Blackstone

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Chairman Frank Pallone, Jr.
Ranking Member Greg Walden
Committee on Energy and Commerce
United States House of Representatives
Washington, D.C. 20515

Re: Blackstone's Response to the Committee's Letter of September 16, 2019

Dear Chairman Pallone and Ranking Member Walden:

Thank you for your letter dated September 16, 2019, to Stephen A. Schwarzman, Blackstone's Chairman, Chief Executive Officer, and Co-Founder. I serve as a Senior Managing Director and Head of Global Government Affairs for Blackstone, and I am responding to this letter on his behalf.

Blackstone is a trusted partner to many of the country's top institutional investors and retirement systems that represent more than 31 million pensioners across the United States—including tens of thousands in New Jersey and Oregon. I respect the importance of the Committee's inquiry into medical billing practices, and I am pleased to provide detailed information about the practices at TeamHealth, a medical services provider that Blackstone-affiliated investment funds acquired in 2017.

We are deeply proud that emergency departments run by TeamHealth provide lifesaving care to all patients regardless of their ability to pay. Indeed, for every 100 patients treated in a TeamHealth emergency department, 15 of them are uninsured and receive treatment regardless of their ability to pay. And although emergency department physicians make up only 4% of overall physicians nationwide, their medical practices represent 66% of acute care to the uninsured.[1] TeamHealth doctors and clinicians are on the front lines of emergency care, fighting for patients to ensure that everyone who seeks lifesaving care is treated.

I hope the following information aids the Committee in its inquiry and offers more insight into the critical services that TeamHealth provides across emergency departments nationwide. Most importantly, this letter makes clear that TeamHealth has and has had a longstanding policy against balance billing, ensures that patients are removed from the middle of any billing disputes

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with insurance companies, and fully supports banning surprise medical bills through federal legislation.

About TeamHealth

As a leading physician practice in the United States, TeamHealth doctors and clinicians care for roughly 29 million patients annually across the country. Through its more than 16,000 physicians and advanced practice clinicians, TeamHealth offers emergency medicine, hospital medicine, critical care, anesthesiology, orthopedic surgery, general surgery, obstetrics, ambulatory care, post-acute care, and medical call center solutions to approximately 3,100 acute and post-acute facilities and physician groups nationwide.[2] Supported by a world-class operating team and medical professionals, TeamHealth is driven by a commitment to quality and safety.

Blackstone is fully aligned with TeamHealth's stated purpose of perfecting the practice of medicine, every day, in everything it does. Blackstone's investment in TeamHealth relieves physicians of time-consuming administrative burdens, makes the emergency department more efficient, and ultimately better enables TeamHealth doctors to focus on what they do best—providing emergency care to patients in their time of greatest need. Since our acquisition in 2017, Blackstone has supported funding initiatives and investments designed to enhance TeamHealth's support of physicians and reduce the administrative burdens that take time away from direct patient care. These initiatives have included enhanced educational offerings that promote increased clinical quality and patient safety, a new system for digital employee communications, and upgraded electronic medical record systems in certain service lines. We have also invested in developing recruiting resources and technology to improve clinician staffing levels, enhanced tools and resources to identify and address clinician burnout, and a scheduling technology that optimizes the ability to ensure that the right clinicians with the right skills are available to care for patients when needed.

The TeamHealth value proposition is built on more than just operational excellence. The real value TeamHealth provides is built on its people and is demonstrated in the way TeamHealth doctors respond to profound events that significantly impact the communities it serves. On some of our country's darkest days, TeamHealth's clinical and administrative teams were on the front lines providing care to Americans in their hour of need. Consider TeamHealth's response to tragic shootings in Las Vegas and El Paso and natural disasters like Hurricanes Sandy, Harvey, and Irma. In these critical moments, TeamHealth emergency departments were some of the only access points open and available to provide the care that would ultimately save lives.

TeamHealth clinicians provide lifesaving care 24 hours a day, 7 days a week, 365 days a year. In 2018 alone, TeamHealth provided emergency medicine services for 16 million emergency department visits. TeamHealth delivers these services—as noted above—to all patients no matter their insurance or ability to pay for the care they receive. The emergency department serves as the social safety net for the most vulnerable Americans among us—especially those in rural and underserved parts of our country where care can often be scarce.

This safety net, however, is part of a fragile system that depends on the insurance industry's historical and continued willingness to sustain the cost for underfunded and uncompensated care. Uninsured, Medicare, and Medicaid visits are reimbursed at rates *below the cost of delivering care*, if they are reimbursed at all. For that reason, TeamHealth and other emergency medicine providers must rely on commercial reimbursement to off-set the underfunded and uncompensated care—especially considering those on Medicare, Medicaid, and the uninsured make up a large percentage of the overall patient population. In fact, three out of four patients who visit TeamHealth's affiliated emergency departments provide reimbursement for its services below its average cost of $153 per patient. Without a viable source of positive revenue, TeamHealth would not be able to recruit and retain the high-quality medical personnel necessary to provide the exceptional care all patients deserve.

What makes the safety net viable is that insurers pay higher reimbursement rates than the government—and are still able to make record profits. These higher rates are particularly important in rural and underserved areas, which often have a disproportionately high rate of uninsured, Medicare, and Medicaid patients—patients to whom emergency room doctors and clinicians must provide services below cost (or for no compensation). Commercial reimbursement made at a sufficient level is an existential matter for hospitals and other medical facilities in these areas, entities already under enormous financial strain. Indeed, according to a recent report by Navigant Consulting analyzing data from the Centers for Medicare & Medicaid Services, more than 110 rural hospitals have already closed since 2010, and 21% of rural hospitals today are nearly insolvent.[3] The higher reimbursement rates from insurers are crucial to ensuring that emergency departments—particularly those in rural areas, with less volume but the same 24/7 staffing needs—remain viable and adequately staffed for the millions of low-income patients who depend on them. These reimbursements do not put an undue burden on insurers in large part because they are already making record profits. As the *Wall Street Journal* reported just this week, net income for UnitedHealth Group in the most recent quarter beat analysts' expectations and rose to $3.54 billion from $3.19 billion a year ago.[4]

The arrangement between emergency medical providers and insurance companies sustains the social safety net that allows all patients to receive the emergency medical care they need. Recently, however, the insurance industry has poked holes in this safety net—seeking to reduce emergency clinician reimbursement by as much as 50%—in order to increase its soaring profits. To further this effort to reduce such reimbursement, the insurance industry is using as its vehicle federal legislation that would ban surprise medical billing—a ban that, as I explain below, TeamHealth wholeheartedly supports—with an accompanying "poison pill" that would facilitate price manipulation. This price manipulation would result in a crushing reduction in reimbursement rates and related impairment of delivery of emergency services to patients.

This effort by insurers to maximize profits at the expense of doctors and patients endangers those who rely on TeamHealth for critical care. In rural America, which already faces serious access challenges, insurers' actions could effectively shutter the only hospitals or medical practices available in those communities. And as the emergency medical delivery system continues to run the risk of collapse, it will become increasingly difficult to recruit and retain qualified emergency

medical personnel, a dire prospect that would put in jeopardy the lives of patients in the communities you represent.

Balance Billing

The balance billing (sometimes called "surprise billing") at issue here occurs when patients unexpectedly receive out-of-network care and then get a bill for the unpaid balance after their insurer arbitrarily underpays. This practice can happen in emergency care, when patients experiencing a medical emergency do not have the opportunity to research whether the closest hospital is part of their insurance network.

TeamHealth has a longstanding policy against balance billing. To start, less than 5% of care delivered by TeamHealth's 9,000 emergency medicine clinicians nationwide is provided on an out-of-network basis. Moreover, when care is out-of-network, it is often the result of insurers unilaterally canceling network agreements as part of a tactic to achieve lower prices. TeamHealth believes that any resulting disputes over reimbursement should not affect patients and remains a matter between TeamHealth and the insurers who reimburse it for its services. For this reason, TeamHealth pursues legal action against insurers, taking the patient out of the middle and requiring insurers to uphold their financial commitments to their own members. To the extent balance billing occurs from a TeamHealth facility, it is rare and unintended. Indeed, less than 0.16% of all claims result in a balance bill from TeamHealth, and these bills are an unintended byproduct of errors in processing or unclear remittances from insurers. In keeping with its policy against balance billing, TeamHealth has been working diligently to identify the precise causes of these errors and to prevent them from happening.

The Committee's letter cites a study by researchers at Yale that discusses out-of-network billing and purports to show that emergency medical providers threaten to go out-of-network—a threat the researchers claim that providers can credibly make because emergency care is not elective and therefore patient demand will remain steady irrespective of price—as a means to secure higher in-network payments.[5] This study and others like it are completely irrelevant to balance billing. Indeed, the Yale researchers themselves acknowledge that "[u]nfortunately, we do not observe whether patients were balance billed by physicians," that "[t]o our knowledge, there are no datasets with information on the balance billing of patients," and that "there is no systematic evidence on the frequency that patients are balance billed by physicians."[6] Instead, the researchers assume that out-of-network charges do, in fact, automatically result in balance bills, which is a false assumption and conflicts with TeamHealth's longstanding policy and practice of keeping patients out of the middle of disputes.

The Insurance Industry's Proposal

As Congress advances surprise medical billing legislation, the insurance industry has lobbied for a law that would increase insurers' profits by artificially suppressing reimbursement with an arbitrarily determined rate-setting approach, which is detrimental to doctors and ultimately patients. If enacted into law, the legislation would allow insurers to manipulate out-of-network reimbursement rates by having the government benchmark them to the insurers' own, unilaterally

controlled in-network reimbursement level. This rate-setting process gives insurers the ability to drive down their own median in-network rate simply by terminating providers paid above the median.

This concern is not theoretical. Just a few months ago, UnitedHealth Group notified TeamHealth that it was terminating TeamHealth contracts in 18 states, thus firing more than 5,500 emergency department clinicians (and another 1,300 providers in other specialties) from United's networks and denying United's members the right to see TeamHealth clinicians in-network. United expressly acknowledged that this decision was made in anticipation of the law's passage—because the prospective law requires United to pay only its own average in-network payment for out-of-network emergency services. As this example demonstrates, without a mechanism to establish fair, negotiated, and mutually agreed-to in-network rates, insurers have no incentive to negotiate or even contract with an emergency medical provider.

This approach to reimbursement for out-of-network care would lead to an immediate and precipitous drop in physician reimbursement rates by an estimated 15 to 20%, according to the Congressional Budget Office.[7] Such a drastic reduction in reimbursement would prove unsustainable for emergency medical physicians across the country, serving as a death-blow to America's rural hospitals and making it impossible to meet TeamHealth's legal and professional obligation to deliver high-quality medical care to every patient regardless of ability to pay. This would represent the erosion of the social safety net, and it would have dire consequences for already-vulnerable patients.

California's recent experiment with a similar approach at the state level is illustrative. The California Medical Association, which represents more than 43,000 physician members, stated that the 2017 California surprise medical billing law's rate-setting mechanism failed to incentivize contracting, thereby diminishing patient access to doctors, increasing out-of-pocket costs for consumers, and driving premiums higher statewide.[8] In light of this example and the concerns expressed above, I would urge the Committee to consider the unintended consequences that could result from an approach that fails to maintain current levels of commercial reimbursement. This approach would devastate emergency care providers and the patients they serve as well as violate the Hippocratic Oath's guiding principle—"Do No Harm."

A Better Solution

TeamHealth is part of a broad coalition of physicians across the country that fully supports banning surprise medical bills nationwide through federal legislation. From the beginning, TeamHealth, its leadership team, and Blackstone have been actively working to reach a comprehensive legislative solution that is a better alternative to the insurers' approach. This solution would prohibit balance billing, limit patient responsibility to in-network co-pays and deductibles, and, most importantly, remove patients from billing disputes between insurers and providers by creating a "baseball-style" independent dispute resolution system. Such a system would be efficient, cost-effective, and fair while removing patients from the process altogether.

This alternative approach has met with success in as many as 12 states, from New York to Texas. As even the Yale study states, the New York law, which created an independent dispute resolution process to resolve out-of-network billing disputes between physicians and insurers, "reduced out-of-network billing by 34 percent and lowered in-network [emergency department] physician payments in the state by 9 percent."[9] A large bipartisan group of lawmakers in Congress is currently advancing a bill that embodies this approach at the federal level. The Senate version of the legislation, sponsored by Senators Cassidy (R–LA) and Hassan (D–NH) and known as the STOP Surprise Medical Bills Act (S. 1531), is the product of a two-year bipartisan working group—an effort that TeamHealth has fully supported—to which Congress specifically delegated the task of finding a solution to surprise medical bills. The legislation currently has the support of 27 Senators, while the House counterpart version, the Protecting People from Surprise Medical Bills Act (H.R. 3502), currently has the support of 96 House members—high levels of bipartisan support by any measure.

These bills recognize the importance of protecting patients from surprise medical bills while preserving our fragile emergency medical delivery system. Both pieces of legislation offer a more equitable approach that safeguards the availability of high-quality care for patients and preserves the social safety net on which so many patients critically depend. It is for these reasons that TeamHealth fully supports the key principles embodied in these bills and has been working to make them into law.

I hope this information assists the Committee in its inquiry, demonstrates the critical role that TeamHealth plays in providing medical services to all patients, and makes clear that TeamHealth has and has had a longstanding policy against balance billing and fully supports banning this practice through federal legislation. Please feel free to contact me if you have any questions about this information.

Sincerely,

Wayne Berman

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[1] *See* Kristy G. Morganti et al., *The Evolving Role of Emergency Departments in the United States* at 2, RAND Corporation (2013), https://www.rand.org/pubs/research_reports/RR280.html.

[2] *See generally* https://www.teamhealthputspatientsfirst.com/.

[3] *See* David Mosley & Daniel DeBehnke, *Rural Hospital Sustainability: New Analysis Shows Worsening Situation for Rural Hospitals, Residents* at 1, Navigant Consulting (Feb. 2019), https://www.navigant.com/-/media/www/site/insights/healthcare/2019/navigant-rural-hospital-analysis-22019.pdf.

[4] *See* Anna Wilde Mathews & Dave Sebastian, *UnitedHealth Raises Profit Targets on Higher Sales*, Wall St. J. (Oct. 15, 2019), https://www.wsj.com/articles/unitedhealth-raises-profit-targets-on-higher-sales-11571135461?mod=lead_feature_below_a_pos1.

[5] *See* Zack Cooper, et al., *Surprise! Out-of-Network Billing for Emergency Care in the United States* (Nat'l Bureau of Econ. Research, Working Paper No. 23623, 2018), https://www.nber.org/papers/w23623.

[6] *Id.* at 11, 16–17.

[7] *See* Congressional Budget Office, CBO Cost Estimate for H.R. 2328 at 10 (Sept. 18, 2019), https://www.cbo.gov/system/files/2019-09/hr2328.pdf.

[8] *See* Erin L. Duffy, *Influence of Out-of-Network Payment Standards on Insurer–Provider Bargaining: California's Experience*, The American Journal of Managed Care (Aug. 2019), https://www.ajmc.com/journals/issue/2019/2019-vol25-n8/influence-of-outofnetwork-payment-standards-on-insurer-provider-bargaining-californias-experience.

[9] *See* supra note 5 at 6.