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before the
U.S. House Committee on Ways & Means
Hearing on Reduced Care for Patients: Fallout from Flawed Implementation of Surprise
Medical Billing Protections

Good morning, Chairman Smith, Ranking Member Neal, and distinguished members of the Committee. My name is Jeanette Thornton, and I am Executive Vice President for Policy & Strategy at AHIP, the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, our members 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, and access to care. AHIP is committed to improving the health and well-being of all Americans.

On behalf of AHIP and our member companies, I appreciate the opportunity to testify today on a topic of tremendous significance to American patients, consumers, health care providers, employers, labor unions, health insurance providers, and our economy. I sat at this witness table in May 2019 as this committee, and others in the House and Senate, were considering legislation to end the practice of surprise medical billing. As I said then, every American deserves affordable, high-quality coverage and care and the practice of surprise medical billing was a barrier to that goal. At that time, approximately 1 in 5 emergency department visits in the U.S. resulted in a patient receiving a surprise medical bill.¹ Additionally, each year millions of patients receiving care at hospitals or other facilities that participated in their health insurance network received a surprise medical bill because a specific health care provider who treated them was out-of-network. In many cases, patients did not actively choose that particular provider or were not aware the provider was out-of-network. Indeed, in many instances, hospital-based providers would not participate in any health plan network.

Protecting Patients

Today, the worry and uncertainty of an emergency or hospital stay resulting in the financial harm of a surprise medical bill has been greatly reduced for America's patients, thanks to the No Surprises Act. Enacted with strong bipartisan support in Congress, the No Surprises Act largely has been a success in providing peace of mind and financial security to the AHIP and health plans across the country. Much work remains to make the No Surprises Act work not only for patients, but for all health care stakeholders so that affordable, high-quality health care, especially in an emergency, is accessible for everyone. Much work also remains to achieve the promise of the No Surprises Act – lower health care costs and more in-network providers.

With that important work ahead, it is worth reflecting on how far we have come since the No Surprises Act was passed in late 2020.

¹ Pollitz K, Lopes L, Kearney A, et al. US Statistics on Surprise Medical Billing. *JAMA*.2020;323(6):498. [doi:10.1001/jama.2020.0065](https://doi.org/10.1001/jama.2020.0065)

Before the No Surprises Act, going to the emergency department or being treated at the hospital meant uncertainty and worry, not only about the procedure or health emergency, but also uncertainty and worry that your specialist or another provider would send you a bill. These costs could range from several hundred dollars to thousands or even tens of thousands of dollars.² Families across America were routinely burdened with the high costs of surprise medical bills and some were financially devastating.³

Before the No Surprises Act, a 9-year-old hiking at her summer camp could be bitten by a venomous snake, receive immediate and excellent care and be discharged from the hospital less than 24 hours later, only for her parents to receive a bill for \$143,000.⁴ Before the Act, two hours in an emergency room for a rabies shot and antibiotic after a cat bite could mean a bill of more than \$48,000,⁵ and a 27-mile air ambulance transport could result in a \$51,000 bill⁶ - just under \$1,900 per mile cost to the patient in a time of emergency. Even a routine throat swab for a cough and sore throat could mean a \$28,000 bill from an out-of-network lab.⁷

Before Congress thoughtfully acted to end the practice, billed charges – often exorbitant amounts – dominated as the payment demand for out-of-network care. Those high costs I listed are unrepresentative of the actual cost of care and bear no resemblance to either negotiated, contracted rates, or the rates paid by programs like Medicare. Health insurance providers negotiate lower payments on behalf of their members and would work to settle the out-of-network bill, aiming to protect their members from having to pay the full cost of those billed charges. Health insurers and employers would find themselves paying billed charges or amounts close to billed charges to take the patient out of the middle, which could increase health insurance premiums for everyone. The practice of surprise medical billing was not only costly for patients, but also costly for everyone, including taxpayers.⁸

What's Working

Today, patients in every state are protected from most surprise medical bills. Research conducted by AHIP last year repeatedly found that the No Surprises Act was preventing approximately 1 million claims per month from reaching consumers in the form of a surprise bill.⁹ That's 20 million claims since January of last year that did not become surprise bills. Whether or not patients realize it, the No Surprises Act is protecting them from these costly and unnecessary out-of-network bills. Today, patients are seeing lower and more predictable out-of-pocket costs when they receive out-of-network care at an in-network hospital or in an emergency, and that's because

² Office of the Assistance Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. (2001). [Evidence on Surprise Billing: Protecting Consumers with the No Surprises Act.](#)

³ American Heart Association. (2020). [Poll: Surprise medical bills pose significant financial burden.](#)

⁴ Carmen Heredia Rodriguez. Kaiser Family Foundation Health News. (2019). [Summer Bummer: A Young Camper's \\$142,938 Snakebite.](#)

⁵ Julie Appleby. Kaiser Family Foundation Health News. (2019). [Meow-ch! The \\$48,512 Cat Bite.](#)

⁶ Anna Almendrala. Kaiser Family Foundation Health News. (2019). [The Air Ambulance Billed More Than His Surgeon Did For A Lung Transplant.](#)

⁷ Richard Harris. Kaiser Family Foundation Health News. (2019). [For Her Head Cold, Insurer Coughed Up \\$25,865.](#)

⁸ Duffy, Erin, Erin Trish, Loren Adler. Brookings Institute. (2020). [Surprise medical bills increase costs for everyone, not just for the people who get them.](#)

⁹ AHIP. (2022). [New Study: No Surprises Act Protects 9 Million Americans from Surprise Medical Bills.](#)

of the Qualifying Payment Amount – or QPA – that Congress wrote into law as a centerpiece of the No Surprises Act, including as the basis for determining cost-sharing.

Operations Are Not Working as Intended

Patient protections took effect for plan years beginning January 1, 2022, just one year after the law was enacted. Less than four months later, the Administration opened the federal IDR portal to begin processing disputes for out-of-network payments. AHIP and our members have worked in good faith from the day the No Surprises Act became law to be reliable partners in implementing the many provisions of this far-reaching law. Standing up sweeping new regulations and developing the infrastructure and staffing technology required to process disputes – and to do so in just over a year – has been a daunting process filled with many challenges and lessons learned. We share many of the frustrations of other health care stakeholders and members of this committee regarding the technical aspects of implementation and dispute resolution process.

Today, it is what patients *do not* see that requires improvements if we want the No Surprises Act to protect patients for generations to come. The Independent Dispute Resolution, or IDR, process established by the No Surprises Act was meant to be a backstop – a recourse for providers and hospitals to utilize in limited instances where market rates for health care items or services may not be applicable to the circumstances of a unique case or a payment amount could not be resolved through good-faith open negotiation. For nearly 9 in 10 out-of-network claims subject to the patient protections of the No Surprises Act, the law works without issue. In 9 out of 10 claims, an initial payment is made by a health plan to a provider or hospital, typically based on the QPA, and this amount is accepted without any dispute.

Our view as Congress was debating this legislation – a view shared by employers, labor unions, patient and consumer groups – was that any proposal that would use arbitration to determine payments to out-of-network providers would be costly to the health care system and fail to address the root cause of surprise medical billing. Today, we have an arbitration process – the federal IDR process – that is costly, inefficient, and heavily weighted in favor of initiating parties.

Our goal should be a balanced IDR process that works in tandem with the other provisions of the law – including the patient protections, limits on cost-sharing, and calculation of the QPA based on negotiated, market rates – in a way that reduces health care spending. That requires the law to be implemented in a way that encourages broader participation in health plan networks while discouraging commonplace use of IDR. In the No Surprises Act, Congress placed the QPA at the center of the two pillars that make the entire Act work – limiting consumer cost sharing and establishing a process for resolving payment disputes when an initial payment was deemed insufficient. Limited use of IDR, where the payment determinations are most likely to reflect reasonable market rates for a health care item or service, is necessary for this law to achieve the intended cost savings.

Just as the overwhelming majority of surprise bills originated with a subset of health care providers or hospitals, the overwhelming majority of claims that go to IDR are from a small

subset of physician staffing and billing companies.¹⁰ One company alone is responsible for nearly 1 out of 3 non-air ambulance disputes. More than half of all the emergency and non-emergency items or services disputed under the No Surprises Act are claims from 1 of 3 companies. Just as some provider staffing firms disproportionately relied on surprise billing as a business strategy, there is a small, but active number of physician groups disproportionately using – and misusing – the IDR process:

- 17,000- the initial estimate by the Administration were of disputes initiated during the first year of IDR.¹¹
- 334,828 – the actual number of disputes initiated by a small number of physician staffing and billing firms during the first year the IDR portal was open – 14 times what was predicted.¹²
- 60% of all disputes initiated in Q4 of 2022 came from 5 states.
- For more than a third of those disputes, there were eligibility questions and tens of thousands closed after being deemed ineligible.¹³
- CMS reports that the primary cause of delays in the processing of disputes is the complexity of determining whether disputes are eligible for the federal IDR process.¹⁴

Between an overwhelming number of disputes and repeated litigation from the Texas Medical Association that has created regulatory uncertainty and repeated starts and stops, the Departments have been hindered in developing an IDR process that works.¹⁵ The IDR process should be fair to all parties, with consistent rules, transparency into decisions, and ultimately used rarely. At present, CMS estimates the IDR process overwhelmingly favors health care providers and air ambulance suppliers, with initiating parties prevailing in 71% of disputes that reached a final determination.

While use of IDR to resolve surprise bills was not our preference, AHIP has been unwavering in our commitment to taking patients out of the middle and making sure the No Surprises Act succeeds in lowering health care costs for the American people. With regulatory certainty and improvements to the federal IDR portal, we are confident the approach laid out in the No Surprises Act can work for all parties involved.

Part of our commitment to protecting patients and lowering costs through the success of the No Surprises Act is our goal of having more health care providers, particularly facility-based providers, enter into network agreements so that IDR is rarely used. The success of our business model largely depends on having large networks of high-quality, high-value health care

¹⁰ Cooper, Zack, Fiona Scott Morton, Nathan Shekita. National Bureau of Economic Research. (2018). [Surprise! Out-of-Network Billing for Emergency Care in the United States](#).

¹¹ Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55980 (October 7, 2021). <https://www.govinfo.gov/content/pkg/FR-2021-10-07/pdf/2021-21441.pdf>.

¹² Centers for Medicare and Medicaid Services. (2023). [Federal Independent Dispute Resolution Process – Status Update](#).

¹³ U.S. Departments of Health and Human Services, Labor, and the Treasury. (2022). [Partial Report on the Independent Dispute Resolution \(IDR\) Process](#).

¹⁴ Centers for Medicare and Medicaid Services. (2023). [Federal Independent Dispute Resolution Process – Status Update](#).

¹⁵ O’Neill Institute, Georgetown University. Health Care Litigation Tracker. [No Surprises Act](#).

providers. As an industry, we must be good faith partners with health care providers, which includes collegial communication and timely, accurate payments to health care providers. Timely payments require sufficient information from an IDR entity to make proper payments, for correct claims, to the right provider. Presently, in too many disputes, particularly batched disputes, IDR entities are not supplying sufficient information about payment determinations, and this has at times delayed payments. The idea that health insurance providers are intentionally withholding required payments to health care providers defies our fundamental business model. While we advocate for a regulatory structure that incentivizes network participation over IDR, when a provider is owed additional amounts after IDR, because we aim to bring more providers in-network, we have every incentive to view that provider as a potential partner and make timely payments. We have asked that IDR entities are required to furnish health plans with necessary and complete information to facilitate timely payment.

AHIP has repeatedly come to the table with recommendations for improving the federal IDR process and there are reasonable changes that can be made to the benefit of all disputing parties. We continue to believe the tri-Departments must ensure the federal IDR process is efficient, reduces ineligible claims, facilitates on-time and accurate payments, and provides direct communication that ensures unbiased IDR entities are evaluating factors in a uniform and transparent manner that aligns with Congress' intent and direction.

AHIP and our members view the No Surprises Act as an important landmark law that has already significantly and noticeably improved the lives of millions of Americans. Today, as the bipartisan law intended, patients no longer have to worry about receiving a surprise medical bill when they return home from a hospital or emergency department. We believe there is a path forward to making the open negotiation and IDR processes work as intended and, this is important, do so in a way that reduces health care spending.

Thank you for the opportunity to testify. AHIP and our members appreciate the continued bipartisan commitment to protecting patients from surprise medical billing and to lowering consumer health care costs. We remain ready to work with this Administration and Congress and future Administrations to implement the No Surprises Act and make health care more affordable. By working together and putting the best interests of patients first, we can strengthen our health care system and reduce costs for all Americans.