

**Testimony for the Record  
Submitted to the  
House Committee on Ways and Means  
For the Hearing  
“Reduced Care for Patients: Fallout from Flawed Implementation of Surprise Medical  
Billing Protections”**

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**About Wellstar**

Wellstar Health System is a not-for-profit, community-based health system, serving more than 1.5 million Georgians. Wellstar operates 11 hospitals, 9 emergency departments, 9 cancer centers and more than 300 medical office locations. Wellstar operates 6 of the top 20 busiest emergency departments in Georgia and operates Georgia’s largest trauma network. We employ over 30,000 team members and have over 3,000 physicians on our medical staff. We provide more uncompensated care than any other provider in Georgia – totaling nearly \$1 billion last fiscal year alone.

We are also expanding and investing in robust efforts to train and educate the next generation of healthcare providers. Examples include: our Graduate Medical Education program, our nursing school at Kennesaw State University, our relationship with Augusta University and the Medical College of Georgia, and our partnership with Georgia State University. We are working with these institutions to help them grow the number of their clinical graduates.

Nearly one in every six Georgians, or over 1.5 million people from diverse communities, depends on Wellstar for care annually. As a mission-driven, non-profit system, we reinvest in the healthcare needs of the communities we serve. We provide care well beyond the walls of

Wellstar facilities and directly into our communities through unique partnerships and collaborations, including initiatives focused on combating the opioid epidemic, addressing food insecurity, behavioral health, and the maternal health crisis, to name a few.

### **Effects of the Implementation of the No Surprises Act on Wellstar**

Wellstar supports the No Surprises Act, which protects patients from surprise emergency services and certain other bills. Americans have undoubtedly benefited from the protections against surprise medical billing granted by the No Surprises Act. However, the unintended negative consequences of the way the Act has been implemented, specifically with respect to the independent dispute resolution (IDR) process, are already noticeable and have significantly disadvantaged hospitals and health systems, presenting long-term implications for patient access to care.

The U.S. District Court for the Eastern District of Texas has several times set aside certain regulations implementing the No Surprises Act. In particular, the Court ruled against the Administration's overemphasis on the qualifying payment amount (QPA) in the IDR/arbitration process, which significantly tilted the process in insurers' favor. The Court also found the methodology for calculating the QPA unlawful, as it depresses insurers' payments to hospitals and health systems. While we agree with these rulings, they are evidence of the implementation challenges hospitals and health systems face, and they do not resolve all the problems with implementation of the law.

The law was never intended to pick winners and losers. Unfortunately, the way the No Surprises Act has been implemented has done just that – and the health insurers are winning – further increasing their profits at the expense of community not-for-profit hospitals and health

systems that are facing significant financial challenges that threaten their ability to continue to meet their community needs.

The IDR rules have been written and rewritten several times and are still problematic. The process is inefficient, and the results, when there are results, are arbitrary. The lack of timely, fair and equitable determinations through the IDR process benefits the health insurers at the expense of those, like Wellstar, that provide medical care. A study conducted by the Centers for Medicare and Medicaid Services (CMS) found that a payment determination was reached in only 15 percent of cases. For Wellstar, the results have been even worse – Wellstar has 8,000 claims that we are attempting to resolve through the IDR process, and only 7 percent have been heard and closed to-date. At this rate, it will take 20 years to resolve our pending claims.

In addition to throughput issues, there are numerous other problems with the administrative processes of the Act, including:

- Batching rules that are based upon the physician reimbursement model, which effectively makes batching of hospital claims impossible,
- Bundling rules, which ignores the way hospitals are actually reimbursed and require multiple appeals for a single episode of care for a single patient,
- Inconsistent and seemingly arbitrary findings between IDR entities and within IDR entities on cases that present the same issues,
- IDR entities and payers that ignore the timelines required by the Act without consequence, while providers are required to comply, and,
- Duplication of work required by providers, causing increased administrative cost burdens.

The problems with the IDR administrative processes are not the only unintended consequences of the Act. The Act has unintentionally encouraged bad payer behavior. Now, without consequence, payers are able to sell health insurance in counties in which they have no in-network hospital emergency departments. The Act and its administrative process have allowed those insurers to receive in-network level discounts from hospitals without the need for good faith negotiations, and some take discounts below even in-network rates. The consequence for patients is that their access to high-quality healthcare will suffer. Already, health systems are forced to make difficult decisions about where and how to spend limited resources. As payors reduce reimbursement below fair and reasonable levels, those limited resources will be further challenged. A report from Gibbons Advisors indicates the number of healthcare bankruptcies increased by 84 percent from 2021 to 2022, driven by rising costs, workforce shortages, and high interest rates.<sup>1</sup> Though not explicitly named, the No Surprises Act has likely contributed to this statistic.

Wellstar is directly impacted by the No Surprises Act, perhaps more than other systems, because we operate some of the busiest emergency departments in the State of Georgia in a region of a higher concentration of “narrow network” health plans. Narrow network health plans limit the choice of patients, as they only have a limited number of providers from which to choose. This is one reason that Wellstar has been relying on both hospitals’ responsibilities under the *Emergency Treatment and Active Labor Act (EMTALA)*, as well as the reimbursement policies of the No Surprises Act, to ensure access to this care.

The estimated reimbursement due to Wellstar on our requests exceeds \$40 million – funds owed to us by some of the largest health insurance companies in the country. And, despite

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<sup>1</sup> <https://gibbinsadvisors.com/healthcare-sector-bankruptcy-filings-increased-by-84-from-2021-to-2022/>

all the administrative processes tilting in insurers' favor, IDRs have found in Wellstar's favor 53 percent of the time. Unfortunately, despite determinations in favor of Wellstar, we have only been reimbursed on a timely basis for one-third of these, with insurers failing to pay what they owe for the care provided to their enrollees.

In addition, as stated above, payers are relying on the NSA to be able to sell health insurance in counties in which they have no in-network hospital emergency departments. For example, one national insurer with whom we are out-of-network reduced our reimbursement by nearly 50 percent immediately following the implementation of Federal and State surprise billing laws and indicated the cut was made because of the enactment of recent legislation. This change represented a \$50 million annual reduction in reimbursement to us. Further, another national insurer recently threatened to terminate our twenty-plus year contract unless we agreed to a 20 percent decrease in payment. This demand represented a reimbursement loss of over \$4 billion over the next ten years, at a time when our pandemic-induced cost of care has increased by over 25 percent. While we were able to resolve this matter with "only" \$1 billion in cuts over the next ten years, this emboldened behavior by insurers is not unique to Wellstar, and it is one of the reasons for the negative median health system operating margin, as reported by Standard and Poor's last month.

The \$40 million in outstanding reimbursement for these out-of-network claims represent a significant sum for a health system working in an environment nationally that has seen negative margins for the last several years and margins that typically are very low. This is an additional financial pressure that hospitals and health systems in our country can ill afford right now as they face the worst financial situation in decades.

Further, Wellstar has had to adapt to the changing administrative rules of the No Surprises Act. This is in addition to challenges from bundling and batches, which restricts what types of similar claims can be bundled for resolution.

### **Lack of Feedback Following the Review Process**

When a decision is made in the independent dispute resolution process, Wellstar receives no feedback about why they ruled the way that they did. Consequently, there is no “learning” to be had, and our teams are unable to become more effective and efficient in filing relevant claims to alleviate backlogs. In our experience, the same facts receive different outcomes from case to case.

### **Insurers Refusing to Negotiate**

Furthermore, the No Surprises Act disincentivizes health insurance companies from maintaining robust networks. By prioritizing the QPA, the details of which insurance companies don’t disclose, health insurance companies can bank more of their members’ premium dollars when claims are filed under out-of-network benefits or under the No Surprises Act.

Wellstar has seen firsthand the actions by large health insurers who refuse to negotiate with us, insist on going out of network and rely on the independent dispute resolution process. We see this as a prime example of how flawed the No Surprises Act implementation has been.

### **Summary**

The challenges that have been created by the implementation of the No Surprises Act have created financial strain that has created an environment where fewer dollars are able to be

reinvested in the communities we serve; instead, these dollars are going to some of the largest and most profitable conglomerates that exist in the United States — for-profit health insurers.