Ohio Senate Bill – 198 Surprise Billing

by

Jeanette Thornton
Senior Vice President, Product, Employer, and Commercial Policy
America's Health Insurance Plans

for the
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Chairman Hackett, Vice Chairman Hottinger, Ranking Member Craig, and distinguished members of the Senate Insurance and Financial Institutions Committee, thank you for the opportunity to present testimony in opposition to Senate Bill 198 on behalf of America's Health Insurance Plans (AHIP). I am Jeanette Thornton, Senior Vice President of Product, Employer, and Commercial Policy for AHIP. AHIP is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

We appreciate this opportunity to provide comments on SB 198 and offer solutions that will protect Ohioans against surprise bills without increasing healthcare costs. Every American deserves affordable, high-quality coverage and care, as well as control over their own health care choices. Surprise medical bills stand in the way of this commitment, which is why health plans have been advocating for state legislation, including action in Ohio, that will protect all patients from these unexpected and unjustified costs.

My testimony addresses:

- Why and how often Ohioans receive surprise medical bills;
- How to protect Ohioans from surprise medical bills;
- Information on the relationship between surprise billing protections and health plan networks;
- Why using arbitration as the primary means to address surprise medical billing will increase health care costs for everyone and harm consumers;
- Lessons learned from three states that have recently enacted protections for their citizens.
- How potential federal legislation to address surprise bills will impact Ohioans.

How Surprise Medical Bills Occur

Surprise medical bills occur when patients are treated by certain types of out-of-network providers under circumstances where consumers cannot reasonably plan for or avoid treatment from these providers. When patients have health care coverage and get care from doctors in their plan's network, the health plan typically covers all costs beyond required cost-sharing under their health plan at a negotiated, market-based rate. It is important to remember that most doctors work *in* a hospital, not *for* that hospital – they work as independent contractors who see patients in that hospital.

When patients receive care from out-of-network providers – either care that is elective or unanticipated– the provider often will send patients a bill for charges for which the patient is responsible. This is because, under current law and practice, most states allow a doctor to bill a patient for any balance that may be outstanding after the health plan pays the costs for which it is responsible. In many instances, health plans and employers pay well above what is required of them in an effort to satisfy the bill and protect the consumer. Unlike health insurance prices which is highly regulated under state law, there is no oversight over or obligation to justify these

charges, which means that the provider can charge whatever they want, exposing patients to enormous financial liability.

The Frequency and Magnitude of Surprise Medical Bills

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

In February 2019, the USC-Brookings Schaeffer Initiative for Health Policy published a white paper[1] reporting that approximately 1 in 5 emergency department visits involved care from an out-of-network provider that could result in a surprise out-of-network bill (if not prohibited by state law). In 15% of hospitals, the researchers reported that a patient was seen by one or more out-of-network providers in at least 80% of emergency cases.

Surprise billing is not only happening with great frequency, but the actual amount of the billing is equally problematic for Ohioans. The USC-Brookings paper provides insight on this issue "out-of-network emergency physicians charged on average about eight times what Medicare pays for the same service, while in-network contracted rates paid by commercial insurers averaged about three times what Medicare pays." These provider charges are not just exorbitant in relation to Medicare; they are charges widely agreed to have no basis in reality. They do not reflect the cost of care, but rather what a provider can demand.[2]

Even for consumers who never receive one, surprise medical bills mean higher premiums. This is important and an example from New Jersey demonstrates the impact. A 2015 analysis of out-of-network charges in New Jersey[3] shows that for the largest health plan in the state, out-of-network claims comprised 8% of their total commercial spending in 2013. If that plan had paid these out-of-network claims at 150% of Medicare rates, rather than the billed charges, the insurance plan would have paid 52% LESS for out-of-network services, amounting to savings of almost half a billion dollars ($497 million), which could have resulted in a reduction of 4.3% in total commercial claims and consumers paying 9.5% less out-of-pocket.

Surprise billing is not an issue seen across all types of providers. The problem of surprise

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

[2] https://khn.org/news/analysis-pulling-back-curtain-on-hospital-prices-adds-new-wrinkle-in-cost-control/, https://www.nytimes.com/2013/12/03/health/as-hospital-costs-soar-single-stitch-tops-500.html?module=inline, Christopher P. Tompkins (January 2006) The Precarious Pricing System For Hospital Services. *Health Affairs*, https://www.healthaffairs.org/doi/10.1377/hlthaff.25.1.45

[3] Avalere Health (2015). "An Analysis of Policy Options for Involuntary Out-of-Network Charges in New Jersey." http://avalere-health-production.s3.amazonaws.com/uploads/pdfs/1427291367_AH_Analysis_of_Policy_Options__WP_v3b2.pdf

medical bills tends to be concentrated among a select number of physicians from certain medical specialties often in certain geographic regions that are taking advantage of market dynamics where the patient has no choice in selecting the provider. These providers are likely to charge substantially more than similarly trained and qualified peers in other specialties. They are also more likely either to not accept private insurance or to require extraordinarily high reimbursement rates to participate in insurance networks. Studies have found that surprise medical bills are most likely to come from emergency medicine physicians, anesthesiologists, radiologists, and pathologists.[4]

One study documented prices from these providers as well above Medicare:

- Anesthesiologists charge, on average, 5.8 times the Medicare reimbursement rate;
- Radiologists charge, on average, 4.5 times the Medicare rate; and
- Emergency medicine physicians and pathologists charge, on average, 4 times the Medicare rate.[5]

Bottom Line: Surprise bills of this frequency and magnitude are having a significant impact on Ohioans – whether or not they personally receive one.

Solutions for Protecting Patients From Surprise Medical Bills

State legislation must protect patients from surprise medical bills. Consumers, employers, health focused business groups, unions and health plans agree surprise bills must be addressed and we've all agreed to four (4) key principles to accomplish this:[6]

First, balance billing should be banned and patients should be held harmless in situations where patients are treated by an out-of-network provider they did not select.

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

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

Second, health plans should be required to reimburse out of network providers an appropriate, reasonable, and market-based amount in these situations.

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[4] Loren Adler, Paul B. Ginsburg, Mark Hall, Erin Trish (September 25, 2018) Analyzing New Bipartisan Federal Legislation Limiting Surprise Medical Bills. Health Affairs. https://www.healthaffairs.org/do/10.1377/hblog20180924.442050/full/

[5] Bai, G., & Anderson, G. F. (2017). Variation in the Ratio of Physician Charges to Medicare Payments by Specialty and Region. JAMA, 317(3), 315

[6] See https://www.ahip.org/wp-content/uploads/Surprise-Billing-Consensus-Statement-12.10.18.pdf, https://www.ahip.org/wp-content/uploads/Hill-Sign-on-Letter-Surprise-Medical-Bills-031819-2.pdf and https://stopsurprisebillingnow.com/.

Third, states should be required to establish a resolution process that works in tandem with the established reimbursement requirement.

A dispute process, established at the state level, should be available when there is disagreement as to whether a reimbursement was paid correctly according to the market-based established rate. The process should serve as important regulatory oversight to ensure that the health plan has paid the reimbursement rate accurately –and not to allow the arbitrator to unilaterally set prices. Arbitration should not be the default or primary vehicle to determine a payment amount. It should act as the exception; not the rule.

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

For non-emergency situations or elective care, providers should be required to notify patients at their first point of contact that some of their providers providing that patient's care may be out-of-network and inform them of their right to select in-network providers or decline care. It is important that this notice is meaningful, documented and sufficiently in advance for the patient to make alternate arrangements.

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

Surprise Medical Billing Legislation Will Not Weaken Health Plan Networks

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

As a first step to eliminate surprise medical bills, we want providers and hospitals to voluntarily contract with health plans. This benefits everyone – both by advancing value-based payment arrangements and prompt claims payments.

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

This incentive is further exacerbated by the involvement of private equity-owned staffing firms. About two-thirds of U.S. hospitals outsource emergency department care to private physician-staffing companies, many of which are owned by private equity firms. Envision, EmCare and

TeamHealth are dominant players in this sector and are owned by private equity firms KKR and Blackstone Group. One study found that in the case of EmCare, out-of-network billing rates increased dramatically in the months after it took over a staffing contract and physician charges increased an average of $556, a 96% increase exposing patients to increased cost sharing and financial risk. The study found that EmCare's entrance into a hospital increased out-of-network rates by 81.5% while TeamHealth's entrance drove up rates by almost 33%.[7] As noted in a financial report on private equity opportunities in this health care sector, "Emergency medical practices are a perfect buyout target for private equity managers because demand does not decline when prices go up."[8]

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

We support legislation that creates a competitive market environment where health insurance plans and doctors can continue to actively collaborate on offering affordable, high quality care that puts patients first. If we effectively lower costs and incentivize greater network participation by ancillary physicians, Ohioans will find health care more affordable and have better access to the care they need from the other providers in their health plan's network.

Arbitration Would Increase Administrative Burdens and Health Care Costs

We have serious concerns about SB 198 that uses arbitration to determine payments to out-of-network providers. The fundamental problem with arbitration is that it enables – and may even encourage – the underlying practice of exploiting patients to continue. It creates a new forum to dispute the bill, without disincentivizing the behavior of certain physicians that refuse to participate in networks so that they may bill whatever they please. State-imposed arbitration adds costs, time expenditures, and administrative burdens that can be avoided.

A recent Congressional Budget Office score of Senate proposals to protect patients from surprise medical bills found that relying solely on a market-based benchmark would save taxpayers the most money: $25 billion over the next ten years.[9] When arbitration is part of the legislation, there are fewer savings – or even increased costs. For example, bills from the U.S. House Energy & Commerce Committee and a draft from the Senate HELP committee that rely on an initial

[7] Zach Cooper "Surprise Out-of-Network Billing by Emergency Care in the United States" Yale University, December 2018 and Congressional Letter to private equity firms, October 16, 2019.
[8] McGuireWoods, "Private Equity in Healthcare – An Updated Review of Selected Nice Investment Areas," October 7, 2019 and *Financial Times*, "US Congress examines private equity role in surging healthcare costs," October 15, 2019.
[9] https://familiesusa.org/wp-content/uploads/2019/11/CBO-Savings-for-Suprise-Billing-Legislation.pdf

benchmark with the option to dispute through arbitration save $22 billion and $20 billion, respectively. An introduced bill in the House (H.R. 3502) that closely resembles the approach in SB 198 would increase costs to the taxpayers by $15 billion over ten years and lead to higher premiums.[10] The administrative cost alone of arbitration to health insurance providers and employers is estimated to be $1 billion over 10 years. We know from experience and analysis that arbitration comes with a cost.

The experience of Texas, which we discuss below, shows how arbitration can slow down the claims process, increase administrative burden, exacerbate patient aggravation, and limit payment certainty. When Texas established an arbitration system to resolve surprise medical bill disputes, the number of complaints increased dramatically. In 2013, the Texas Department of Insurance received 43 requests for mediation. A year later that figure had increased to more than 600, with at least 8,000 complaints expected this year. By the fall of 2018, there was a backlog of more than 4,000 cases.[11] The administrative burdens associated with these proceedings – for all parties involved – take away resources that could be better focused on our shared goal of advancing high-quality, patient-centered health care for all Americans.

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

Billed charges from these specialists represent a form of price gouging. The end result will be payments that are excessively high – which in turn will increase premiums. And if health plans must continue paying these exorbitant bills – even if slightly reduced – everyone who buys health insurance will shoulder the burdensome costs resulting from this price gouging. Arbitration will not succeed in correcting this market failure; indeed, it could enshrine it into law.

Lessons to be Learned From State Legislation

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

California

In California, a state law passed in 2016 provides surprise medical billing protections and establishes reimbursement requirements for *non-emergency* services received from non-

[10] USC-Brookings Schaeffer Institute on Health Policy: Rep. Ruiz's arbitration proposal for surprise billing (H.R. 3502) would lead to much higher costs and deficits. https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/07/16/rep-ruizs-arbitration-proposal-for-surprise-billing-h-r-3502-would-lead-to-much-higher-costs-and-deficits/

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

contracting providers at contracting facilities. This law applies to both health care service plans and health insurance providers.[12]

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

The California law has encouraged health plans and health care providers to enter into mutually beneficial contracts. If the legislature chooses to implement this type of methodology to address the issue of surprise medical bills, it will allow health plans to continue to manage costs through contracting with health care providers while maintaining existing incentives for contracting providers and negotiating with new providers to join networks.

By banning surprise medical billing, protecting provider networks, and not adding new costs to the system, California represents the best current approach to protecting patients. Contrary to some public reports from provider organizations, we are not aware of health insurance providers refusing to contract with doctors or dramatically reducing reimbursement rates since the law took effect. In fact, as previously stated, the data show that health plan network participation is increasing under the California law.[13]

Texas

By contrast, existing Texas state law ties reimbursement for non-contracting providers to billed charges by requiring carriers to pay the providers' usual and customary charges. To understand the impact of this approach, we note that in Texas billed charges at the 80th percentile of FAIR Health data (usual and customary rates) for a high severity emergency department visit total $1,902. This represents a payment of 3.94 times the average negotiated rate (allowed amounts by health plans) of $483. This outcome demonstrates that linking payments for out-of-network services to unjustified provider-set charges will lead to significantly greater out-of-network charges meaning higher costs for patients. In Texas**,** it is also challenging the stability of provider networks where 65% of ER physician spending is out of network, substantially higher than all other physician specialties.[14]

Not only has this system led to higher costs, it has also done nothing to tamp down surprise billing. In fact, Texas currently has the highest rates of surprise medical billing in the country

[12] Health care service plans are those entities regulated by the California Department of Managed Health Care and include all HMO plans, plus some PPO and EPO plans. Health insurers are those entities regulated by the California Department of Insurance and include some PPO and EPO plans.

[13] https://www.ajmc.com/contributor/america's-health-insurance-plans/2019/08/can-we-stop-surprise-medical-bills-and-strengthen-provider-networks-california-did

[14] TAHP, Out of Network Claims Survey, IBID.

and some of the lowest network participation by ancillary providers despite robust and stringent network adequacy requirements for plans. Put simply, the perverse incentives to remain out of network were exacerbated by the 2013 Texas surprise billing law.

Recognizing the dire need to address the market failure in the state, the Texas legislature has approved legislation to standardize consumer protections across state-regulated health plans and remove patients from billing disputes. This bill, which was signed into law on June 4, 2019, and takes effect immediately, would prohibit surprise medical billing by providers of emergency services and certain facility-based services, require carriers to reimburse providers the usual and customary rate, and transform the existing mediation system into an arbitration program between the provider and insurer only. While we appreciate that patients will be taken out of the middle, the new law will do nothing to address the perverse provider incentives to remain out of network or to lower costs for consumers.

New York

In New York, state law provides for a "baseball style" dispute resolution process whereby providers submit a rate for consideration and health insurance providers submit their own reimbursement rate.[15] Whichever submission the mediator finds more reasonable is determined to be the reimbursement amount for the disputed claim. The New York State system relies on a practicing physician to serve as mediator, which adds an inherent level of bias into the process. Additionally, unjustified provider-set charges are required to be a consideration in the arbiter's determination which is similar to the approach in SB 198.

Costs in the New York dispute resolution system can be significant, with standard claims disputes filing fees costing plans, anecdotally, between $500-800 to resolve. For many arbitration systems, the filing fee in a two-party dispute is $1,500 per party, as identified by JAMS, a leading third-party mediation and arbitration firm, which represents a typical market rate for such services.[16] These fees do not include additional in-house or outside counsel or other costs involved in arbitration. Plans are required to factor these administrative costs into premiums, which has a direct impact on consumers and their ability to access affordable coverage.

While initial reports from the New York state government showed that costs may have declined from their egregious highs, an analysis from October of this year found that New York's surprise billing law increased costs in the state.[17] The New York law, like that in Texas, directs arbiters to look at the 80th percentile of billed charges to determine what a health plan must pay. This has resulted in arbitration decisions averaging 8 percent above the 80th percentile of billed charges. As a result, costs were unsustainably high.[18] And then the law meant to protect consumers

[15] Experience with New York's arbitration process for surprise out-of-network bills, https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/10/24/experience-with-new-yorks-arbitration-process-for-surprise-out-of-network-bills/

[16] Arbitration Schedule of Fees and Costs. JAMS. https://www.jamsadr.com/arbitration-fees

[17] Experience with New York's arbitration process for surprise out-of-network bills https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/10/24/experience-with-new-yorks-arbitration-process-for-surprise-out-of-network-bills/

[18] An Unwelcome Surprise, How New Yorkers Are Getting Stuck with Unexpected Medical Bills

actually increased costs to New Yorkers. To impose this type of arbitration based on billed charges would increase costs in other states that do not currently mandate that health insurance providers pay billed charges for out-of-network care.

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

Reports from the implementation of the California law which includes a benchmark payment rate is that network participation is increasing – 16% across all providers types, and as much as 26% for specialties like radiology,[19] while rates of surprise billing are decreasing. The opposite is true in states like Texas that previously enacted policies to require payments of billed charges and have proven to undermine network value. The California approach is working for consumers. The Texas approach is not.[20]

Looking at the different approaches taken in these states, we know what works for patients and taxpayers. We urge the committee to pursue a California-style solution, such as HB 388, that protects patients and consumers with common sense rules that do not undermine health care networks, do not lead to higher cost-sharing or premiums, and help increase access to affordable coverage options.

Federal Surprise Billing Efforts

Ohio legislation would impact the approximate 1.8 million Ohioans enrolled in the fully insured market in Ohio (individual, small group and large group).[21] Federal legislation is needed to protect the 2.4 million Ohioans that receive coverage through a self-funded group health plan which is regulated by the United States Department of Labor.[22] Should Congress pass legislation to prohibit surprise medical bills, those protections and the payment standard Congress sets, would apply to self-funded health plans in Ohio. While the nuances of potential federal legislation vary, any bill would allow states that have passed their own protections to continue to apply those to fully-insured health plans. Otherwise, in a scenario where Congress passes a law, the federal scheme would apply to all plans within a state. In order to ensure all Ohioans are protected from surprise medical bills, federal legislation will be required, and AHIP continues to work towards that goal.

Conclusion

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from Out-of-Network Providers, March 7, 2012, http://www.statecoverage.org/files/NY-Unexpected_Medical_Bills-march_7_2012.pdf

[19] *Can We Stop Surprise Medical Bills AND Strengthen Provider Networks? California Did.* American Journal of Managed Care (August 22, 2019). https://www.ajmc.com/contributor/america's-health-insurance-plans/2019/08/can-we-stop-surprise-medical-bills-and-strengthen-provider-networks-california-did

[20] Texas Association of Health Plans Out of Network Claims Survey, February 2019. Available at: https://cdn.ymaws.com/www.tahp.org/resource/collection/16E3C8B1-6C50-4F6D-8C23-EA29F4AE4818/Texas_Findings_OOn_Claims__Final_2-15-19-compressed.pdf

[21] AHIP State Data Book, Ohio. https://www.ahip.org/wp-content/uploads/Ohio_StateDataBook_2019.pdf

[22] AIS's Directory of Health Plans: Data is as of the first quarter of 2017.

Thank you for this opportunity to testify. AHIP and our member health plans appreciate the committee's commitment to finding solutions to surprise medical bills that will ensure quality care and lower costs for everyone. AHIP is ready to work with the Committee to alleviate the financial burdens imposed on consumers by surprise medical bills and make health care more affordable. By working together and putting the best interests of consumers first, we can strengthen our health care system and reduce costs for all Ohioans.