



Statement before the Senate Committee on Health, Education, Labor, and Pensions
On the Lower Health Care Cost Act

Testimony on the Lower Health Care Costs Act

Benedic Ippolito
Research Fellow

June 18, 2019

The American Enterprise Institute (AEI) is a nonpartisan, nonprofit, 501(c)(3) educational organization and does not take institutional positions on any issues. The views expressed in this testimony are those of the author.

Chairman Alexander, Ranking Member Murray, and Members of the Committee. Thank you for the opportunity to appear before you today to discuss the Lower Health Care Costs Act.

I want to applaud the Committee on this evidence-based and bipartisan effort. Together, the provisions in this bill would meaningfully increase competition and transparency in health care markets. If enacted, this legislation would lower insurance premiums and drug prices for consumers, and would ensure patients are no longer exposed to surprise medical bills. By lowering costs, this bill would also improve access to health care.

In this testimony, I discuss a few of the specific provisions—some of which echo those submitted to the Senate HELP committee by health policy experts at the American Enterprise Institute and the Brookings Institution at the request of Chairman Alexander.¹ Specifically, I focus on two titles of the proposed bill: ending surprise medical billing and increasing transparency in health care.

Ending Surprise Medical Bills

Surprise medical bills occur when patients are unexpectedly treated by health care providers who do not accept their insurance, but whom they could not reasonably avoid. When patients are treated by these out-of-network providers, they can be billed at “list prices,” which are typically many times higher than what any insurer would pay. Surprise medical bills are one of the most pernicious features of the modern health care market.

Unfortunately, these bills are not rare. An estimated 20 percent of emergency department visits, 50 percent ambulance rides, and even one-in-ten scheduled stays at in-network hospitals, where patients have the opportunity to do their due diligence, result in a bill from an out-of-network provider.² These rates are fairly constant across employer-sponsored plans and those purchased on the individual market.³ It is important to note that these bills are also not random. Physicians that are least likely to be actively chosen by patients, like anesthesiologists and emergency physicians, set

¹ “Cost-reducing health policies: A response to Chairman Alexander of the Senate Committee on Health, Education, Labor, and Pensions.” Henry Aaron, Joseph Antos, Loren Adler, James Capretta, Matthew Fiedler, Paul Ginsburg, Benedic Ippolito, and Alice Rivlin. May 1, 2019. <https://www.aei.org/wp-content/uploads/2019/03/cost-reducing-health-care-recommendations-antos-capretta-ippolito.pdf>

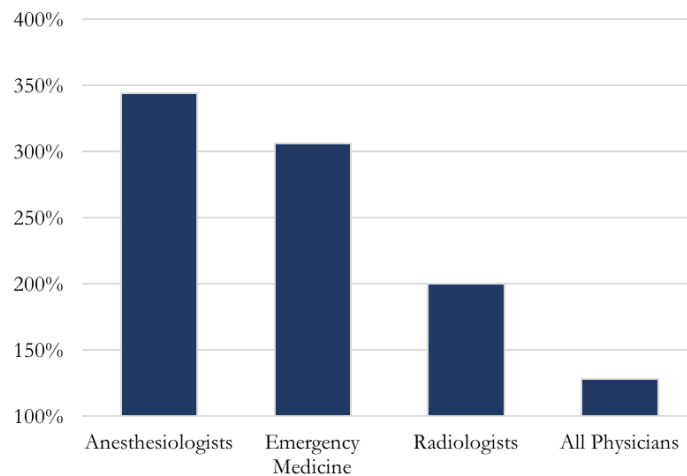
² Cooper, Zack and Fiona Scott Morton. 2016. “Out-of-Network Emergency-Physician Bills—An Unwelcome Surprise.” *New England Journal of Medicine*. 2016; 375:1915-1918. <https://www.nejm.org/doi/full/10.1056/NEJMp1608571>; Garmon, Christopher and Benjamin Chartock. 2017. “One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills.” *Health Affairs*. 36(1). <https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0970>.

³ Garmon and Chartock, 2017.

their list prices highest. Doing so increases the size of resulting surprise bills and is suggestive that physicians are behaving strategically.⁴

It is not only those consumers who receive surprise bills that are affected by this phenomenon. Because some health care providers can implicitly threaten to engage in this kind of behavior, they will only agree to join insurance networks if in-network payments are very generous. Because of this, the physicians with the greatest ability to surprise bill also receive the highest in-network payment rates. Figure 1 presents data on average contracted payment rates for selected specialties relative to Medicare payment rates (these data were originally presented in Adler et al., 2019). For example, anesthesiologists and emergency physicians receive average in-network payments that are over 300 percent of Medicare reimbursement. Among all physicians, however, average payments are under 130 percent of Medicare rates. As a result, the lucrative outside option to surprise bill patients means that all commercially insured patients are left paying higher premiums.

Figure 1: Average Contracted Payment Relative to Medicare Rates



Note: Anesthesiologist comparison based on relative mean conversion factors in 2018. Emergency physician comparison based on relative mean payment rates for CPT code 99285 in 2012. For radiologists, 200% represents mean commercial payment for CT Head/Brain scans relative to the Medicare rate (CPT code 70450). All physicians comparison based on data from commercial PPO claims for one large national insurer. Source: Stead and Merrick 2018; Trish, Ginsburg, Gascue, and Joyce 2017; MedPAC 2017

⁴ Adler, Loren, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Christen Linke Young, and Erin Duffy. "State Approaches to Mitigating Surprise Out-of-Network Billing." *USC-Brookings Schaeffer Initiative for Health Policy*. February 2019. https://www.brookings.edu/wp-content/uploads/2019/02/Adler_et-al_State-Approaches-to-Mitigating-Surprise-Billing-2019.pdf

The very unpredictability which defines surprise bills is the same feature that makes it hard for markets to correct this behavior. If patients cannot reliably avoid providers who engage in such practices, they cannot send market signals to end it. Because of this market failure, targeted legislative intervention is well merited. I commend the committee for including multiple options to address this in the Lower Health Care Costs Act.

The Wisdom of the In-Network Guarantee

While all three proposals represent serious attempts to resolve this issue, adopting an in-network guarantee is the best option. It represents a straightforward and market-oriented way to stop surprise bills from occurring in the first place, rather than adjudicating them after the fact. By tasking hospitals with ensuring that physicians are in network for insured patients, market actors would need to bargain over prices themselves, rather than having those prices set by arbitration or regulation. Physicians at in-network hospitals would have two choices: come to an agreement with the insurer, or chose to be paid by the hospital. This would force the small number of bad actors to stop surprise billing patients and impose few additional burdens on the majority of providers who do not engage in this behavior.

This option (or very similar options) has received support from a wide array of health policy experts, including those at the Brookings Institution,⁵ the Center for Budget and Policy Priorities,⁶ Georgetown Law,⁷ Yale University,⁸ and my colleague James Capretta at AEI.⁹ Scholars at Brookings, who have studied surprise billing extensively, emphasized that the in-network guarantee is “the only option that would fully address the market failure that gives rise to surprise bills.”¹⁰ They go on to note that under this solution “payment for these services would be negotiated among the insurer, hospital, and clinician. This would then resemble a more typical market negotiation, rather than today’s situation where certain clinicians can leverage the threat of surprise billing patients to

⁵ Adler, Loren, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Christen Linke Young, and Erin Duffy. "State Approaches to Mitigating Surprise Out-of-Network Billing." *USC-Brookings Schaeffer Initiative for Health Policy*. February 2019.

⁶ Straw, Tara. "Lawmakers can prevent surprise medical bills, lower health costs." Center on Budget and Policy Priorities. June 11, 2019.

⁷ Ippolito, Benedic and David Hyman. "Solving surprise medical billing." *AEI Economic Perspectives*. 2019.

⁸ Cooper, Zack, Fiona Scott Morton, and Nathan Shekita. "*Surprise! Out-of-network billing for emergency care in the United States*." No. w23623. National Bureau of Economic Research, 2017.

⁹ Capretta, James. "Congress should force the medical industrial complex to end surprise bills" RealClearPolicy. May 17, 2019.

¹⁰ Adler, Loren, Matthew Fiedler, Paul Ginsburg, and Christen Linke Young. "Comments on the Lower Health Care Costs Act of 2019." *USC-Brookings Schaeffer Initiative for Health Policy*. June 5, 2019.

secure higher contracted payment rates.”¹¹ Scholars at Yale further emphasize that the resulting payments would be “generated by market forces.”¹²

Similarly, my AEI colleague, James Capretta, argues that, “if a patient goes through the trouble of ensuring the hospital and main physician (such as a surgeon) are in-network, then the entire care process should be treated as an in-network episode. That means the insurers, working with the hospitals and physicians, should be required to build networks that prevent this kind of surprise billing from ever occurring.”¹³ I agree with these assessments. This is the best way for Congress to restore normal order to this market.

As the Committee moves forward, I would suggest that they consider two possible improvements to this proposal. (Note: the following two paragraphs are largely taken from Adler, Fiedler, and Ippolito, 2019.)¹⁴

Providers and insurers could seek to skirt these requirements by setting up creative arrangements in which a facility was notionally out of network, but the facility tacitly agreed to accept a rate similar to the one it would have accepted in network and the insurer agreed to apply cost-sharing terms similar to in-network cost-sharing terms. The Senate HELP discussion draft includes some language that appears to be aimed at foreclosing this possibility, but it would be also worth considering additional safeguards. For example, a facility could be “deemed” in-network for the purposes of these provisions if it treated a large enough fraction of an insurer’s enrollees in a given geographic area.

Notably, the network matching requirements in the current Senate HELP discussion draft appears to apply more broadly to all out-of-network services at an in-network facility, not just out-of-network services delivered by emergency and ancillary clinicians. In revising the draft, consideration should be given to narrowing the requirement to exclude other categories of clinicians in cases where they meet notice and consent standards.

I want to address a few concerns that have been raised regarding this proposal. First, some suggest that this approach will transfer too much bargaining power to insurers. Under a worst-case scenario, a dominant insurer could use their leverage to drive down rates for affected physicians so

¹¹ Ibid.

¹² Cooper et al., 2017

¹³ Capretta, James. “Congress should force the medical industrial complex to end surprise bills” RealClearPolicy. May 17, 2019.

¹⁴ Adler, Loren, Matthew Fiedler, and Benedic Ippolito. “Network matching: An attractive solution to surprise billing.” *Health Affairs Blog*. May 23, 2019.

far that they would be unwilling to work. This is a concern that appears to particularly resonate in rural states where ensuring the supply of providers can be more challenging. In practice, however, I believe this is unlikely to be a problem. In order to stay open, hospitals need to ensure adequate staffing. Even under a scenario with a dominant insurer, hospitals can ensure this in two ways. One option is to “top up” the payment rates to anesthesiologists, and similarly affected physicians, to ensure they are willing to work. A more likely option is to demand that insurers guarantee reasonable market rates to these doctors as part of their broader negotiations with insurers. That is, hospitals can leverage access to their entire facility to ensure that payments to physicians remain at acceptable levels.

To the extent that rural states remain concerned about the supply of health care providers, there are a number of other steps they can take. Chief among them is ensuring that a state’s scope of practice laws support a robust supply of providers. For example, CMS requires anesthesia services to be provided by an anesthesiologist (i.e. a MD), or nurse anesthetist—but only if the nurse anesthetist is supervised by an anesthesiologist.¹⁵ However, CMS allows states to opt out of this and permits nurse anesthetists to practice independently if the governor (in consultation with the state medical board) submits a letter to CMS opting out. Opting out provides states with a way to make sure the supply of qualified providers remains robust. And number of states with substantial rural areas have done just that—these include Alaska, North Dakota, New Hampshire, Montana, Idaho, Nebraska, Kansas, and Iowa. Taking steps like these can further ensure a healthy number of providers even in rural states.

Second, some have argued that this represents an untested reform. While it is true that no state has implemented this exact proposal to resolve surprise billing, it is not the case that this type of contracting arrangement is untested. The vast majority of physicians or other health care professionals already secure payment from hospitals or insurers. Moreover, data from a large, national health insurer shows that most hospitals already effectively require that physician and hospital networks align. Indeed, most hospitals have surprise billing rates that are below 2 percent.¹⁶

Finally, I acknowledge that intervening in the contracting practices of private firms and workers should not be entered into lightly. Any such regulation must be motivated by clear evidence of a market failure and be a case where contracting reforms can restore market forces to the

¹⁵ 42 CFR § 482.52

¹⁶ Cooper, Zack, Fiona Scott Morton, and Nathan Shekita. “*Surprise! Out-of-network billing for emergency care in the United States.*” No. w23623. National Bureau of Economic Research, 2017.

situation. In this case, I believe the evidence is sufficiently compelling that this type of intervention is well supported.

Concerns with Independent Dispute Resolution

A separate option would have Congress solve this issue by having disputes over out-of-network billing be adjudicated by an arbiter. Both the insurer and provider would submit final offers to an arbiter, who would then choose which is “more reasonable.” The appeal of this option is understandable—in theory, arbiters could have flexibility to tailor resolutions to specific cases. In practice, however, arbitration effectively represents an inferior version of rate setting. The arbiter must decide what a “reasonable” price for a service is, just like any price fixer. Moreover, this process is not transparent, is unnecessarily expensive, can be unpredictable, carries the greatest risk of unintended consequence, and takes the resolution out of the hands of market actors. I believe that arbitration is not the best solution to surprise medical billing.

Some may argue, however, that this process is not opaque or uncertain since the independent dispute resolution gives some guidance to the arbiter on what to consider when adjudicating cases. If the goal is to reduce unpredictability or variability in the outcome of arbitration, however, setting a transparent benchmark payment at this same rate is a preferable option since it eliminates those concerns and costs nothing to implement.

I am not alone in my concerns about arbitration. Researchers at Yale who studied the effects of the arbitration system in New York note, “it is extremely unlikely that a regulated price of this sort will match the market price for any given transaction.”¹⁷ My colleague, James Capretta, has also warned that this approach is “likely to lead to an ever-expanding role for government rate-setting.”¹⁸ If Congress must put limits on payment rates, it should do so in the most transparent and restricted way possible.

Opportunities to go further

I encourage the Committee to consider further reforms surrounding ambulance transportation. Roughly half of all ground ambulance rides and nearly 70 percent of air ambulance rides are out of

¹⁷ Ibid.

¹⁸ Capretta, James. “Congress should force the medical industrial complex to end surprise bills” RealClearPolicy. May 17, 2019.

network.¹⁹ By its very nature, emergency transportation is an area where patients generally have limited scope for choice, making it hard for markets to solve this issue. Among other possible reforms, the Committee may consider whether federal pre-emption of state regulation of air ambulances is worth revisiting.

Improving Transparency in Health Care

I further applaud the Committee for its efforts to improve the competitiveness and transparency of health care markets. If markets are to tame health care costs, they need the data and opportunity to do just that. The provisions in this section of the bill are a bold step towards that goal.

Pro-competitive contracting reforms

Dominant health care providers make use of a number of contracting strategies to reduce potential competition. These include gag clauses, which prohibit enrollees, plan sponsors, or referring providers from seeing data on cost and quality of providers. These provisions can also prevent plan sponsors from accessing de-identified claims data for plan administration and quality improvement purposes.

I agree that denying information in this manner is anti-competitive behavior. Without information on costs and quality of services, market forces have no way of disciplining costs of the health care system. Congress is well justified in banning this type of contract. Doing so will increase transparency and introduce more downward pressure on health care costs.

The Lower Health Care Costs Act would further restrict contracting by disallowing “anti-tiering” and “anti-steering” clauses which prevent plans from incentivizing patients to see providers with lower costs or higher quality. In cases where dominant providers engage in this behavior, they can solidify their market dominance and inflate costs over time. I would, however, suggest that the Committee consider adding some caveats to this provision. In a provider market that is very competitive, these clauses are not necessarily unduly anticompetitive. If insurers can simply exclude providers who demand these kinds of clauses in their contracts, and instead direct patient volume to other providers, they would be naturally disincentivized by the market. Thus, the Committee could consider applying such bans to markets that are deemed “sufficiently consolidated” (for example, if

¹⁹ United States Government Accountability Office. March 2019. <https://www.gao.gov/assets/700/697684.pdf>

the Herfindahl-Hirschman Index, or another measure of concentration, is sufficiently high). The same considerations should apply to proposed bans on “all-or-nothing” or “most-favored-nation” contracting clauses.

Some will argue these proposed reforms would force consumers to choose narrower networks or otherwise limit choice. For example, the American Hospital Association argues that “banning so-called ‘all or nothing’ clauses could lead to even more narrow networks with fewer provider choices for patients.”²⁰ I believe this framing is misleading. Under the status quo, dominant providers can effectively force consumers to have very broad and costly plans, without any other option. Insurance plans do not reflect patient preferences, but those of the large provider. The contracting provisions in this draft would give insurers, and ultimately consumers, more choice over the kind of plan they want. If providers are confident that consumers only want the kinds of plans that result from this anti-competitive contracting behavior, then they have no reason to worry. Consumers will presumably continue to choose those very plans. If, however, consumers prefer lower cost plans, they would now have more options to choose them.

Establishing a transparency organization

I applaud the Committee’s efforts to further increase transparency by designating a nongovernmental, nonprofit entity which will use de-identified health care claims data from self-insured plans, Medicare, and participating states to help patients, providers, academic researchers, and plan sponsors better understand the cost and quality of care, and facilitate state-led initiatives to lower the cost of care. Assembling and disseminating this kind of information is crucial for addressing the long-term health care cost growth.

In 2009, Atul Gawande famously profiled the town of McAllen, Texas in the *New Yorker*.²¹ Data from Medicare had shown that the unassuming city in the south of Texas held an inauspicious title: It was one of the most expensive health care markets in the country. In 2006, Medicare spent \$15,000 per enrollee there. The national average was just half of that. McAllen was the example of health care markets gone horribly awry, and if we failed to act, “McAllen won’t be an outlier. It will be our future.” Little did Gawande know at the time, but that might have been a good thing.

²⁰ Nickels, Tom. “AHA statement on Senate HELP Committee draft legislation on health care costs.” *American Hospital Association*. May 23, 2019. <https://www.aha.org/press-releases/2019-05-23-aha-statement-senate-help-committee-draft-legislation-health-care-costs>

²¹ Gawande, Atul. “The cost conundrum: What a Texas town can teach us about health care.” *The New Yorker*. May 25, 2009. <https://www.newyorker.com/magazine/2009/06/01/the-cost-conundrum>

In the mid-2000s, data on the commercial market was extremely rare, so researchers had to rely on data from public insurers, like Medicare. Unfortunately, this led to gross mischaracterizations about U.S. health care. Only later did we learn that health care spending by commercial insurers in that same McAllen, Texas was actually pretty unremarkable. Data on private insurers from the Health Care Cost Institute shows that McAllen's commercial price level is near the national average and its use of health care is actually meaningfully lower than normal in the commercial market.²² In other words, Medicare data only told part of the story.

The federal government is tasked with regulating parts of the private market, yet much of our understanding of health care has traditionally come only from public insurers like Medicare. Ensuring a vibrant and competitive private market requires that policymakers are not flying blind. Accurate data is an important element of ensuring this is not the case.

Joint Ventures

The bill would further task the Government Accountability Office with producing a report which describes what is known about profit- and revenue-sharing relationships in the commercial health care markets. This information is important for helping researchers and policymakers better understand the nature of market dynamics in health care markets. I believe this report could be useful for future efforts to make sure health care markets retain competitive forces where possible.

²² "Healthy Marketplace Index." *Health Care Cost Institute*. <https://www.healthcostinstitute.org/research/hmi/hmi-interactive#HMI-Price-and-Use>