
**Testimony of Claire McAndrew, MPH**
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Subcommittee on Health

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Chairwoman Eshoo, Dr. Burgess, and members of the House Energy and Commerce Committee, Subcommittee on Health: Thank you for the opportunity to speak with you today. I am Claire McAndrew, the Director of Campaigns and Partnerships at Families USA. For nearly 40 years, we have served as one of the leading national voices for health care consumers both in Washington, D.C. and on the state level. Our mission is to allow every individual to live to their greatest potential by ensuring that the best health and health care are equally accessible and affordable to all.

**Testimony Summary**
My testimony seeks to convey a number of key points for the Subcommittee's consideration. Specifically:

- Surprise bills are a significant and longstanding problem, causing economic insecurity and stress for millions of families each year.
- Surprise bills are the product of distorted market incentives in the negotiation between health plans and providers. In surprise bill situations, consumers are caught in the middle of these powerful industries with no recourse.
- Surprise bills occur across health care settings and must be dealt with holistically.
- While Families USA supports committee's bipartisan legislation, several changes are needed to ensure the bill protects all consumers affected by surprise bills.
- Only Congress can fully protect consumers against surprise billing. The time for bold action is now.

**The Larger Context of Health Care Costs for Families**
High and rising health care costs place an untenable burden on millions of families across America – even those with health insurance. Four in ten people with employer coverage have difficulty affording health care costs.[1] Additionally, a startling 30 percent of people in our nation report that health care costs are interfering with their ability to meet the most basic necessities of their life, like securing food, heating, or housing.[2]

The United States is one of the wealthiest nations in the world and we spend twice as much as other high-income nations to provide health care.[3] People across the country should not have to live in fear of getting sick and facing a sudden, crippling financial burden. And, yet, this what so many American families experience every day.[4] In fact, a larger percentage of the population actually fear medical bills from a serious illness more than the serious illness itself (40 percent vs. 33 percent).[5] What's more, according to the American Psychological Association, the stress associated with medical bill anxiety can actually make them sicker.[6]

**The Cost and Frequency of Surprise Medical Bills**
Surprise bills— also known as out-of-network "balance bills"— are a particularly egregious health care cost, as they are unpredictable for families and occur despite every effort consumers make to avoid them. Surprise medical bills occur when consumers are charged for care from out-of-network providers that they receive due to no fault of their own. Families who make their best attempt to navigate the health coverage and care

system by identifying in-network facilities and providers still receive surprise medical bills that can amount to hundreds, thousands, and even tens-of-thousands of dollars.[7]

Surprise medical bills are incredibly common. One-in-five emergency department visits results in a surprise medical bill.[8] Surprise medical bills also occur even when families do their very best to go to an in-network provider and suddenly, after-the-fact, discover ancillary services like anesthesiology, radiology, lab, or ambulance fall outside of their provider network.[9] For example, more than one-in-five lab claims (22.1 percent) for inpatient hospital care in an in-network hospital were billed as out-of-network.[10]

*Allow me to highlight the experience of Nicole Briggs, from Morrison, Colorado. Nicole woke up in the middle of the night with intense stomach pain. After first visiting a freestanding ER, she was told she needed an emergency appendectomy, and she went to the local hospital. She did her due diligence to confirm repeatedly that the hospital and its providers accepted her insurance. However, months later, she received a surprise bill from the surgeon for $4,727. While the hospital was in-network, the surgeon was an independent, out-of-network provider.*

*Nicole explained the situation to the insurer, but they continued to demand payment. She declined to pay the bill, and within two years, a credit agency representing the surgeon took her to court, and won the full amount, including interest. As a result, a lien was placed on her home, and the collection agency garnished her wages by 25 percent each month. This came right as she was pregnant and about to go on maternity leave.[11]*

Air ambulance services are particularly likely to lead to surprise medical bills. Nearly 70 percent of air ambulance patient transports that people often require in life-or-death situations are out-of-network, and balance bills from these air ambulance providers are rarely below $10,000.[12]

**Surprise Bills Occur Across Health Care Settings**

Surprise bills do not just occur in emergency situations. Families can schedule medical procedures far in advance and still be vulnerable to surprise billing. For example, Pennsylvania Insurance Commissioner Jessica Altman has described multiple people in her state receiving surprise bills after visiting their in-network OB/GYN's office because their mammograms were sent to out-of-network labs for review.[13] One recent study found that people who selected in-network facilities and in-network providers for the delivery of their babies still had surprise bills from ancillary providers 11 percent of the time.[14] Families may schedule a procedure with an in-network surgeon weeks or even months in advance, only to end up with a surprise bill because, unbeknownst to them, an out-of-network assistant surgeon or anesthesiologist participated in their care.[15]

**The Cause of Surprise Bills**

Surprise out-of-network bills are a terrible example of how distorted economic incentives in the health care sector are overwhelming the interests of patients. They are the result of a systemic problem in our health care system that places families directly in

the middle of a tug-of-war between health care providers and insurers over the price of services.[16]

The rate negotiated between providers and insurers for services is at the center of their business models. Larger hospital systems have significant leverage, allowing them to command top dollar for in-network rates. Insurers are often forced to pay their high charges for in-network status, or insurers may simply walk away from the negotiation.[17] On the other hand, when hospitals are smaller, insurers hold the leverage. Those hospitals must choose between accepting lower negotiated rates than they desire, or walking away from the negotiation and providing care out-of-network.[18] These distorted market incentives frequently lead to out-of-network provider status and ultimately, harmful surprise bills for families. In general, compared to in-network providers, out-of-network providers charge nearly three times as much for care.[19] This leaves families with balance bills that average over $600, but can exceed $20,000.[20]

One driver of this problem is the movement by hospitals to offload staffing requirements for their emergency departments to third-party management companies. These companies have no responsibility to ensure hospital-based providers are in the same networks as the hospitals themselves.[21] In fact, two-thirds of hospitals in the U.S. outsource the staffing of their emergency departments to third-party physician management firms.[22] Research shows that out-of-network claims are higher in hospitals that contract with common staffing companies.[23] All too often, these firms use a business model that leverages the higher prices that can be charged with an out-of-network status.[24] As a result, a patient with a medical emergency, who rightly thinks they are going to an in-network hospital, often receives professional services from an out-of-network physician. This is inexcusable behavior on the part of the hospital, doctor, and health insurer. They each know or should know that patients have no real way of understanding the financial trap they have walked into. In these surprise bill instances, we and many believe it is the providers and payers who should bear the burden of settling on a fair payment.[25]

Despite claims by some stakeholders,[26] evidence does not conclude that narrow networks are a driving factor behind surprise bills.[27] People covered by plans that tend to have broad provider networks are nearly as likely as those in plans with typically narrower networks to receive surprise bills.[28] Families USA strongly supports network adequacy requirements. We have advocated for such standards at the state and federal level for years, as well as standards to improve provider directory accuracy.[29] We also criticized recent actions that relaxed network adequacy and provider directory requirements for plans in the federally facilitated marketplaces.[30]

However, broadening network adequacy will not, by itself, solve the problem of surprise bills. Network adequacy standards are designed to ensure that a health plan has a sufficient number and variety of network providers to deliver the benefits the plan covers to its enrollees. For example, network adequacy standards ensure there are a sufficient number of primary care doctors and specialists in a plan's network relative to the number of enrollees in the plan. These standards ensure enrollees will not have to wait unduly long or travel unduly far for appointments.[31] They do not, however,

guarantee that any particular provider or facility is in a plan's network. Requiring a plan to include each provider and facility as a participating provider would defeat the cost-control purpose of having a network.[32] Since surprise bills occur when a consumer ends up at a *particular* out-of-network emergency or at an in-network facility where a *particular* provider is out-of-network, they require targeted protections.

**The History of Surprise Medical Bills**

Another common misconception is that surprise bills are a new phenomenon. That is false. Consumers have been subjected to these unexpected and unaffordable costs for decades. Early discussions of protecting consumers from surprise billing occurred in response to the "managed care revolution" of the 1980s and 1990s. The revolution occurred when health insurers began shifting more risk to providers with the creation of networks, as opposed to bearing that risk through fee-for-service models.[33] Under fee-for-service models common previously, insurers would simply reimburse the usual and customary rate (UCR) for services to the provider, except for a share paid by the enrollee.[34] However, consumers could still be balance billed for provider charges that exceeded the UCR.[35] Insurers played little role otherwise, and enrollees could see any doctor of their choosing, with no network structure in place.[36]

From 1980 to 1999, network-based managed care plans grew enormously in efforts to help employers contain rising health care costs. In 1980, 5 percent of Americans were enrolled in health maintenance organizations (HMOs). By 1999, 30 percent of Americans were HMO enrollees. Other forms of managed care grew at this time as well, such as preferred provider organizations (PPOs). By 1998, less than 15 percent of people with employer-based coverage in the United States had traditional fee-for-service plans.[37]

With the advent of networks, surprise billing became more apparent. Now that care from certain providers could expose families to much higher out-of-network costs compared to the same care from other providers, families could find themselves in situations where they received out-of-network care due to no fault of their own.

Throughout the 1980s and 1990s, states began to work to address surprise bill problems for managed care enrollees. States first took measures to ban participating providers from balance billing HMO enrollees, and some extended these protections to non-participating providers.[38] Some states later expanded these laws to other types of managed care plans, and slowly continue to expand these protections today.[39]

Even at the federal level, Families USA and other stakeholders discussed the need for surprise bill protections as early as the 1990s. The Advisory Commission on Consumer Protection and Quality in the Health Care Industry, appointed by President Clinton on March 26, 1997, to "advise the President on changes occurring in the health care system and recommend measures as may be necessary to promote and assure health care quality and value, and protect consumers and workers in the health care system," made recommendations to prevent surprise billing in emergency situations.

The Consumer Bill of Rights that President Clinton asked the Commission to draft recommended that:

> *"Health plans using a defined network of providers should cover emergency department screening and stabilization services both in network and out of network without prior authorization for use consistent with the prudent layperson standard.* ***Non-network providers and facilities should not bill patients for any charges in excess of health plans' routine payment arrangements."***[40]

Families USA served on this 34-member advisory panel in 1997 and contributed to its recommendations on surprise billing.[41] However, our work on surprise bills began before then, as we assisted states in their efforts to pass protections on the issue even earlier.[42] As Families USA and others[43] have fought to protect consumers from surprise bills for over two decades, we strongly urge this Subcommittee and Congress to wait no longer to pass comprehensive legislation on this critical issue for families.

**It is Past Time for Congress to Address Surprise Bills**

The ubiquity of surprise medical bills in all types of health plans and in all states warrants immediate federal action. Current federal law provides limited protections for families who receive out-of-network care in emergency situations.[44] Specifically, the ACA limits copayments and coinsurance charged by an insurer to in-network amounts when families receive services from an out-of-network emergency provider.[45] Despite these protections, however, providers may still balance bill families for additional out-of-network costs. Furthermore, insurers are not required to count copayments or coinsurance paid by a family toward in-network deductibles and out-of-pocket caps.[46] Thus, current federal law leaves families with considerable financial exposure for surprise out-of-network bills for emergency services and no protections for other categories of surprise out-of-network bills.

Across the country, some states have stepped up to address this problem for their residents in the absence of federal protection.[47] However, state protections are patchwork, as only 10 states have comprehensive protections in place for plans that fall under state regulatory authority.[48] Even in those states, many residents are left unprotected, as states do not have meaningful authority over ERISA-regulated self-insured plans.[49] A large majority of working families across the nation— 61 percent— are enrolled in ERISA health insurance products.[50] These families are no less likely to receive a surprise bill than those in fully insured group or individual plans.[51] With so many states and families left unprotected from surprise medical bills, people across the country are looking to this Subcommittee and Congress for action.

**Legislation under the Committee's Consideration**

Families USA commends the Energy and Commerce Committee for the release of its draft "No Surprises Act." This legislation would both 1) take important steps to hold families harmless from surprise bills and 2) ensure that payments between insurers and out-of-network providers are not inflationary, so that families do not experience increased insurance premiums.

Specifically, the bill includes important provisions that:

- Protect families from paying more than they would pay in cost-sharing if they received in-network care during surprise bill situations. Further, it specifically ensures that these payments count toward in-network deductibles and out-of-pocket maximums.
- Establish a benchmark payment rate such that in a surprise bill situation, insurers will pay out-of-network providers median contracted rates.
- Provide grants to states for the establishment of All-Payer Claims Databases.

Protecting Families from Out-of-Pocket Expenses beyond In-Network Cost-Sharing
To providing meaningful protection from surprises bills, the No Surprises Act explicitly ensures that families in surprise bill situations will pay no more than they would if they received care from an in-network provider. This recognizes that families should not be left holding the bag when they do everything they can to obtain care from an in-network provider, but still receive out-of-network care due to no fault of their own. **We strongly support that the No Surprises Act protects families from paying more than they would in-network and explicitly states that these payments count toward in-network deductibles and out-of-pocket maximums.**

Establishing a Benchmark Payment Rate between Insurers and Providers
Families USA believes that the payment mechanism between insurers and providers in a surprise billing situation is a consumer issue: If payments are unduly high, they will be passed on to consumers in their insurance premiums**. We therefore strongly support the establishment of a benchmark payment rate, which will prevent nontransparent and fluctuating payments that may lead to inflationary costs.**

In particular, we support the benchmark of median in-network rates because it avoids tying payment to billed charges. Billed charges are set based on the rates providers want to get paid, not on the rates they actually get paid by insurers. Therefore, they vary widely and are determined arbitrarily. Furthermore, charges are highest for the very providers most likely to send surprise bills: While provider charges generally are about two times Medicare rates, anesthesiologists and emergency doctors charge five times what Medicare pays.[52] Including billed charges in any payment methodology for resolving surprise bills, including a benchmark rate or an arbitration system, would inflate costs and ultimately harm consumers.

Providing Funding for the Creation of All-Payer Claims Databases
We support incentives for the creation of All-Payer Claims Databases (APCDs) in states. APCDs can assist in addressing surprise billing, network adequacy, and a host of other issues related to costs and access. For example, Colorado recently passed the tenth comprehensive state law to protect consumers from surprise medical bills. The state has an APCD, and it is using that database as the source of information on in-network rates for its out-of-network provider payment formula in the law.[53] This allows the state to use a payment rate that is based on what all insurers in the state reimburse providers,

instead of using separate rates for each insurer. This will protect against some insurers paying unduly high rates or some with great market power paying unduly low rates, creating a more level, competitive playing field among insurers.[54]

However, *Gobeille v. Liberty Mutual Insurance Company* restricted the ability of state APCDs to require self-insured, ERISA-regulated health plans to participate in APCDs.[55] It would therefore be beneficial for Congress to develop strategies to obtain claims information from self-insured plans, such as through the creation of a database at the federal level.

**Families USA supports the No Surprises Act, though we recommend three significant changes to better protect consumers from egregious and unpredictable surprise bills:**

1) Expansion of consumer protections to ensure all provider and facility surprise bills are captured
2) Establishment of federal surprise billing law as a protective "floor," so that states cannot implement weaker laws that undermine it
3) Improved consumer notice requirements

Surprise Bill Protections should include all Providers and Facilities

Families USA recommends modifying the No Surprises Act to ensure that families are protected from surprise bills in all facilities and from all providers that can expose them to involuntary out-of-network bills. The draft legislation uses a list of "participating facilities" and list of "facility-based providers" to establish the scope of surprise bill protections. We are concerned this approach will fail to capture all of the locations and providers from which families may experience surprise bills, and therefore will still leave them exposed to unfair balance bills.

**Rather than creating discrete facility and provider lists to which surprise bill protections apply, we recommend that the legislation take an approach that defines a surprise bill *situation*. Specifically, protections should apply to:**

- **Emergency services provided by an out-of-network health care professional or at an out-of-network facility;**
- **Health care services provided:**
  - **At an in-network facility (including use of equipment, devices, telemedicine services, or other treatments or services); and**
  - **By an out-of-network health care professional; and**
- **Additional health care services required for an enrollee who initially entered a hospital through the emergency department but then receives non-emergency services from an out-of-network provider or at an out-of-network hospital or facility after the enrollee has been stabilized, unless the enrollee can safely travel to an in-network hospital. (And for which in-network medical transportation is available, if necessary.)**

Whether in this bill or in future legislation, federal protections should hold consumers harmless from paying more than in-network cost-sharing for both ground and air ambulance transport when they have no option for in-network ambulance transport. Additionally, federal preemptions that prohibit state regulation of air ambulance rates and networks should be eliminated.

Without these modifications, consumers will still be vulnerable to surprise bills from providers who are not currently listed in the draft legislation, such as lead surgeons and labs to which they are referred by in-network providers.[56]

Congress should Prevent State Law from Undermining Federal Protections

Families USA believes states should have the opportunity to develop innovative solutions to providing surprise bill protections for their residents. However, these solutions must not undermine federal surprise billing protections such that consumers in some states are afforded fewer rights than federal law provides nationally. If federal law does not provide a floor of consumer and cost protections, state laws could swiftly undermine federal efforts to protect consumers and improve cost stability for the health care system.

Families USA recommends permitting states to apply their own surprise bill laws, if state law is equally or more robust than federal law, in terms of both consumer protections and a payment rate between insurers and providers that holds costs down. We are concerned that the draft legislation currently would allow state laws that have less robust protections than federal law to preempt federal law. **We recommend clarification in the No Surprises Act that federal law applies unless state law is equally or more robust.**

Consumer Notice Requirements Must Provide Sufficient Protection

The No Surprises Act allows out-of-network providers to balance bill as long as providers deliver 24-hours' advanced notice of their network status to consumers. Families USA believes that permitting a non-participating provider to balance bill when a consumer has received only 24 hours' notice of the provider's network status and estimated out-of-network charges is an insufficient protection. If a consumer is scheduled for surgery, or a C-section delivery, or another critical procedure that requires the care of anesthesiologists, surgeons, or other highly-specialized providers, rescheduling care that is to occur in just over 24 hours may put their health at risk. Even if it does not jeopardize health, it may require rescheduling medical leave or making burdensome choices between families' wellbeing and large financial burdens. People should not receive a mere 24 hours' notice to choose between hundreds or thousands of dollars in out-of-network costs or delaying an important medical procedure.

**We therefore recommend revising the No Surprises Act to provide no less than 7 days' notice to consumers regarding the participation of any out-of-network providers in their care. If any provider or facility does not give a consumer at least 7 days' notice that a specific non-participating provider will be involved in their care, along with estimated charges from that provider, the provider must not be allowed to balance bill. We also**

**recommend clarifying that a general notice about the possibility of an out-of-network provider is not sufficient notice: Notices must be specific to an individual care episode and mention the provider or service that will be out-of-network by name with a corresponding cost.**

Without such modifications, notices may be used by facilities and providers to waive their liability for balance billing and not to provide consumers with useful information.

**A Call to Action**

Families USA is grateful to the subcommittee for holding this important hearing today. For decades, families have been trapped in the tug-of-war between providers and payers that leads to surprise medical billing, and without your action it will only get worse.

The public has identified health care costs as a top priority for action this Congress.[57] Addressing surprise billing is a chance to demonstrate real bipartisan leadership to our nation. Families USA urges Congress to swiftly take advantage of this opportunity and to pass legislation to protect consumers from surprise medical bills this year.

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