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before
PUBLIC HEARING ON SURPRISE BALANCE BILLING
OF HEALTH INSURANCE CONSUMERS

Thank you for the opportunity to address the subject of balance billing. My presentation will cover three points:

First, under Pennsylvania law, providers have no right to collect arbitrarily-defined "charges" from consumers in the absence of explicit agreement to pay that amount. Case law is clear that providers are limited to the "usual, customary and reasonable" (UCR) amount that prevails for a given service. In instances where the provider has been paid the UCR amount by the insurer, the consumer should owe nothing further under Pennsylvania law.

Second, the refusal of emergency medicine physicians to participate in insurers' provider networks will have consequences that ripple through the health care system. With "captive clienteles" owing to their exclusive contracts to staff hospital emergency departments, these doctors have declined to negotiate fees and demand higher out-of-network payments from insurers, while balance-billing patients. With no network bonds, the ED is outside of accountable care arrangements, with no financial incentives to address complex patients' long term-needs, as happens within globally-budgeted systems. Further, as emergency physicians' compensation rises, more medical graduates will choose this track over primary care. In short, the balance billing problem is only the tip of an iceberg that threatens more expensive, less effective care in the future.

Third, although there are good models for legislation to curb balance billing, I believe voluntary, cooperative efforts by the stakeholders assembled at this hearing might be able to solve this problem short of legislation. I will conclude my remarks with suggestions for such a course of action.

My organization, Dialysis Patient Citizens (DPC), represents persons with end-stage renal disease (ESRD). We are a nationwide group, with 1,100 members in Pennsylvania. Needless to say, health insurance is very important to our population. Each year we survey our members and this past summer we posed some of the questions from the Consumers Union survey to our members. Our results were virtually identical—30 percent of commercially insured patients received a surprise bill. Of those patients, 32 percent were charged an out-of-network rate by a provider they thought was in-network. This is similar to CU's finding with regard to patients who had been to a hospital during the past two years, as would be expected since the average ESRD patient is hospitalized three times every two years.

The problem of surprise bills creates a dilemma for ESRD patients. Generally speaking, they prefer to keep their private insurance rather than switch to Medicare, as the actuarial value is richer, access to care is better, and satisfaction ratings are higher. Additionally, in the Exchange, low-income subsidies can be more generous than Medicare's. But out-of-network bills can quickly erode the financial advantages of private insurance. Our patients should not have to be ducking crossfire between physicians and insurers as they try to cope with their kidney failure.

I. Under Pennsylvania Law, Out-of-Network Physicians May Not Bill Patients for the Balance of their "Charges" When an Insurer Has Paid the Market Value of the Service

I will begin with an overview of the common law principles relating to out-of-network services. When a consumer obtains a service without an express agreement as to price, the legal of doctrine of *quantum meruit* applies. The classic example of this, as explained by Judge Richard Posner in *Confold Pacific, Inc. v. Polaris Industries, Inc.* 433 F.3d 952 (2006), is the patient who comes to the emergency room with no ability to inquire into or negotiate over prices. In such circumstances, "the plaintiff [doctor] is entitled to the market value of his services rather than to the benefit that he conferred on the defendant, which might be much greater- for example if the plaintiff physician had saved the defendant's life. The court tries to simulate a competitive market; and in such a market, price is based on the cost to the seller rather than on the subjective value to the buyer, which often is much greater."

The Pennsylvania Superior Court applied this doctrine in its decision in *Temple Univ. Hosp. v. Healthcare Management*, 832 A.2d 501 (2003). That case involved the amount that the hospital was owed by a health insurer for services rendered after the network contract between the parties expired. The hospital insisted that the insurer was liable for billed charges at its "published rates," i.e., chargemaster. But evidence at trial established that the hospital received eighty percent or more of its full published charges only six percent of the time. Further, data indicated that the hospital was paid its full published charges only one to three percent of the time, and that its full published rates represented 300% of the hospital's actual input costs.

The Superior Court explained that in the absence of agreement on price terms, Pennsylvania law "implies a quasi-contract which requires the defendant to pay to plaintiff the value of the benefit conferred," or "a reasonable fee for a health provider's services. Thus, in a situation such as this, the defendant should pay for what the services are ordinarily worth in the community. Services are worth what people ordinarily pay for them."

Since the relevant question is "what healthcare providers actually receive for those services," if a provider rarely recovers its billed charges, those charges "cannot be considered the value of the benefit conferred because that is not what people in the community ordinarily pay for medical services." The purpose of quantum meruit is to place the provider in the position he would have been in had services been delivered in the ordinary course of business, not in a "better position

than [he] would have been had the services been performed for the majority of [his] other patients."

Therefore, in instances where the insurer has tendered a usual, customary and reasonable amount, the doctor has been compensated in full. As such, there remains no lawful balance to collect from the patient. While there is no Pennsylvania law on that direct point, a Connecticut case, *Gianetti v. Riether*, has so held. It is a testament to the complexity of, and consumer confusion about, health care prices that providers are able to blatantly violate the law with impunity. How we can effectively enforce patients' rights is a subject I will turn to below.[1]

II. The Policy Goal Must Be to Bring Hospital-Based Physicians, and Particularly Emergency Medicine Physicians, Into Insurer Networks

Our policy objective must go beyond a halt to balance billing to encompass getting hospital-based physicians to join insurer networks. For consumers, the immediate necessity of this goal arises from the fact that out-of-network expenditures do not count toward their out-of-pocket maximum, thereby undermining the Affordable Care Act's limitations on medical debt. But the refusal of hospital-based physicians to participate in networks also has far-reaching consequences for the payment and delivery system reforms that many policymakers and stakeholders hope will improve the quality of care while reducing costs. This is particularly true of emergency medicine physicians.

Generally speaking, current payment and delivery system reforms are aimed at giving a group of providers accountability for the total cost of care of a population's health needs, or for the cost of an individual's episode of care. In such circumstances, providers will be more mindful of opportunities to avert a potentially avoidable hospitalization, and to use resources efficiently. In global budget models—whether a staff-model HMO, an accountable care organization, or Maryland's unique Global Budget Revenue program—providers must deliver care to covered persons within fixed financial benchmarks. Providers' incentives are to manage patients' chronic

[1] One might ask, what if the patient has signed those typical admission papers that say "I understand I am financially responsible for charges not covered by insurance"? There is no Pennsylvania case deciding this question, and case law from other states has reached differing conclusions under differing circumstances. But Pennsylvania applies the "unconscionability doctrine" to forms such as these. Several procedural and substantive aspects of providers' use of such forms militate in favor of deeming them void as unconscionable:

- The fact that patients are at the hospital because it is in their insurance network, and physicians have relied on the hospital's participation as bait to capture patients all the while knowing that they have declined to follow the hospital into the network.
- The fact that the forms' purpose is to strip the patient of her common-law right to be charged a reasonable fee.
- The exigent circumstances of emergency medical care, which do not permit price shopping or negotiation, and in which consumers sign forms under duress.

conditions through primary care and care coordination, so they aren't hospitalized; and when patients do appear at a hospital, to refrain from unnecessary resource utilization.

The emergency department is at the fulcrum of any efforts to integrate care.

According to a recent Rand Corp. study, the ED now accounts for more than one half of hospital admissions, up from only about one third of admissions in the early 1990s. While inpatient admissions overall have declined relative to U.S. population growth, there has been a 17 percent increase in admissions from the ED, offsetting the decrease in admissions from physician offices and other outpatient settings.

Meanwhile, a study recently published in the Annals of Internal Medicine indicates nearly 1 in 12 patients who visit an emergency department (ED) return to an acute care setting within 3 days, with the 30-day re-visit rate nearly 1 in 5 patients.

Yet even as there is consensus on the need to reduce avoidable hospitalizations and ED use, ED physicians increasingly position themselves outside the insurance system. Their only bonds are to the physician staffing corporations that employ them and the hospital that contracts with them—two entities that generally have financial incentives to *increase* admissions and *increase* emergency room traffic.

Beyond the monetary costs this imposes on patients and policyholders, there is an additional cost to patients with complex medical needs. Some of DPC's members are served by case management programs that insurers operate in partnership with large dialysis organizations in Pennsylvania. These programs aim to provide integrated care to ESRD patients, but the out-of-network ED physician is an unwelcome interruption to what is supposed to be a seamless continuum of care. Dialysis clinics typically have difficulty obtaining information on their patients' emergency room visits, and free-lancing physicians have even less incentive to be helpful.

Earlier this year, the Brookings Institution published three case studies of emergency departments that have improved care coordination for complex patients. What each had in common is that physicians' financial incentives were aligned to cooperate in these efforts—because the physician, or the hospital, or both, stood to lose money if patients returned to the hospital.

The sites are: Kaiser Permanente–California, where primary care, acute facilities, and insurance are integrated in a staff-model HMO; Upper Chesapeake Health in Maryland, where each hospital is held to a finite budget and extra care in the ED brings no additional revenue; and Washington State's "ER Is For Emergencies" Program, in which a threat by the Medicaid agency to put providers at risk for emergency care beyond the 3rd visit spurred reforms.

While each intervention has some unique elements, all of the programs include a high-risk care plan program, in which frequent users of the ED who generate high costs are identified and assigned case managers to follow up. Needless to say, such programs rely on referrals from and

close communication with ED physicians. But increasingly the ED physician works for a staffing corporation whose profits are threatened by such programs.

The refusal of emergency physicians to join networks has brought them higher reimbursements from insurers and led to windfall balance collections from patients. Physician compensation reports indicate that in 2004, emergency medicine doctors made 127% of what internal medicine doctors made. In 2014 they made 155%. This comes in spite of 10 years of policy initiatives, such as the Medical Home, intended to pay primary care physicians more and keep patients out of the ED. It appears that the market power of the ED doctors has more than offset those efforts. Last year, emergency medicine compensation rose by 15%, with that specialty surpassing oncology in the specialty pay rankings. If their compensation continues to rise at the same pace they will out-earn cardiologists next year.

It is difficult to imagine that this trend will not affect medical graduates' residency choices. As emergency medicine compensation rises, it takes a higher degree of altruism on the part of medical students to choose PCP training. I fear that in some rural and underserved communities, doctors will prefer doing primary care tasks in the ER where they can make twice the money. And since hospitals make more money off their facility charges in the ED than they do for an office visit to a PCP they employ, hospital-centered health systems have little incentive to replace retiring PCPs if the ED is viewed as a substitute. Indeed, the American College of Emergency Physicians recently ran a PR campaign in which they seem to suggest that emergency medicine physicians and PCPs are interchangeable. This trend augurs much higher costs and premiums if unabated.

III. Under the Supervision of the Commissioner, Insurers Should Pledge to Defend Consumers from Collection of Balance Bills.

As I've noted, Pennsylvania law caps out-of-network physician fees at the market price, so legislation is not necessary to prohibit balance billing. The first step should be a coordinated effort to enforce current law. While the Commissioner may not have jurisdiction over providers, she does have jurisdiction over insurers, and can therefore convene insurers and consumer advocates to act cooperatively. Patients pay balance bills because (1) they don't know their rights, (2) they are afraid of unpaid bills affecting their credit scores and (3) they would be unable to defend a collection lawsuit if the physician staffing company filed one. All three of these barriers can be overcome through subregulatory action by the Commissioner and cooperation by insurers. This has been done before.

Back in the 1990s, no-fault auto insurers in Michigan were involved in a similar dispute with providers over the legality of balance billing. The insurers banded together, and with the approval of the insurance commissioner, did the following: (1) advised their insureds NOT to pay the balance bill; (2) told the insureds that if they were sued by the provider, the insurer would defend them and indemnify them if they lost the suit; (3) warned the credit reporting agencies NOT to report the balance on the consumer's credit report. The providers did not file

collection suits but instead filed two class action lawsuits (one in state court, one in federal) seeking a declaratory judgment of their right to collect balances. Both suits were quickly dismissed, and the problem was resolved.

I believe the favorable case law can be leveraged to protect Pennsylvania consumers who are balance-billed by piloting an enforcement effort. I envision a collaboration in which stakeholders undertake the following activities:

- *Insurers*: commit to defending and indemnifying their insureds in the unlikely event of a physician's collection lawsuit; notify consumers of their rights on EOB forms.
- *Insurance Commissioner*: respond to consumer complaints about balance billing by telling consumers they are free to disregard bills if the insurer has paid the UCR amount (the commissioner may have to verify that insurers are using a legitimate method of determining UCR); confirm that the *Temple* holding applies to all hospital-based out-of-network providers; admonish credit reporting agencies that they must not report balance-bill debts furnished by these providers because they are inaccurate; promulgate an official EOB blurb.
- *Consumer Advocates*: coordinate activities; publicize the project; disseminate the project to other states; find consumer attorneys willing to sue under the Fair Credit Reporting Act if credit reporting agencies do not cooperate.

I would not anticipate a need for insurers to actually defend individual lawsuits. The staffing companies would need to pull physicians away from their hospital shifts to testify in court if collection cases were defended; further, these companies operate across states and could not afford the risk of "making bad law"—generating a direct unfavorable legal precedent—that could immediately force changes to their business model in other states. I believe that the simple fact of a joint announcement by the Commissioner and insurers to pursue the Michigan option, communicated to consumers on the EOB, would suffice to end balance billing in Pennsylvania. This could be done statewide, or piloted in a specific region where the problem is particularly egregious.

In the event that insurers are reluctant to make a financial guarantee, another approach would be to seek grant funding for a pilot. A non-profit consumer organization could then undertake the duty to defend any lawsuits.

We need to move toward a "norm of networkedness" in our hospitals. In addition to the steps that I've proposed, all stakeholders should apply pressure on hospitals to require network participation by their physicians. As Dr. Donald Berwick has noted, the only way our health care system can take on accountability for population health is through consumers' enrollment with an entity that assumes the role of "integrator." Today, the only entities capable of this are insurers, ideally working in full partnership with providers. We must not let hospital-based physicians stand in the way of improving population health.