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House Committee on Ways and Means

Hearing on "Reduced Care for Patients: Fallout from Flawed Implementation of Surprise Medical Billing Protections"

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Chairman Smith, Ranking Member Neal, and members of the Committee, thank you for the opportunity to testify during today's hearing, entitled "Reduced Care for Patients: Fallout from Flawed Implementation of Surprise Medical Billing Protections."

My name is Seth Bleier, MD, FACEP, and I am a board-certified emergency physician from Raleigh, North Carolina. I currently serve as the Vice President of Finance for Wake Emergency Physicians, PA (WEPPA), I am also a member and fellow of the American College of Emergency Physicians (ACEP) which represents nearly 40,000 members, and a member of the North Carolina College of Emergency Physicians. On behalf of our practice and the emergency medicine specialty as a whole, we appreciate the Committee's ongoing commitment to ensuring the No Surprises Act is implemented fairly and according to congressional intent.

Wake Emergency Physicians, PA is an emergency medicine practice serving central North Carolina. Since our founding in 1992, we have always been physician-owned, and have never had any corporate or private equity backing or interests. Every owner regularly works in our emergency departments. WEPPA currently employs more than 200 dedicated emergency medicine specialists, comprised of about 120 residency trained, board certified emergency physicians and 95 advanced practice providers. We serve in 11 different emergency departments across four different hospital systems in the region. Four of those emergency departments are located in rural communities. Our providers care for more than 450,000 patients every year. Our goal is and has always been to be in-network with every payer, and until the first regulations for the NSA were issued, we were in-network with all four major insurance carriers in our region of the state.

To be clear, the No Surprises Act is a critical bipartisan accomplishment that removes patients from the middle of billing disputes between physicians and insurers, and we strongly supported this goal. In an emergency where seconds and minutes are often a matter of life or death, patients should never have to think about their insurance coverage or whether they will receive a bill they did not expect.

Beyond these important patient protections, the law established an equitable solution to resolve billing disagreements - at least in intent. Unfortunately, the implementation of the law to date has proven to be exceptionally challenging for smaller practices like ours. While we have so far

been able to weather some of the impacts, if these challenges are not resolved, we are deeply concerned that practice models like ours may not be viable in the near future, and access to lifesaving emergency care may be severely affected, especially for rural and underserved patients.

As noted above, WEPPA had historically been in-network with all major carriers in our region of North Carolina. Most of those contracts had been in place for at least a decade without any changes or updates. Not only did our reimbursement rates not increase, they have actually significantly decreased due to factors such as inflation not being included in the contracts, as well as an increased patient burden due to high deductibles without the ability to pay.

In November 2021, WEPPA and many other physician groups in the state received letters from one of these insurers demanding significant cuts to our contract rates. The letters explicitly cited the Interim Final Rule on the NSA as justification for the reduction, and stated that if we did not agree to these new payment terms, our contract would be terminated. Thankfully this did not come to pass, but we have since had two other payers unilaterally terminate a long-standing contract. These insurers are now paying at rates that are up to 70 percent less than our previous contracts for what are now out of network services. These actions have pushed about 9 to 10 percent of our total patients out of network.

Our practice is a critical safety net for a substantial portion of our patients and for our communities. Approximately 44 percent of our patients are either uninsured or covered by Medicaid, which pays far less than the cost of care. 26 percent of our patients are covered by Medicare or TRICARE, and the remaining 30 percent are covered by commercial insurance. While these newly out-of-network patients only represent about 9 to 10 percent of our total patient population, it represents about **one-third** of our total commercial population and is a significant reduction in our practice's reimbursements.

Adding to this burden is the fact that the IDR process has been virtually inaccessible for small practices once we are out of network. Many smaller practices have been advised by their billing contractors to avoid going through IDR altogether as the costs outweigh any benefit. Most emergency department provider bills are less than $1,000. We cannot afford to challenge every underpayment when just the non-refundable portion of the arbitration fee is $50, much less $350. Even though the government's own statistics show providers prevail the majority of the time over insurers in IDR, to date we have only submitted about 200 IDR claims. Batching rules, the IDR processing backlog, and delay tactics by payers (for example, failing to abide by the arbitrators ruling and promptly remitting payment for cases won by the provider group, as has happened to WEPPA, or in some cases, not paying at all) have also contributed to this substantial burden. Now that at least some of these issues have been resolved due to recent court decisions and the resulting pending regulatory changes, we do hope to reengage with the IDR process when the portal reopens.

This increased focus on our collections and the rates being paid by insurers takes up valuable provider and staff time as well as resources that we would rather devote to patient care. We would rather not be forced to submit IDR claims. We WANT to go back to being in-network with every payer and our long-lasting contracts in place prior to passage of the NSA show that we always did our best to be in network. If these conditions persist, we may be forced to confront a financial reality where we must reduce salaries, reduce physician and advanced practice provider staffing hours, cut positions, or make difficult decisions about what areas we can realistically serve. The current climate not only threatens our ability to provide "everyday" emergency care, but it also significantly diminishes our readiness for a major disaster, mass casualty event, pandemic, or other significant event.

Frequently throughout the surprise billing debate at the federal level, emergency physicians as a profession were vilified by erroneous assertions that they purposely stay out of network so that they can charge higher rates. But our group and countless others are evidence of local, community-based emergency department (ED) practice groups who have been (or were) in long-term, stable contracts with the major insurers, and who would continue to be in network were it not for the regulatory implementation of the No Surprises Act – particularly the continued efforts to establish an artificially-low payment standard via the Qualifying Payment Amount (QPA).

Emergency physicians provide care under circumstances and laws that are unique among other physician and provider specialties. We provide more uncompensated care than any other physicians, as the federal Emergency Medical Treatment and Labor Act (EMTALA) requires that anyone coming to an emergency department must be stabilized and treated, regardless of their insurance status or ability to pay. The burden of uncompensated care only continues to grow, particularly in communities with high populations of uninsured patients. Additionally, in order to ensure 24/7/365 access to the emergency department, we work under stricter staffing and standby requirements than other types of medical providers so that we can meet the needs of patients who experience a wide range of emergencies every day, such as heart attacks, strokes, trauma, and mental health conditions, or as we have all experienced over the course of the last several years, the ravages of the global COVID-19 pandemic.

Those who support the approach that has been taken to date in implementing the No Surprises Act have suggested that cutting reimbursements to physicians and providers will enable insurers to lower premiums, allowing for more affordable and accessible coverage for Americans. Yet there is nothing in the law, or in its regulatory implementation, to ensure that happens. Several of our contracts were in place for a decade without any sort of increase to the negotiated reimbursement rates. If rising costs were "forcing" insurers to raise premiums year-over-year, it was not due to our contracts. In the meantime, insurers continue to see record profits, in no small part due to lower health care utilization during the height of the COVID-19 pandemic. Premiums for employer-sponsored family health coverage continue to grow, averaging $22,463 in 2022 and representing a 20 percent increase since 2017.[1] Meanwhile, UnitedHealth Group posted nearly $5 *billion* in quarterly profit in the final quarter of 2022, and more than $20 billion total over the

[1] https://www.kff.org/report-section/ehbs-2022-section-1-cost-of-health-insurance/

year – a more than 16 percent increase from 2021.[2] We remain skeptical that any savings, borne on the backs of providers under the implementation of the law to date, will ever be passed on to consumers.

Emergency departments throughout the country are already under immense strain due to the ongoing ED "boarding" crisis, where patients must wait hours, days, and even *months* for care or to be transferred to the appropriate setting they need and deserve. This has exacerbated physician stress and burnout – a persistent, pervasive issue for emergency physicians who consistently report the highest rates of burnout among any physician specialty (65 percent in 2021).[3] Continued cuts of this magnitude combined with growing frustrations in our attempts to negotiate in good faith for reasonable and fair contracts will have ripple effects throughout our practice, throughout the health care system in North Carolina, and throughout our country.

There is no doubt that these effects will be felt even more deeply in our rural and underserved communities, where the health care safety net is already under threat. Many emergency physician practices will be unable to afford to continue to operate in the areas where patients need them most, and millions of your constituents will have less access to the lifesaving emergency care they need and deserve. The growing trends of health care consolidation will only accelerate as practices are unable to endure the weight of these economic pressures.

WEPPA is only one practice, but sadly we know our experience is not unique. We believe the No Surprises Act clearly struck a delicate balance as to not tip the scales too far in favor of any party, but the regulations have not been consistent with the law that Congress passed. Thank you once again for your attention to these issues and for the opportunity to be here to share our experience. I look forward to any questions you may have.

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[2] https://www.fiercehealthcare.com/content/which-payer-raked-most-cash-last-year-answer-likely-wont-surprise-you

[3] https://www.prnewswire.com/news-releases/medscape-physician-burnout-and-depression-report-burnout-worsening-depression-increasing-301732504.html