February 18, 2019

Dear Senators Cassidy, Bennet, Young, Carper, Murkowski, and Hassan:

On behalf of AARP’s nearly 38 million members, thank you for the opportunity to provide data and information on surprise medical billing. With members in all 50 States, the District of Columbia, and the U.S. territories, AARP is a nonpartisan, nonprofit, nationwide organization that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

We applaud your bipartisan leadership in improving price transparency, and we greatly appreciate the productive conversations we have had with members of your staffs on the issue of price transparency and out-of-pocket costs. AARP strongly supports your effort to protect consumers from expensive surprise medical bills when they believe they are appropriately seeking care from in-network facilities or during an emergency. Cost is often a key determinate as consumers decide what care to seek, as well as where to receive it. Unfortunately, there are times when an individual makes every effort to obtain affordable care under their insurance coverage, but is surprised to receive a bill from a non-network provider whom they did not choose or were not given the opportunity to choose.

While we recognize that your data inquiry is primarily directed at insurers and providers, we believe that data illustrating the impact of surprise billing on consumers should be part of the conversation. As you refine your legislative proposal, please consider the following statistics, which highlight the true cost of surprise billing:
A 2011 survey found that while only 8% of privately insured individuals used out-of-network care, 40% of those claims involved surprise (involuntary) out-of-network claims, most of which were related to emergency care.

A 2011 study by the New York Department of Financial Services examined over 2,000 complaints involving surprise medical bills, and found the average out-of-network emergency bill was $7,006; of that, consumers had to pay an average of $3,778 out of pocket. The study also found that 90% of surprise medical bills were for non-emergency in-hospital care (i.e. anesthesiology, lab services, surgery, and radiology). For instance, out-of-network assistant surgeons, who often were called in without the patient’s knowledge, billed $13,914 on average, while insurers paid $1,794 on average. Surprise bills by out-of-network radiologists averaged $5,406, of which insurers paid an average $2,497.

According to 2013 data provided to the Texas Department of Insurance, emergency physicians often do not participate in same health plan networks as hospitals in which they work. In fact, the three Texas insurers with the largest market share reported that as much as 68% of dollars billed to the insurer was for emergency physician care at in-network hospitals submitted by out-of-network emergency physicians. Analysis of provider directories of these three insurers found that the percentage of in-network hospitals that had no in-network emergency room physicians ranged from 21% to 45%.

A 2015 Consumers Union survey found that 30% of privately insured individuals reported receiving a surprise medical bill within the previous year.

In 2016, the Commonwealth Fund found a similar rate of surprise medical bills in employer and marketplace plans – about 1 in 5 in both groups.

A 2016 study published in the New England Journal of Medicine analyzed data from a large commercial insurer and found that 22% of their in-network emergency department hospital visits included a primary physician claim from an out-of-network doctor.

A 2017 report in Health Affairs found that 20% of emergency department cases may lead to surprise bills.

A study conducted at Yale in 2018 found 15% of U.S. hospitals have extremely high out-of-network billing rates.

We also urge you to not overlook the Medicare program as you consider ways to protect consumers from surprise medical bills. Medicare has necessary and strong protections limiting balance billing and private contracting by physicians and other health professionals. These protections must be maintained and appropriately enforced in traditional Medicare and Medicare Advantage. However, there is a glaring absence of consumer protection in Medicare regarding the use of “observation status”.

Under Medicare law, patients must have an inpatient stay in a short-term acute care hospital spanning at least three consecutive days (not counting the day of discharge) in order for Medicare to pay for a subsequent stay in a skilled nursing facility (SNF). However, acute care hospitals are increasingly identifying patients as in “observation,” an outpatient designation, rather than admitting them as inpatients. These designated “outpatients” may stay for multiple days and nights in hospital beds and receive medical and nursing care, diagnostic tests,
treatments, medications, and food, just as inpatients do. However, although the care received by patients in observation status can often be similar to the medically necessary care received by inpatients, outpatients who need follow-up care do not qualify for Medicare coverage in a SNF. As a result, the Medicare beneficiary ends up financially responsible for the SNF stay, which places an unfair burden on beneficiaries – through no fault of their own – and often comes as a surprise. While the enactment of the NOTICE Act (P.L. 114-42) was a step in the right direction, it does not actually protect beneficiaries from paying possibly thousands of dollars in out-of-pocket costs from a potentially surprise medical bill. That is why we have supported the bipartisan Improving Access to Medicare Coverage Act (soon to be reintroduced) that would count the time a Medicare beneficiary spends in observation toward the three-day stay requirement for Medicare coverage of SNF care. Additionally, services delivered while under observation are billed to Medicare Part B, and involve a 20% coinsurance paid by the beneficiary. Depending on treatment and duration, a Medicare beneficiary could very likely end up paying significantly more than if they were admitted as an inpatient, and were only subject to the Part A deductible. We urge you to address this issue and consider this legislation as you aim to bring relief from surprise medical bills to individuals and their families.

Thank you, again, for leading the effort for greater health care information transparency. We appreciate the opportunity to provide feedback, and look forward to working with you to improve care and lower costs for all Americans. If you have any questions, please contact me, or have your staff contact Andrew Scholnick of our Government Affairs team at ascholnick@aarp.org or 202-434-3770.

Sincerely,

Joyce A. Rogers
Senior Vice President
Government Affairs

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