid.

In your Medicare example I believe that is a change that needs to be made in

Medicare law that would probably not occur to someone with private insurance. I think that is -- I don't want to call it a glitch, but that is something the Medicare statute needs to be amended to fix.

*Mr. Marchant. Okay, thank you. Any other comments?

Thank you, Mr. Chairman.

*Chairman Doggett. Thank you.

*Mr. Marchant. I yield back.

*Chairman Doggett. Ms. Chu?

*Ms. Chu. Yes, Mr. Chair. Even though my state of California does have a surprise medical billing law, it addresses only part of the problem. For instance, it doesn't cover ERISA employer plans, and it doesn't cover a particular situation, a particularly egregious case of surprise billing that happened in Zuckerberg San Francisco General Hospital in San Francisco.

And I wanted to draw your attention to this, as has been detailed by the Vox reporter Sarah Kliff's many investigations. This is the largest public hospital in San Francisco, and it was out of network for all private insurers. And the reason for this is that, up through the beginning of 2019, it didn't participate in the networks of any private insurers. Yes, that is right. Every single private health insurance offered in the city was out of network for this hospital.

And so I would like to submit this Vox article for the record.

*Chairman Doggett. So ordered.

[The information follows:]

**********COMMITTEE INSERT**********

*Ms. Chu. And it points out that this resulted in abnormally high surprise bills for the patients. And so an ER visit for a bike crash cost $20,000; an ER visit for a migraine cost $10,000. It was $31,000 for a broken ankle. Now, since then, Zuckerberg San Francisco General has since come out and changed its policies after a lot of public pressure. But I am concerned about why this was an acceptable and legal business practice at all.

So Mr. Nickels and Ms. Thornton, how common are practices like those carried out at Zuckerberg General, and how often do major hospitals exclude -- or even most private insurers, in order to subsidize their patients on public programs? And does this happen in certain areas of the country more than others?

*Mr. Nickels. Ms. Chu, I am familiar with that situation. I have read the same stuff that you produced. And I know the California legislature has prevented that from happening in the future, as well they should. I know of no other hospital in America -- there is probably one out there, but I don't know of it -- that was out of network for every insurer in that area.

Now, there is a negotiation involved here, and hospitals and physicians have -- need to have the ability to be in network and not in network, depending on the negotiation. If they are in -- not in network, it shouldn't impact the patient. It should impact the negotiation between the hospital and the plan.

But in that case it affected everybody for everything and was, frankly, inexcusable. I don't know of any other instance like that.

*Ms. Chu. And Ms. Thornton?

*Ms. Thornton. We agree. This was just a horrible situation. You don't have any choice when you get hit by a bike, right, in where you are taken to the hospital. And it would have been our preference that that hospital would have joined health plan networks. But I think this is why we need federal legislation to step in in those situations where there

isn't a network for that person, and they can still be protected and not have to get -- go -- get worried about going on a bike ride.

*Ms. Chu. And to anyone on the panel, I want to ask about what would happen if we pass a federal law to address surprise billing that differs from state laws that are currently operating?

Do you believe that federal law should supersede the state laws? And if not, what would the impacts be to providers, patients, and plans in states with different surprise billing laws?

*Mr. Gelfand. If I could just speak to it from a perspective of national employers that run plans for employees in every single state, it would be important for us that there is one standard that applies to all of our beneficiaries, no matter where they live, work, or receive medical care.

That being said, those are only for those self-insured large plans. For a fully-insured plan that is already regulated on the state level, it would make perfect sense for state law to govern, unless there is no state law.

*Mr. Nickels. I would fundamentally agree with that. I think we have to have maximum flexibility to allow states that have made these changes, such as your own, to allow that to continue to be the law of the state. But to the point made -- and I think, again, I keep saying I think it is 60 million people -- states can't touch, because they are under ERISA. There should be a standard for those folks, and then states should be given maximum flexibility to do their own thing. For states that don't do anything and don't have any law, I think the federal statute should apply.

*Ms. Chu. Anybody else?

*Ms. Thornton. We agree. States should be the primary regulators of their plans in their state. And this really is starting with a state issue where the Federal Government

comes into play as the ERISA plans that James mentioned, as well as states that haven't enacted comprehensive protections.

*Ms. Chu. Thank you. I yield back.

*Chairman Doggett. Thank you very much.

Mr. Evans?

*Mr. Evans. Thank you, Mr. Chairman. I thank you for your leadership on this particular issue. I also thank the witnesses.

I am from the City of Philadelphia. We have a number of leading health facilities in the city. Half of the city I represent -- Children's Hospital, University of Pennsylvania, Temple University Hospital, Einstein Medical Center, and Jefferson. And it is not often that representatives from different institutions will come to meet with me to speak on the same exact issues. Given the diversity of specialties among practitioners, health care professionals from across the city have come to my office to discuss the need to end the surprise medical billing.

Currently, as we know, Pennsylvania has a partial legislation relating to medical billing. I want to go to Mr. Gelfand to ask the question relating to some examples you can give me.

Where have you seen the most surprising billings for your members, hospitals or ambulance, and where the patients are experiencing the highest balance -- balancing bills (sic)?

*Mr. Gelfand. So those balance bills are very heavily focused on providers that are ancillary, that are at the hospital, that, once you go to the hospital, whether it is in network or not, you don't have a choice. You don't get to choose your anesthesiologist. You don't get to choose who operates on you in the emergency room, and especially when you are talking about transportation air ambulance.

*Mr. Evans. Ms. Thornton, I have heard a lot about the increase of narrow networks and how it may contribute to the issues we are seeing with surprising billing. Can you explain what narrow networks are, and how they contribute to the issue of unexpected medical bills?

*Ms. Thornton. Thank you for the question. A network is a really important part of a health insurance design. It is a way to improve quality, manage care. As the doctor mentioned, it is a way that we work together to improve care.

Frankly, I don't think the issue -- surprise billing occurs more or less, whether the network is big or small. We see equal numbers, whether it is a large employer plan that typically has a broad network, as well as plans that have a smaller network.

Another important thing that has been mentioned is that these are often providers that someone doesn't choose. So you don't go searching for the -- you know, the perfect anesthesiologist, right? There are providers that are -- you know, do services to offer without you choosing.

*Mr. Evans. Let me follow up to you, then. In your testimony you stated that balance budgeting (sic) should be banned in situations where patients are treated by out-of-network doctors. How are patients allowed to be treated by out-of-the-network providers they do not select themselves in the first place?

*Ms. Thornton. That is a really great question. It sort of gets to the heart of this issue, right? It is like sort of a complicated process, where you could be at a hospital and you expect that every provider that is going to treat you is going to be in those same networks. And unfortunately, that isn't the case today, which is why we are so supportive of federal action in this area.

*Mr. Evans. Then that leads to follow-up to Mr. Nickels relating to hospitals, then.

The question is why can't hospitals require all facility-based providers that patients

cannot choose themselves?

*Mr. Nickels. Yes, a couple of things. I just can't resist. I am also from the great City of Philadelphia, so --

*Mr. Evans. Yes, yes, I know.

*Mr. Nickels. From your district, actually.

*Mr. Evans. Yes.

*Mr. Nickels. So nothing goes wrong there, I know.

So the issue -- we cannot force by law physicians who are not employed by us to take in-network rates. That is -- if we did that, we would be sued. It would be restraint of trade.

However, what we are trying to suggest here -- and I think the other panelists are trying to suggest -- is we have a way to protect the patient from that surprise bill.

To your question about who are these physicians that you don't even know about who are treating you, if you come in in an emergency, you don't know what is going on, and you need to be taken care of. Whoever is there is going to take care of you. The other situation, which we have talked about, is when you knowingly come into inpatient -- in-network facility, you did all the right things, but an out-of-network physician -- an anesthesiologist, perhaps, or radiologist, pathologist -- takes care of you, and that is where the bill is generated from.

So we cannot make people do that. We try to get physicians to be in our networks and the same networks. But again, this is an issue of private contracting.

*Mr. Evans. Thank you, Mr. Chairman. I yield back the balance of my time.

*Chairman Doggett. Thank you.

Mr. Kelly?

*Mr. Kelly. Thank you, Mr. Chairman. Thank you all for being here.

I don't know if there is anything more complicated than trying to understand how people get billed for medical procedures.

Now, I am in the automobile business. And people say, "Don't -- please don't try to compare it with automobiles." But we repair a lot of cars, both in the mechanical end of the business and in the body shop end of the business. We use something called a labor time guide. It could be the Mitchell's manual. It could be the Chilton's manual. It could be the manufacturer's manual that actually -- they have run time studies on how to do all these different procedures. Now, I know it there is a difference. I know there is a difference. But I am just trying to see.

Doctor, when you are going to enter into an agreement with the insurer, how do you determine -- or how do they determine what should be the fair price to do whatever it is that -- I think you used, what, an appendectomy?

Okay, so there are variations, because there are no two models that are the same? There is wear and tear and different things that enter into it. So how do you come up with what you think is a fair price to do the operation that or the procedure that you are being asked to do?

*Dr. Mukkamala. Right. So I am from Flint, Michigan, automobile town. I am a car guy, too. But I guess -- let me start by rephrasing it back to you.

You presumably do a great job servicing the automobiles that you service, right? You provide a -- you are doing the same transmission swap in an Impala.

*Mr. Kelly. Well, you know what, though? Before we go any farther, that is not what we do, because, depending on what region of the country you are in, there is different procedures, and it takes different times to do different operations. So there is taken into consideration that the age of the car, the mileage on the car, where that car has been operated in.

*Dr. Mukkamala. Right.

*Mr. Kelly. Same as a human person.

*Dr. Mukkamala. Right. So -- but apples to apples, if you are doing the same job as somebody else, you may charge a certain amount because you are the only one around, or you would do a great job of it.

In the same way, the reason that this negotiation comes into play is that if I am the only person for 100 miles that can sew this finger back on, that has that skill, that is something that I should be able to sit across from the person paying the bill for that procedure to say, "You know what? This is the situation here. Nobody else can do this. This is my fee. This is what you usually pay. Let's work out a number that is reasonable for both of us." Right? And so that is the difference between one geographic location, where there are multiple options, and another geographic location where there is a paucity of providers.

*Mr. Kelly. Yes. So I think I am like Ms. Sewell. I come from an area that is largely agricultural. You are not going to find a lot of those providers out in some of those areas. You just don't have that specialist. So you have to go someplace else.

But I am wondering, because I think Mr. Doggett is on to something. There should not be this surprise at the end of -- especially in different situations. Emergency rooms would be the one I think that is most prevalent and the one that it happens the most in. So there is a difference between being in a metropolitan area, being in an urban area, being in a suburban area, being in an agricultural area. How do we ever solve that problem, though?

Because I do agree with you. If there is limited talent there to take care of that specific problem, there has to be a way of compensating for it. Because, at the end of the day, it is a business.

*Dr. Mukkamala. Right. So the solution is if an insurance company is going to come into Flint, Michigan and sell insurance, they know that eventually they are going to need a hand surgeon. Right? How do they sell insurance to a town that is an industrial-based town -- there is a lot of hand injuries -- and not have any hand surgeons in their network?

When they put up the billboard saying, "We are selling insurance here," they should at the same time look at their provider list and say, "You know what? We are missing an orthopedic hand surgeon. Let's go find one and figure out how to get him in network, or get her in network." Right? And that is a step that is skipped routinely. Right? They will sell the product for years and then fill in this way with a lack of a good provider network by trying to negotiate out-of-network rates that are the same as in-network because they skipped that first step, right? Maintain a network adequacy. Establish a network adequacy before you sell your product.

*Mr. Kelly. My chief of staff last year, we were out somewhere, and he was skiing, and he had actually had a skiing accident. This was out of state, so he is out of network. But one of things he kept doing was, well, I better call and check to see if I have coverage, if there is going to be a surprise billing at the end of this. But you know, not everybody has that situation where you can actually sit back and make some of those decisions.

So, Mr. Nickels, you seem to have a great depth of experience with all this. I don't know how we approach this, because certainly it has got to be much more expensive to run a big hospital in Philadelphia than a small hospital in some rural part of Pennsylvania. And again, not having the talent onboard to maybe handle different situations.

*Mr. Nickels. Yes, a couple of comments on that. First is keep in mind that half of our payments are dictated by government. We have -- there is no variation, other than

wages that are paid in that particular area of the country. And so we are not billing for that. Government has decided the feds or the states -- over half in some parts of this country, half on average. So that is the first thing.

On the rural issue there is no question that this is a perfect example of an issue that is only exacerbated in rural America because of the paucity of physicians, lack of choice, et cetera, et cetera. So it is really a problem. But we think if we get the patient out of the middle of it we solve the biggest part of the problem, and we need to negotiate the rest.

*Mr. Kelly. Well, thank you. Thank you all for being here.

Mr. Doggett, thanks for bringing this up. The direction you are going -- and we have to find a way to get through this problem. There is nothing worse for some of these folks than to get that surprise bill, because it just shocks them. Thank you so much. Thanks for being here. Thank you, sir.

*Chairman Doggett. Thank you very much.

Mr. Schneider?

*Mr. Schneider. Thank you, Mr. Chairman. And I agree. Thank you for holding this critically important hearing. And to the witnesses, thank you for sharing your perspectives, your expertise.

According the Kaiser Family Foundation, surprise medical bills are the top financial concern for Americans, above transportation costs, above utility bills, above rent and mortgages, even above food. Two-thirds of Americans say they are very worried about receiving an unexpected medical bill. And indeed, they should be. According to a recent survey by the University of Chicago -- my state, Illinois -- nearly 60 percent of Americans have been surprised by a medical bill.

Some of these stories are actually truly heartbreaking. One story, a recent example, a family waiting in a hospital parking lot for hours after their two-year-old child

accidentally ingested an entire bottle of common over-the-counter medication instead of going inside, because they were too fearful of the bill they would incur. And that is the serious -- often times you hear stories that are the absurd, but all of these are problems.

As I am thinking about this -- and again, thank you for sharing your perspectives -- one of you used the term -- we are talking about cost shifting. And there are so many moving parts in our health care system. There are so many stakeholders.

But as a patient, if I am going to a hospital -- I am going to use the example of a ski accident. If I have a ski accident and I need to be airlifted because I am out in back country -- to the hospital, and from where I am I can't get helicopters, so I am -- it is a plane, I have to take a plane, and then I land at the airport, and then take an ambulance to the hospital. I go and I have the emergency surgery, you know, on and on.

What I am hearing is the biggest source -- well, what is the most likely source going to be in that case of the potential surprise bills that are coming my way? Anyone?

*Dr. Mukkamala. So, I mean, they -- naturally, there is going to be the emergency room visit, the trip to the operating room, the surgeon does the procedure, fixes the arm, the anesthesiologist puts the patient to sleep, wakes the patient up. There is some recovery afterwards, and then they go home. There is no reason --

*Mr. Schneider. But I had an air ambulance and a regular ambulance.

*Dr. Mukkamala. Right, yes, they are all -- the trip to there -- I mean the trip to the hospital, as well. And the fact that some of these physician groups -- like the anesthesiologist, for example -- if they are not in-network, that is the root of the problem. Right? And the question is why aren't they in-network?

*Mr. Schneider. Well, I am out of state.

*Dr. Mukkamala. Pardon?

*Mr. Schneider. I am out of state. I am using the example where someone is out

of state.

*Dr. Mukkamala. Yes. Then it is always going to be out-of-network. But then, naturally, there has got to be a solution for that. That is not a problem that can be prevented by contracting, because you are going to be on vacation in some random place. And obviously, your insurance company is not going to have a contract with the local facility. But that is exactly the opportunity for those people that produced that bill that provided that service to have a conversation with the insurance company, instead of having some assigned random number.

*Mr. Schneider. Okay. I just want -- I am going to pull it back, just because of time.

So now I get all these bills in, and we heard the stories, and the insurance pays for some, I get threatened by others. But ultimately, let's say the patient at the end of the day is held harmless. So it all gets taken care of. But any -- in the system there seems to me to be a lot of windfalls and -- or a lot of shortfalls along the way, a shortfall to the patient, a shortfall to the hospital, potentially the insurance company.

Is there a windfall? Is someone in this system making a windfall in the dilemma we are talking about?

*Mr. Gelfand. If I could just interject, for one thing, we will do a disservice to patients if we protect them from hospital bills, but they are already bankrupt just from the trip to get there.

*Mr. Schneider. Fair enough.

*Mr. Gelfand. And that is why ambulance and air ambulance has to be included.

I don't think that we have mentioned yet today that many of the hospitals are not doing what Zuckerberg Hospital was doing. The hospital will be in-network, but they will have outsourced their emergency room to a Wall Street-owned private company, and that

company won't take insurance. And those guys are definitely making enough profits that Wall Street is suggesting that people should invest in those companies because of these relationships they have with the in-network hospitals and the out-of-network emergency rooms.

*Mr. Schneider. Anyone else?

*Ms. Thornton. I would say that that -- you know, the mother sitting in the parking lot is not only concerned about what her out-of-pocket costs would be for that visit, but also her premiums. And so it is really important that we think about -- when we are thinking about how to solve this issue, we are not doing it in a way that is going to raise her premiums going forward. So it is important to think about --

*Mr. Schneider. And I guess that is where I was going with the idea of shortfalls, is that if we don't address this issue it is costing all of us in the end.

*Ms. Thornton. Exactly.

*Mr. Schneider. We have to find a way to address it.

I am out of time. And again, I thank you, and I yield back.

*Chairman Doggett. Thank you. And if either of you -- any of you have suggestions about the air ambulance issue, it has not really been addressed in any of the proposals. And we could use your specific recommendations about a complex but serious problem.

Mr. Gomez?

*Mr. Gomez. Thank you, Mr. Chairman. Thank you for having this hearing.

I was in the California legislature when the bill passed AB-72. I will get into that in a little bit.

I think, when it comes to health care -- and this is an idea that I have been having discussions with -- that most Americans just want to be health care secure. And what does

that mean? And I think that it means that, you know, they understand that they have to pay something for their premiums. They understand they have to pay deductibles. But what they don't understand is that -- they don't want to be in a scenario where they can't get the care that they want and need, the best care possible.

They want to be able to make sure that they can afford it, and they want to make sure that their insurance plan includes real benefits. And especially, they don't want to end up in a situation where they get a bill, you know, sometimes days or weeks or months after a procedure that they didn't know that they were going to get. It is a -- it is something that keeps up a lot of Americans at night. I believe it is unacceptable. And I think that it is a problem that we will be dealing with in our health care system.

And then I think it is true, no matter whether a patient researches their options for in-network care ahead of time, they end up in the emergency room, or they lack the resources, time, and language skills to navigate some of the most complex health care systems in the world.

You know, my father died of pancreatic cancer. He didn't speak the language very well. And I had to help him deal with a lot of those issues. And it is difficult. And then, when you are dealing with the stressful situation of life and death, it is even more difficult. So it is something that I think that we are -- that -- it is not going to be easy, right?

On AB-72, there was a negotiated agreement between the plans, the hospitals, and the docs. The docs ended up going neutral on the bill in the end, and it passed unanimously, 72 to, I think, 2 people -- a bunch of abstentions, of course. So you can say that those were noes, or didn't want to take a position, but it was pretty much unanimous.

I want to ask. How is the California law working, and where are some of the shortfalls? I understand the big shortfall is it doesn't deal with a, you know, big chunk. But how is it working in the field? And we can just go down the down the line.

*Dr. Mukkamala. Yes. So the -- my understanding of the aftermath of the California law is that if an insurance company can get the care for their subscribers from an out-of-network physician at, let's say, 125 percent of Medicare, and they are currently paying their in-network physicians 140 percent of Medicare, what is likely to happen? It is exactly what happened. They don't renew the contracts for the physicians that are in-network, and they make them out-of-network. Right? It solves one problem, and it creates a massive other problem.

So groups that were working in a hospital for 19 years go to renew that contract for the 20th time, and it doesn't get renewed because it is cheaper for the insurance company to knock them into the out-of-network status. So there is an aftermath to these things if they are not thought out properly.

*Ms. Thornton. So, as you mentioned, AB-72 was passed with bipartisan support. Consumer groups supported it. Our industry health plan supported it. And from -- you know, the regulations really just went into effect in January, as was mentioned. But our plans have thought that it is really starting to work really well. We feel like consumers are protected. And, like I mentioned before, it addresses the issue in a way that doesn't raise overall health care costs, which I think is important.

*Mr. Nickels. My understanding of the California law -- you would know better than me -- is it -- that the benchmark doesn't affect hospitals. I know that is being debated in the state legislature, as we speak, about whether they want to extend the law to hospitals. But it wasn't.

But I think what we feared was what happened with the physicians. If you set a rate -- especially if it is based on Medicare, which everybody understands underpays both physicians and hospitals -- it does lend itself to, again, our fear that you have a benchmark and that we get fewer people in network. Then insurers resort to the benchmark because it

is cheaper than what they would have to pay otherwise.

*Mr. Gelfand. And it is our understanding that California took bold steps to solve this problem, and we have not seen borne out some of the warnings that were given about various solutions. There has not been a mass migration of physicians out of the State of California. People are not losing access to care. Rather, surprise bills are being stopped.

*Mr. Gomez. Well, I have a lot of questions. I know there is -- California is a very unique place, and I have a lot of questions. But I know that this is an issue that -- we just don't want to see that the patients continue to be the losers in the situation. And we will be asking for your advice and your input as we move forward. So thank you so much.

*Chairman Doggett. Mr. Horsford?

*Mr. Horsford. Thank you, Chairman Doggett. I am glad we are addressing this issue that has plagued Nevada residents and people across the country for far too long.

I know we have talked a lot today about kind of the different players, but I really want to focus on cost, not just shifting the responsibility of who pays at the end.

One Las Vegas family experienced the shock and stresses of soaring hospital bills earlier this year in my district. Michael took his wife, Marta, to the emergency room in January after she fainted and appeared to be having a seizure.

Despite having health insurance, the two self-employed musicians were stuck with more than $5,700 hospital and doctor bills after an hour-and-a-half visit. Five thousand seven hundred dollars.

Now, 39 percent of insured adults under age 65 said they received an unanticipated medical bill within the last year that they thought would be covered by their insurance, or that was higher than they anticipated. Half of those people said the bill was less than $500, but nearly 1 in 8 said that they were on the hook for $2,000 or more. This represents a large concern for many Americans, not only fears about unexpected medical bills, but

also seeing cost of those bills much higher than they could have ever anticipated. And that is a legitimate concern. Reports show that out-of-network providers are charging an average of 150 percent more for procedures than in-network providers.

And I think we really have to drill down to the question of why. Now, luckily, in my home state in Nevada, just last week Governor Steve Sisolak signed into law a bill which represents the culmination of years of work. This compromise bill ensures that patients have more protections in medical emergency situations. The final proposal that was signed into law holds patients harmless by requiring them to only pay whatever copay, coinsurance, or deductible that they would have been responsible for at an in-network facility for emergency care.

Under the legislation, if a hospital and insurer were recently in network, the insurer would be required to pay 108 or 115 percent of the previously contracted rates, depending on how long they were out of network. And if they never had a contract or were out of network for more than two years, the two parties -- not the patient -- would be allowed to make initial offers to each other before going to arbitration.

So this bill represents every part of the system: insurance companies, providers, and patient advocates coming together to find a solution. And I am very proud of Nevada's leadership on this national problem, and I hope that it can be a guide for federal policy, as we have done on other issues like drug cost transparency.

So my question Mr. Nickels, Dr. Mukkamala, why are my constituents being charged prices that are many multiples of the actual cost of the care they need? And how can we correct for that?

*Mr. Nickels. Let me begin by agreeing with you on the Nevada law. And I know our members are supportive of that, and I think that is a good solution.

So if you come into an emergency department, or if you come into a network

facility, you pay your in-network -- excuse me, out-of-network physicians, you pay your in-network coinsurance, period. And that is the way it ought to be, and that is the way it ought to have been for that couple you mentioned earlier, if it had happened to them. Henceforth, it would be the way it should be, which is they should pay their in-network coinsurance. That will take the patient out of the middle of it, and that is the way it should be.

I think the way that Nevada is looking at it is also reasonable, because it gives the opportunity for the provider and the insurer to negotiate, to come up with the right price between themselves. And that negotiation can occur, the patient is out of it. And I would agree with you that I think it represents a model we ought to be looking at.

*Mr. Horsford. Thank you. What about the cost? How can we drill down on what that bill looks like when you get it at the end of the day?

*Mr. Nickels. Well, the -- when you get the bill there is -- you know, the bill is based on an amount that could be based on charges, hospital charges, et cetera. I think what is important to the patient is what the patient has to pay. And the insurer --

*Mr. Horsford. Yes, but if the bill is still exorbitant, and the patient has to pay 10 percent of the bill that is way more than it should be, they do still care about what the bill looks like.

*Mr. Nickels. But that amount was negotiated between that patient's insurer and the hospital.

And the insurer, I am sure, got as good a deal as they could, and that original charge, the thing that you see when you get the "This is not a bill" from a hospital, physician, or anyone else, is not what that insurer paid the hospital.

And what that subscriber pays is a percentage of what the insurer negotiated for that subscriber.

*Mr. Horsford. Okay. I know my time is up, Mr. Chairman. I appreciate this hearing. I look forward to us continuing to take action on this very important issue.

*Chairman Doggett. Thank you, and I appreciate all our members and their cooperation here today, and particularly thank our witnesses and remind them that members have two weeks in which to submit written questions to be answered later in writing.

I welcome your supplementing your presentation today with anything in writing you may want to add for the record. Your questions and -- the questions and all the answers will be made part of our formal hearing record.

And with that, thank you for your time this afternoon. And I hope we can continue working together to try to resolve this problem.

The Committee stands adjourned.

[Whereupon, at 5:12 p.m., the Committee was adjourned.]

Submissions for the Record follow:

American Association of Retired Persons

National Business Group on Health

American Association of Nurse Anesthetists

Cancer Action Network

American College of Surgeons

Common Ground

Adventist HealthCare, Inc.

Assure Holdings, LLC

ProPath

Center for Medicare Advocacy

Texas Hospital Association

American College of Emergency Physicians

American Association of Neurological Surgeons

Observation Coalition

FAIRHealth

Michael G. Bindner