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Statement for the Record to:

Committee on Energy and Commerce Subcommittee on Health U.S. House of Representatives

Hearing on Surprise Medical Billing

Submitted by:

Blue Cross and Blue Shield Association

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The Blue Cross Blue Shield Association (BCBSA) is pleased to provide a statement in support of the United States House Committee on Energy and Commerce Subcommittee on Health's thoughtful efforts to address surprise medical billing.

BCBSA is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield (BCBS) companies (Plans) that collectively provide healthcare coverage for one in three Americans. For 90 years, BCBS Plans have offered quality healthcare coverage in all markets across America – serving those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare and Medicaid.

A Kaiser Family Foundation analysis found that 15 percent of patients with large employer coverage who were admitted to an inpatient hospital stay received balance bills from providers, exposing patients to significant and unanticipated costs.[1] We believe that all stakeholders, including issuers, providers and policymakers, have the same goal – to protect consumers from crippling costs when they have a reasonable expectation that they have done everything to seek care at an in-network facility. BCBS companies are invested in this goal, and BCBSA has worked hard to bring forward solutions that offer a meaningful middle ground to protect not only the individuals impacted by the bills, but all consumers. If all stakeholders come to the table ready to give a little, this is a problem that can be solved. To support this goal, we have brought forward a number of common-sense approaches in our discussions with policymakers, including:

- Support for limiting patient responsibility to in-network amounts in these scenarios, understanding that consumers have imperfect information with which to make decisions
- A proposed payment benchmark that ensures out-of-network provider payments are on par with providers who have contracted with payers and agreed to the responsibilities associated with network participation
- A recommendation that the Department of Health and Human Services (HHS) develop the calculation methodology for a reasonable payment benchmark through rulemaking so it is transparent and all stakeholders have the opportunity to inform the approach
- A willingness to consider requiring payers to pay providers directly, a key contracting incentive, in these scenarios so patients are kept out of the middle

We commend the Committee for its thoughtful and bipartisan process in addressing this complicated issue. The Committee's draft legislation will go a long way towards protecting patients from surprise medical bills, will help ensure that patients are informed and engaged and will help protect all consumers from escalating costs. Furthermore, the draft achieves the appropriate balance of incentives that will help ensure that providers are paid fairly while not enabling specific medical specialists to remain out-of-network, which has led to the challenges

[1] Kaiser Family Foundation. "Analysis: For Patients with Large Employer Coverage, About 1 in 6 Hospital Stays Includes an Out-of-Network Bill." Aug. 13, 2018. https://www.kff.org/health-costs/press-release/analysis-for-patients-with-large-employer-coverage-about-1-in-6-hospital-stays-includes-an-out-of-network-bill/

the healthcare system faces today around surprise billing. Below is our specific feedback and recommendations on the Committee's draft.

BCBSA recommendations and feedback on the *No Surprises Act* to address surprise billing

BCBSA strongly supports prohibiting balance billing for all emergency services and by providers that patients cannot reasonably choose, holding patients responsible for only the amount they would have paid in-network.

This is an essential first step to protect consumers by preventing providers from burdening them with additional costs over and above what they owe as part of their cost-sharing obligations and what the providers are already paid by health plans.

The Committee's proposed bill states that the prohibition on balance billing would apply to all out-of-network emergency services and to all out-of-network non-emergency services received at an in-network facility from "facility-based providers," which the bill defines to include anesthesiologists, radiologists, pathologists, neonatologists, assistant surgeons, hospitalists, intensivists, and any additional provider types specified by the Secretary of HHS. We recommend that the Committee also consider including non-physician providers often involved in surprise billing, such as certified nurse anesthetists (CRNAs), in the draft's list of facility-based providers that are subject to the law. Furthermore, understanding that the specific providers most associated with surprise billing may evolve over time, Congress may choose to direct the Secretary of HHS to revisit the specific provider types periodically through rulemaking.

We also support limiting patients' cost-sharing to in-network amounts for surprise bills. The purpose of in-network versus out-of-network cost-sharing is to encourage consumers to seek care with providers who plans have thoroughly vetted and have confidence in. If patients cannot be reasonably expected to know who will be providing them services, then their ability to choose is negated. Patients should not be held responsible for choices they did not actively make by paying out-of-network cost-sharing in these instances.

BCBSA also supports the Committee's proposal that patients receiving scheduled care be given written and oral notice at the time of scheduling about providers' network status and any potential charges they could be liable for if treated by an out-of-network provider.

However, we caution against the use of a consent component as it could be used as a workaround to facilitate balance billing. Furthermore, we believe that the legislation should go further in notifying patients of their rights around surprise billing. To improve transparency, we recommend that facilities be required to make sure patients are informed of their planned providers' network status when scheduling and of their rights regarding balance billing as part of their intake process. Notifying patients of their rights at intake would help inform them of their recourse should they receive a balance bill and where to turn for assistance with interpreting whether it was received in error. To be effective, a notification of rights would need to include information on what qualifies as a surprise out-of-network bill and who to contact (e.g., health plan, hospital, state agency) if the patient is balanced billed in those circumstances. A notification could include a signature of confirmation from a patient to support facilities' and oversight entities' ability to track compliance with the requirement.

BCBSA strongly supports the Committee's proposal to establish a minimum payment standard set at the median contracted (in-network) rate for the service in the geographic area where the service was delivered.

BCBSA commends the Committee's approach to establish a fair payment benchmark for surprise bills that will not increase premiums or impact access for consumers. This approach is superior to other options under consideration in Congress, such as arbitration, that could undermine health plan networks and result in higher costs for consumers over time.

A payment methodology that is simple, transparent and fair to all parties is the most meaningful way to address surprise billing and prevent unintended downstream consequences for consumers when there are disputes between payers and providers. These disputes, in many cases, are driven by forces that distort market dynamics, including inelastic demand for services, lack of transparency in obtaining services and imbalanced negotiating powers that are propelled by limitations on how hospitals contract with certain specialties, and provider consolidation. A benchmark-based payment methodology can rebalance these forces so the environment can function closer to a true market.

We also support the Committee's recommendation to rely on HHS for a determination on how to calculate the median in-network payment rate. We believe this will help address provider concerns with how payers develop contracted rates, while allowing for minimal HHS involvement and resources. The methodology would need to account for provider specialties, lines of business and geographic variation, and HHS should not be permitted to incorporate any rate-setting elements into the methodology (e.g., a calculation plus a specified percent).

Finally, we appreciate the Committee's judiciousness in not tying the payment benchmark to billed charges, relying on a third-party database or defaulting to an arbitration system for settling disputes. These approaches are problematic and will lead to greater costs to the healthcare system in the long-term. The Committee's approach to a clear federal benchmarking methodology brings competition and balance and is a more effective way to support a market-based solution to surprise billing. We urge the Committee to maintain use of the payer's median in-network rate as a fair payment benchmark and to resist using other approaches such as billed charges or arbitration.

- **Currently there is no mechanism to control what providers charge (i.e., billed charges) so charges often increase capriciously and with little transparency.** Any approach that would tie payment to a percentage of billed charges would continue to escalate over time, increasing the impact to premiums exponentially and discouraging network participation by providers. Billed charges are often out-of-sync with costs and can be significantly higher than typical network rates. Setting the benchmark by reference to billed charges creates incentives to artificially inflate billed charges with a so-called "discount" rate that remains well above costs and in-network rates and discourages network participation.

- **Arbitration adds administrative and financial costs to payers and providers, which ultimately leads to higher patient costs. It also increases uncertainty for payers, employers and providers, extends the timelines to resolve claims and adds complexity to the resolution process.** While models focused on arbitration, or dispute resolution, can somewhat rebalance negotiations in a similar way to a benchmark-based

payment, they add new layers of administrative complexity, uncertainty and cost to all entities involved (i.e., payers, providers, employers and the government entity responsible for management of the process) as well as additional complexity to, and prolongation of, the claims resolution process. Arbitration could also have the unintended impact of establishing a baseline for payment as a pattern would likely emerge in how arbiters decide cases. If that amount is too high, it could drive up costs and limit plans' ability to locally manage their networks.

- **Tying a benchmark to a third-party database reduces some of the potential gains of using a defined payment benchmark methodology, particularly around transparency and fairness to all parties.** Payers and other stakeholders have significant concerns regarding the ability and willingness of these databases to be fully transparent with their benchmarking methodologies, the quality of their data and the costs of use. These concerns are compounded by an awareness that with many, if not all, of these databases, their available data remains meaningfully incomplete, creating a potential for bias in their benchmarking.

BCBSA response to common arguments used by physicians and hospitals to turn attention away from their role in surprise billing

Using a payment benchmark to address surprise billing will address current market distortions.

Establishing a payment benchmark replicates the market rate for each individual insurer and does not rely on a government benchmark. Typically, surprise billing happens when patients access care in an emergency or from a provider in an in-network facility that the patient did not know they would need. In these non-elective situations, the patient has limited opportunity to choose his or her providers. Furthermore, due to factors such as market consolidation, these bills occur in situations where the market is not functioning effectively. It is important to correct market imbalances in these instances, and a payment benchmark would be the cleanest, least disruptive solution. However, adoption of a broader payment benchmark in specialties or situations not typically facing surprise billing would be unnecessary, and likely harmful to an already functioning market.

The recommended approach would give authority to HHS to develop the calculation methodology to promote transparency, but would *not* give HHS the authority to determine specific payment amounts. This is not rate setting or "Medicare for all."

Health plans follow state and federal network adequacy laws to ensure consumer have access to the care they need, and current enforcement of network adequacy is robust.

Most, if not all, states have extensive network adequacy laws that require insurers to maintain robust networks based on provider type and/or time and distance standards. Despite these standards and BCBS Plans' compliance with them, consumers have seen a significant uptick in surprise bills in recent years. Surprise bills existed previously, predominately in rural areas, but the number and scale have increased exponentially with little to no change in most network adequacy standards. For example, Texas is a state with some of the strictest network adequacy laws, but is also a state regularly cited for its ongoing issues with excessive surprise billing.

Therefore, arguments that blame surprise billing on network adequacy or narrow networks are unfounded.

When insurers build networks for different products, they focus on which commonly used providers (e.g., primary care, OB-GYNs) and facilities will be in-network rather than the more granular level of which providers within an in-network facility will be in-network. These networks, including narrow networks, are designed to drive consumers to the highest quality, most cost-effective facilities, not to deter access to necessary services. Furthermore, in the narrow network context, products are often designed around the inclusion of particular facilities, and are not aimed at removing specific providers from a network. This is an important distinction for surprise billing purposes, as the goals of current legislative efforts are aimed at surprise bills that are coming from out-of-network providers delivering care at *in-network* facilities. Narrow networks are not relevant to this issue, and are simply an argument made to draw attention away from fair and transparent solutions to solving the problem of surprise billing.

In fact, this point is further confirmed by research from the Commonwealth Fund that indicates that the rate of surprise billing is similar across different types of insurance products.[2] In the case of surprise billing, patients have already used their networks to identify an in-network facility, using the product as designed, regardless of whether the product utilizes a broad or narrow network. The surprise bill comes when an individual provider (or provider group) performing services within an in-network facility refuses to separately contract to be in-network with the insurers with which that hospital contracts.

The Brookings Institution also examined the relationship between network adequacy and surprise billing recently, and noted that "a network adequacy standard for facility-based clinicians would not do anything to address the market failure that leads to surprise out-of-network billing. Network adequacy regulation would strengthen the incentive for insurers to bring these providers into their networks, but surprise bills arise because of the incentives that providers (not insurers) face. Ancillary and emergency providers are guaranteed a flow of patients without regard to their network status and therefore have a lucrative opportunity to remain out-of-network that is not available to their peer physicians in other specialties. Intensifying the pressure on insurers to contract with them would not change their ability to remain out-of-network; it would simply enable them to obtain even higher rates for going in-network – their current in-network rates in relation to Medicare are already extremely high – and would continue to leave consumers exposed."[3]

Both federal and state oversight of insurer networks has been working, and will continue to be robust regardless of what solution is implemented to address surprise billing. At the federal level, the Centers for Medicare & Medicaid Services (CMS) has done nothing to weaken regulatory requirements for qualified health plans. The Affordable Care Act requires plans sold on the Exchanges to maintain a provider network that is "sufficient in numbers and types of providers, including providers that specialize in mental health and substance abuse services, to

[2] The Commonwealth Fund. "Rate of "Surprise Medical Bills" Similar for Adults Insured with Employer and Marketplace Coverage." July 6, 2016. https://www.commonwealthfund.org/chart/2016/rate-surprise-medical-bills-similar-adults-insured-employer-and-marketplace-coverage

[3] Young, Christen Linke et al. The Brookings Institution. "The relationship between network adequacy and surprise billing." May 10, 2019. https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/05/10/the-relationship-between-network-adequacy-and-surprise-billing/

assure that all services will be accessible without unreasonable delay." Recognizing that many states already have strong standards in place and others will consider the best way to improve their oversight based on the updated NAIC Model, the HHS Notice of Benefit and Payment Parameters for 2020 Final Rule indicates that CMS, in its role as Exchange administrator, would defer to state departments of insurance's (DOI) network adequacy evaluations in determining a provider network to be adequate.

While there is considerable variation in state approaches to network adequacy regulation and review, there is good reason to believe that states are, overall, conscientious regulators of provider networks. This is evidenced by:

- Several state-based exchange entities defer to their state's DOI for network adequacy determinations, so the Trump Administration's approach is not unusual.
- As of May 2017, 46 states have enacted some type of provider network adequacy laws.[4]
- States are currently implementing innovative approaches to improve provider network oversight and transparency, including California's provider network utility.
- States conduct robust oversight of their network adequacy provisions. While most health plans are able to demonstrate compliance with the requirements, in instances where a plan does not meet the standard, penalties are assessed. For example, two states assessed fines on insurance carriers for provider network problems in the last two years: Washington fined Coordinated Care (a subsidiary of Centene) $1.5 million and ordered it to stop issuing individual health insurance policies in the state because of inadequate networks; Massachusetts fined Aetna Health Insurance on concerns that their online directories mislead patients and that Aetna has not fully complied with state laws requiring insurers to cover certain substance use disorder treatment without prior authorization.

Our primary recommendation to facilitate network adequacy and encourage provider participation is that Congress include a payment benchmark that is not greater, and is preferably less, than what plans pay to in-network providers. Anything above the median in-network rate will drive providers out-of-network, eroding contracting relationships between insurers and providers, increase costs to consumers and the healthcare system as a whole and undermine efforts to provide care coordination and value-based care programs that ensure patients get the highest quality care in the right setting, at the right time and at the right price. We believe a payment methodology that is simple, transparent and fair to all parties would be the most meaningful way to address this issue given the unique environment where these surprise bills mostly occur.

Networks are core to the business of health plans, and a payment benchmark would support—not hinder—their development.

Creating a benchmark payment will not erode networks. In fact, this argument actually runs counter to a core business proposition for health plans – to develop networks in order to ensure our members have access to high-quality, cost-efficient clinicians and hospitals. Health plans develop different types of network solutions based on client needs, and these range from

[4] America's Health Insurance Plans. "Network Adequacy Requirements: Summary of State Network Adequacy Provisions. " May 22, 2017

narrow to broad types of solutions. To assert that health plans would suddenly stop contracting with certain provider specialties or put these same specialties at a competitive disadvantage because of a payment benchmark tied to a median in-network rate is inaccurate. It is important to note that the specialty types most often linked to surprise billing – emergency medicine, anesthesiology, radiology and pathology – also happen to have the highest charge amounts relative to Medicare for their services. One study[5] found that 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. Another recent study[6] highlighted that the normal price-volume tradeoff that encourages providers to contract with insurers does not apply for these specialties, since it can be *far more lucrative for them to choose to remain out-of-network*. The study found that for "emergency department physicians, patient volume is driven by patients' choice of hospital and is unlikely to be affected by the whether the physician is in-network or not; hospitalists and neonatologists face a similar dynamic, and volume is likely to be similarly insensitive to network status for facility-based ancillary physicians such as radiologists, anesthesiologists, pathologists, and assistant surgeons…thus, emergency department and ancillary physicians, as well as hospitalists, neonatologists, and ambulance companies, therefore, have a potentially lucrative out-of-network billing option that is unavailable to most providers."

Furthermore, a year after implementation of the California surprise billing law which establishes a payment benchmark of the average in-network rate, at least one health plan has seen a six percent *increase* in the percent of providers it contracts with at acute care facilities.

Addressing the accuracy of provider directories requires *both* insurers *and* providers to work together to address inconsistencies.

We agree that the inaccuracy of provider directories is an ongoing issue that needs to be addressed. We support changes to ensure provider directories are effective for consumers by ensuring the accuracy of directory data while minimizing the costs and burdens for everyone, including consumers, issuers and providers. It is important to recognize that accuracy of information in directories also requires cooperation on the part of providers to inform insurers of changes, and providers must collaborate better in this regard. Health plans want to work with the provider community to address these issues, and providers must also be held accountable for providing accurate directory information to issuers. A clear lesson learned from ongoing state and federal provider directory initiatives is that there needs to be more accountability on the part of providers to report information timely.

In addition, providers should be required to document their network status for patients when scheduling and providing services. We recommend that providers notify patients of their participation in the patient's network in writing at the time of scheduling or intake, as well as at the time of service. This is consistent with our notice recommendation for facilities, and it leverages existing and familiar touch-points between patients and providers.

[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] Adler, Loren et al. Brookings Institution. "State approaches to mitigating surprise out-of-network billing." February 19, 2019. https://www.brookings.edu/research/state-approaches-to-mitigating-surprise-out-of-network-billing/

There are solutions that are being tested to improve provider directories that are showing promise. For example, California is currently implementing a new cloud-based technology platform for providers and health plans to improve the accuracy of provider directories. California's platform hopes to improve providers' efficiency as they would update all plan information, demographics and data with contracted plans through a single portal. Providers in California will not need to send data in different formats to each plan, and they will not need to answer multiple requests from different issuers to update their data. A centralized reporting model also allows for easier streamlining across various insurance markets and programs.

A payment benchmark can help reduce the costs for some services that are well above fair market prices but will not reduce provider payments below what is paid in functioning markets.

In a 2017 study published in the Journal of the American Medical Association, researchers indicated median physician charges (i.e., billed amounts) were 2.5 times (or 250 percent) higher than what Medicare pays.[7] As noted above and reinforced here, the researchers further noted that physician charges were the highest for specialties where patients have the least ability to choose, notably the facility-based providers most commonly associated with surprise billing:[8]

- Anesthesiologists' median charge is 5.8 times (580 percent) what Medicare reimburses.
- Interventional radiologists' median charge is 4.5 times (450 percent) what Medicare reimburses.
- Emergency medicine physicians' median charge is 4.0 times (400 percent) what Medicare reimburses.
- Pathologists' median charge is 4.0 times (400 percent) what Medicare reimburses.

It is important to note that not all providers engage in surprise billing. However, the ones that do often take advantage of the lack of transparency for patients and demand even higher prices than the medians highlighted above. When New York examined its surprise billing issue in advance of enacting legislation, it found the fees charged by these providers were sometimes many times larger than what private or public insurers pay:[9]

- The average out-of-network emergency bill was 14 times (1421 percent) what Medicare reimburses.
- The average bill for radiology services was more than 33 times (3372 percent) what Medicare reimburses.

[7] Bai, Ge and Gerard F. Anderson. "Variation in the Ratio of Physician Charges to Medicare Payments by Specialty and Region." Journal of the American Medical Association. January 17, 2017. https://jamanetwork.com/journals/jama/fullarticle/2598253

[8] Bai, Ge and Gerard F. Anderson. "Variation in the Ratio of Physician Charges to Medicare Payments by Specialty and Region." Journal of the American Medical Association. January 17, 2017. https://jamanetwork.com/journals/jama/fullarticle/2598253

[9] Lawsky, Benjamin. New York State Department of Financial Services. "How New Yorkers Are Getting Stuck with Unexpected Medical Bills from Out-of-Network Providers." March 7, 2012. http://www.statecoverage.org/files/NY-Unexpected_Medical_Bills-march_7_2012.pdf

- The average bill for assistant surgeons was 21 times (2100 percent) what Medicare reimburses.

It is critical to find a fair solution to address the unchecked charges billed by these providers in order to best protect consumers. We believe the Committee's proposal would do so. Other proposals that rely on charge amounts as a basis for resolution will doubly impact consumers through higher premiums at the outset *and* higher out-of-pocket costs at point of service.

Research shows providers would be able to operate under a median in-network amount approach. In fact, commercial health plans already pay well above Medicare for many of these providers:

- Anesthesiologist are reimbursed a median amount of 344 percent of Medicare.[10]
- Emergency physicians' average contracted rates are 306 percent of Medicare.[11]
- Radiologists' average contracted rates are 200 percent of Medicare.[12]

An appropriate solution to address surprise billing, such as a payment benchmark, can help contain healthcare costs for individual patients, all consumers and taxpayers without impairing the facilities' and providers' ability to be compensated fairly or consumers' access to care.

Arbitration is not straightforward – it is a complicated and costly solution to a problem where a simpler solution is available.

New York's arbitration-based solution to surprise billing is often pointed to as a success story, but prior to legislation, the situation for consumers was dire. Between 2008 and 2011, the New York Department of Financial Services received 8,339 consumer complaints related to reimbursement for healthcare services,[13] and claims were as high as 3372 percent of Medicare. Almost any solution would have been better than the status quo. This does not mean New York's model is the best possible solution.

Arbitration, or independent dispute resolution (IDR), requires completely new infrastructure that is expensive as well as arbiters with very specific expertise which is difficult to find in many markets.

[10] American Society of Anesthesiologists. "ASA Survey Results for Commercial Fees Paid for Anesthesia Services – 2018." October 2018. https://monitor.pubs.asahq.org/article.aspx?articleid=2705479
[11] Adler, Loren et al. Brookings Institution. "State approaches to mitigating surprise out-of-network billing." February 19, 2019. https://www.brookings.edu/research/state-approaches-to-mitigating-surprise-out-of-network-billing/
[12] Adler, Loren et al. Brookings Institution. "State approaches to mitigating surprise out-of-network billing." February 19, 2019. https://www.brookings.edu/research/state-approaches-to-mitigating-surprise-out-of-network-billing/
[13] Corlette, Sabrina and Olivia Hoppe. Center on Health Insurance Reform, Georgetown University Health Policy Center. "New York's 2014 Law to Protect Consumers from Surprise Out-of-Network Bills Mostly Working as Intended: Results of a Case Study." May 2019. https://nationaldisabilitynavigator.org/wp-content/uploads/news-items/GU-CHIR_NY-Surprise-Billing_May-2019.pdf

It also does little to constrain costs. Regarding New York's model, stakeholders (including issuers) raised concerns that the process may incentivize providers to increase their charges.[14] One way this would happen is if a pattern develops where an arbiter considers a percent of charges (e.g., 80 percent) a reasonable concession on the part of providers. This could incent providers to raise their charges since they are not tied to market forces. There is existing evidence to support this possible outcome. When Major League Baseball (MLB) implemented a best-and-final offer arbitration approach to setting players' salaries, which has been the model for the IDR proposals to address surprise billing, the MLB saw players' salaries increase overtime as a result.

This becomes particularly problematic when structured with inherent bias towards providers. For example, requiring the arbiter to have clinical expertise can, on the surface, make sense, but likely translates to the arbiter having a clinical background and an implicit bias in favor of providers' concerns. Given the size of these cases, any escalation over time could have meaningful impacts on premiums for consumers.

The cost of the IDR process itself is also expensive. At least one judge who represents a District Court in Massachusetts has raised concerns on the cost of arbitration generally (i.e., not specific to healthcare), citing a $1,900 filing fee per case, a $750 care management fee and the arbiter's time. One BCBS Plan estimated that the cost of an arbiter would likely be a minimum of $1,000/hr. This would be in addition to the legal costs incurred by both entities to prepare for and be represented in these cases. In many cases, these costs could quickly exceed the cost of the bill itself and will ultimately be passed on to consumers through higher premiums and to taxpayers through federal subsidies and other consumer support mechanisms.

The use of arbitration, and subsequently the burden, will increase over time, especially if the process is extended to employer-sponsored insurance through federal action. The volume of cases going through independent dispute resolution in New York has been increasing since implementation. In 2015, there were 207 emergency service surprise bills and 36 non-emergency surprise bills that went through the process. As of 2017, the use of the process had increased 450 percent (645 and 451 cases, respectively).[15] As another example, when Texas established an arbitration system for surprise medical bills, the number of cases increased significantly - from 43 requests preceding the law to more than 600 a year later. Four years later, there was a backlog of more than 4,000 cases waiting for resolution,[16] and this backlog is expected to be even larger this year.

However, existing state laws only extend to products the states have jurisdiction over, which typically excludes self-insured products used by companies to cover employees. These plans

[14] Corlette, Sabrina and Olivia Hoppe. Center on Health Insurance Reform, Georgetown University Health Policy Center. "New York's 2014 Law to Protect Consumers from Surprise Out-of-Network Bills Mostly Working as Intended: Results of a Case Study." May 2019. https://nationaldisabilitynavigator.org/wp-content/uploads/news-items/GU-CHIR_NY-Surprise-Billing_May-2019.pdf

[15] New York State Health Foundation. "Issue Brief: New York's Efforts to Reform Surprise Medical Billing." February 2019. https://nyshealthfoundation.org/wp-content/uploads/2019/02/new-yorks-efforts-to-reform-surprise-medical-billing.pdf

[16] 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/

represent over half of all employer-sponsored coverage and a total of 100 million lives.[17] Based on the way self-insured plans are structured between insurance companies and employers, employers would often be the entity responsible for going to arbitration if a provider contests payment. This would be extremely burdensome for many small and mid-sized businesses that would not have the resources to maintain internal staff to resolve these cases but would be forced to either accept provider pricing or hire external legal support, both of which could be extremely costly.

Furthermore, arbitration would not be able to be centralized in a single entity due the nature of existing state laws and legal infrastructure. This will likely result in variation across markets, creating fragmentation and complexity for employers operating in different markets and/or areas of the country.

We believe that use of an arbitration or dispute resolution process should be intended as a *last resort* rather than simply a means to defer decision-making to a third party. A payment benchmark, as referenced above, offers a much simpler, fair, transparent and cost efficient solution.

Conclusion

BCBSA and BCBS Plans believe all patients should be protected from surprise medical bills and remain strongly committed to working with policymakers on solutions to better protect consumers while preventing unintended costs and disruptions to the healthcare system. We strongly support solutions that: protect patients from the significant financial burden tied to surprise medical bills; establish fair and transparent payment for providers that would continue to encourage them to remain in-network; and maintain high-quality networks to ensure consumers have access to high-quality, cost-efficient clinicians and hospitals.

[17] ERISA Industry Committee. “Protecting Patients from Surprise Medical Bills”. Testimony before House Ways and Means Health Subcommittee. May, 21, 2019. https://docs.house.gov/meetings/WM/WM02/20190521/109508/HHRG-116-WM02-Wstate-GelfandJ-20190521.pdf