ERIC
The ERISA Industry Committee
Driven By and For Large Employers
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Dear Senators Cassidy, Bennett, Young, Carper, Murkowski, and Hassan,

Thank you for the opportunity to participate in stakeholder discussions on addressing the surprise medical billing crisis. On behalf of large employers that provide health coverage to their employees and families across the nation, The ERISA Industry Committee (ERIC) is committed to working toward proactive solutions to protect patients from unconscionable bills, while preventing efforts to entrench damaging and anticompetitive behavior by select, problematic parts of the health industry, and ensuring that unfair and unnecessary costs are not simply socialized in the form of higher premium costs for everyone.

ERIC member companies are leaders in every sector of the economy, providing health coverage to millions of families. Their innovations in health plan design and administration improve the quality and lower the cost of health care in communities across the country. ERIC members provide wellbeing programs, telehealth services, and other measures that work to improve health and avoid unnecessary care. ERIC advocates for federal and state policies to support the ability of large employers to offer affordable health coverage. ERIC represents exclusively large employers that sponsor health plans for their employees – as well as retirement and other employee benefits plans – to preserve the employer-based health care system.

The plan sponsors that ERIC represents offer primarily self-funded health insurance to their plan beneficiaries – employees, their families, and often retirees as well. ERIC members generally contract with a third-party administrator (TPA), such as a large health insurance company, and that TPA develops networks, administers claims, and negotiates reimbursement rates on behalf of the plan sponsor. However, it is the plan sponsor that ultimately pays claims, and is liable for the costs of the plan, regardless of whether those costs are covered by premiums, or exceeded, in a given year.

ERIC member companies support market-based solutions, and tend to reject policy proposals that rely on government fiat. However, it is widely accepted among free-market economists (and many others) that in the case of market failures, it is incumbent upon a functioning government to develop and enforce guardrails and structures to facilitate free and fair exchange. It is our belief that surprise medical bills are a result of market failures in the current U.S. health system, and that Congressional action is warranted and necessary.

Some of the problem is caused by the opaqueness of the current system. Patients, even those empowered with the kind of transparency tools ERIC members provide, can rarely tell how much an episode of care will cost. Worse, it can be impossible to know, prior to an episode of care, which providers will treat a patient, and whether any of those providers might be outside of one's network. Some surprise bills could potentially be curtailed simply by improving the transparency of information made available to patients. But in many cases, particularly in emergencies, information will not be enough – Congress must act affirmatively to protect patients from providers exercising monopoly power in a given market, or gaming the system to maximize reimbursement at the patient's expense.

Working with our large employer self-insured members, and in partnership with other groups representing consumers, health insurers, and employers, we developed consensus principles to address the concerns you have

identified. We encourage you to consider these principles as you craft solutions to the surprise billing crisis. Our response to this letter will align closely with the principles laid out therein.

Surprise medical billing is a problem that is isolated to very specific groups of providers. These providers eschew insurance networks, send egregious balance bills to patients, and seek to collect whatever they can either from a third party like an insurer or a plan sponsor, or directly from the patient who, as a result, may have his or her credit destroyed and/or become financially destitute.

We rank those providers in two "tiers" – Tier One includes so-called "PEAR" providers, those practicing Pathology, Emergency medicine, Anesthesiology, and Radiology. Tier Two includes ancillary medical services that have adopted the same financial strategy of eschewing networks: Ambulance and air ambulance providers, so-called "free-standing emergency rooms," and kidney dialysis companies.

We urge Congress to take action to protect patients and the entire health care system by adopting reforms to ensure that surprise (balance) bills are not sent. Specifically, we urge to you address the following situations:

- Patients who obtain care at an in-network facility and, during the course of care, fall prey to providers who practice at that facility but do not participate in the network;

- Patients who receive emergency care;

- Patients who are transferred from an in-network facility to the care of an out-of-network provider without informed consent; and

- Specific medical industries or areas of practice which have nearly monolithically adopted an out-of-network strategy charging sky high prices and extracting the maximum amount of resources out of the medical system.

We note that ERIC is a 501(c)(6) business trade association – we neither offer self-funded health insurance benefits, nor sell health insurance products. Instead, our responses will be based upon informal canvassing of ERIC members for data and robust conversations with our membership about policy concerns related to surprise billing. For scientific survey responses or statistical modelling, we recommend relying on the data provided by our third-party administrator partners.

Responses to Specific Questions for Plans (and Plan Sponsors)

What do plans currently pay for out-of-network care?

According to ERIC member companies, large employers pay existing allowable out-of-network amounts based on a percentage of Medicare. Percentages ranged based upon the service, the market, and other factors aimed at ensuring fair provider reimbursement.

Some ERIC member companies indicated that certain out-of-network payments are calculated with a specific intent of discouraging providers from simply transferring the remainder of the bill on to the patient after collecting as much as possible from the plan sponsor. Those plan sponsors indicated that these efforts were only successful when the allowable amounts were drastically higher than typical Medicare rates, with one citing 400% of Medicare as the amount required to discourage certain providers from financially devastating plan beneficiaries.

It should be noted that many ERIC member companies base in-network reimbursement on a percentage of Medicare as well. As such, the idea that basing provider reimbursement on Medicare rates will somehow lead to a single-payer system or Medicare-for-All, or that this would constitute government price-setting and intrusion upon the free market, is totally inaccurate. Indeed, the use of Medicare rates is incredibly common throughout the health care system, and nearly all providers accept these rates, or rates based upon them – whether reduced (in the case of Medicaid), increased (in the case of private employer-sponsored plans), or otherwise (as in the case of Disproportionate Share Hospital payments, etc.).

As Congress moves to eliminate surprise bills, it is critical that Congress establish a federal benchmark rate to be paid by plans and plan sponsors to providers who otherwise would have generated a surprise bill. This benchmark rate should be based upon a percentage of Medicare, or something akin to 80% of a given market's average in-network allowable amount. **The benchmark should be designed to provide a financial incentive for the provider to participate in the network. The benchmark should not be used to satisfy the full gamut of the provider's requested reimbursement** in such a way that joining a network is no longer an economically significant benefit. This is necessary to ensure that the benchmark serve as a backstop, designed not to govern private sector health care costs, but rather to bring plans, plan sponsors, and providers to the table, to encourage them to negotiate in good faith, and to lead to many more providers agreeing to be in patients' networks – thus eliminating the balance bills in the first place.

What percentage of plans' premiums are attributable to PEAR, ambulance, or lab services?

ERIC does not have data responsive to this question at this time. However, we note that PEAR (Tier 1) and Tier 2 provider bills, while perhaps not the majority of medical claims, are the vast majority of surprise medical bills. From our perspective these providers have adopted an **economic strategy** of eschewing networks, pursuing patients with demonstrably obscene medical bills, and hoping to settle with third parties (plans, plan sponsors) for some percentage of billed charges.

A successful surprise billing reform effort will not simply reroute these bills. Rather, it will change the behavior and strategy of these providers. Instead of pursuing maximum profits, these providers should be incentivized to provide the maximum value to patients and the system, and in doing so, be fairly compensated for their services. **One commonsense reform Congress should adopt to address this is that any physician or medical service provider who is practicing at, or participating in a contractual or other financial agreement with, an in-network facility, should be required to accept the in-network rates for any patient affiliated with that network, for any care at or connected to that facility.**

This single reform would eliminate the majority of surprise medical bills, at least for Tier 1, and some Tier 2 providers (such as air ambulance). It would not wholly solve the problem, but would demonstrate a reasonable and significant step forward.

Can you provide data/modeling to demonstrate the effect on premiums for the draft proposal of 125% of the allowed in-network amount?

Any legislation that requires plans and plan sponsors to pay out-of-network providers, on average, more than they pay in-network providers, will have the eventual effect of severely diminishing or completely eradicating provider networks. These networks are key to controlling costs and driving value for plan beneficiaries, and without effective networks, the employer-sponsored health insurance system will not be sustainable. Plans and plan sponsors use networks to identify the highest quality and most cost-effective providers, and to reward those providers by driving volume of patients to those practices. These network agreements save money for patients, ensure stability for providers, and are critical to the management of large health insurance plans where predictability and actuarial projections are needed to avoid dangerous cost-overruns or lack of needed provider capacity. While we defer to our colleagues in the health plan community on any economic modeling, common sense dictates that if Congress creates an economic incentive for providers to go out-of-network, that is exactly what providers will do.

It is our understanding that the goal of Congress in addressing surprise medical billing is to protect consumers, not to cause their premiums to gradually increase, their networks to gradually constrict, and eventually consign all patients to the dysfunctional individual market, where the federal government will subsidize health insurance for many more people through direct subsidies under the Affordable Care Act (ACA).

More than 181 million Americans get health insurance through their employer. Among ERIC member companies, all of whom offer high-quality health benefits to their employees, their families, and often to retirees as well, the plan sponsor often pays 75% or more of health insurance premiums, and the plans' actuarial value often exceeds 85% (essentially, between a gold and platinum plan in value). ERIC member companies want to continue to provide high quality benefits, and our plan beneficiaries want to continue receiving these benefits – not to end up on ACA exchanges. **As such, we urge you not to craft legislation that would denigrate and eventually unravel the ability of plan sponsors to construct and maintain high-quality networks.**

Describe outcomes in states using alternate dispute resolution or binding arbitration.

ERIC member companies sponsor ERISA plans that operate in many states, and are governed by federal law. Any state law that sought to dictate the terms of an ERISA plan, including provider networks, reimbursement rates, binding arbitration, etc., would be preempted by ERISA and thus invalid. As such, to date, ERIC member companies have little experience with these state laws, except for isolated cases in which a major employer offers a fully-insured plan, such as an integrated HMO offering in California for employees located in that state.

However, ERIC has viewed and analyzed data provided by representatives of fully-insured plans, and in our view, the outcomes of binding arbitration have been dire. **The main reason appears to be that these state binding arbitration rules do not have sufficient guardrails.** In order for binding arbitration to serve as a true incentive to create network agreements and avoid surprise medical bills, that arbitration needs to provide sufficient financial incentives to providers. Unfortunately, existing state laws appear to have led to many providers receiving much higher reimbursement than they would have in a network agreement by allowing arbitrators to base amounts upon the particular provider's charges, rather than reasonable benchmarks such as a percentage of Medicare, or a percentage of allowable in-network amounts in a given market.

ERIC members cannot support legislation that requires them to pay a percentage of billed charges, whether sifted through binding arbitration or not. This constitutes a clear and present danger to overall network integrity, creating an incentive for even more providers to adopt an out-of-network strategy. At this time, we believe that arbitration is unnecessary, as a benchmark backstop will alleviate the need for arbitration. However, if Congress considers arbitration as demanded by virtually all in the provider community, then we urge you to include severe guardrails to prevent arbitration from becoming a way for providers to maximize profits. This includes the need for a balanced approach as to who is required to pay for the actual costs of the arbitration.

Do you have a process for identifying when providers send balance bills?

ERIC members rely upon beneficiaries (their employees and family members) to alert the third-party administrator and/or plan sponsor when a surprise medical bill is received. After all, these bills are generated by providers and sent to the plan participant directly.

Many ERIC members have (out of necessity) developed programs or resources to help participants in the case of an identified balance bill. These could include payment assistance (wherein the plan or a designee will negotiate with the provider and attempt to agree on an amount the plan can pay, such that the provider will agree to hold the patient harmless), negotiation services that can represent the patient before the provider and attempt to reduce the bills, payment assistance programs, and more. **These programs shouldn't need to exist**. They're expensive, inefficient, and to some extent reward the providers who, for economic reasons, have chosen to eschew networks.

The goal of legislation should be to stop the balance bills from being generated and sent – not to create more streamlined ways to quickly process and pay those unreasonable and unnecessary bills. While these programs were created out of a concern for beneficiaries, in some ways they empower providers to hold patients hostage with surprise bills until the third party agrees to cover all or most of the charges.

What recommendations do you have to facilitate network adequacy and encourage provider participation in networks?

Employers, health insurers, and consumers do not believe that network adequacy is relevant to this debate or somehow a cause of surprise billing. Rather, network adequacy is one of dozens of issues (and really, demands) brought up by provider groups in order to distract from the core issue of surprise medical billing, which is that specific groups of providers are refusing to participate in networks in order to maximize their profits.

That being said, ERISA plans are not selling a product; they are attempting to provide high-quality coverage for tens of millions of Americans, to ensure they have networks capable of handling the volume and diversity of care that will be needed by beneficiaries, to ensure that care is high quality and affordable, and to provide peace of mind to employees and their families. **Applying network adequacy requirements to plans will do nothing to alleviate the problem of surprise medical billing.** In fact, all it would do is provide even more leverage to extremely concentrated market actors (such as groups of anesthesiologists or emergency physicians who have all joined together under one company, or one banner, in a given market – almost like a collective bargaining unit).

However, Congress may have a role in creating new incentives for providers to participate in at least one or two networks. While it is possible that a provider may have such a concerning record of quality and outcomes that he or she might be affirmatively excluded from many major networks, the majority of providers generating surprise medical bills have affirmatively *chosen* not to participate in networks. **For these providers, Congress should consider requiring that they participate in at least one or two of the networks most popular among the insured population in their markets, as a condition of participating in government health programs such as Medicare**.

Congress has various levers it can use to encourage providers to choose at least one or two networks. So long as providers have the option of being completely outside all networks, and so long as specific practice areas (such as PEAR) choose this as the rule, not the exception, the surprise billing problem cannot be solved.

What role should hospitals play in combatting surprise medical billing?

While hospitals are not the cause of surprise medical bills, they have a significant role to play in bringing these bills to an end. Some or all of the following changes should be undertaken in order to empower hospitals and hold them accountable, both for driving high-value care and for preventing financial devastation for their patients:

- **Require, to the greatest extent possible, that a hospital match in-network patients with in-network providers**. It won't always be possible, but when it is, hospitals should be held accountable for ensuring that, in cases when an in-network provider practices at an in-network facility, that provider should be affirmatively paired with an in-network patient.

- **Require hospitals to contract with providers in a way that ensures those providers agree to accept in-network rates when a patient in the hospital's networks is treated**. This change would eliminate a majority of surprise bills. If a provider does not wish to accept a hospital's in-network rates… there are many other hospitals in the world where that provider can practice.

    - We understand that some state laws may be obstructing the ability of hospitals to either employ physicians directly, or to negotiate network agreements with those physicians – **Congress should preempt and invalidate those laws**.

- **Ban profit-sharing agreements between in-network hospitals and out-of-network providers or staffing companies**. It has been brought to our attention that large amounts of balance bills are generated by outsourced emergency room companies, who have contracts to exclusively operate emergency rooms at for-profit hospitals. This creates a perverse incentive wherein the in-network hospital profits from in-network patients who receive obscene out-of-network emergency room surprise bills. The arrangements may be legal under current law, but they're unfair and inappropriate, and Congress should ban them.

- **Require hospitals to post, prominently, on their website information about the network status of practicing providers.** The most important information that is currently not obvious to consumers is whether all (or a large percent) of providers in a given area of practice (such as anesthesiology) who practice at the facility, do not participate in major networks. This will not likely be helpful in emergency situations, but it could at least help patients who are planning care.

- **Require that hospitals accept in-network reimbursements for patients referred by a physician who practices at, or has an ownership or profit-sharing interest in, that hospital**. ERIC member companies have reported in some cases in-network physicians referring patients to out-of-network facilities, including ones in which the doctors have ownership or profit-sharing interests. This behavior is destructive to the health care system and must be curbed.

- **Ban exclusive, profit-sharing, or kickback agreements between hospitals and ambulance or air ambulance providers**. It should never be the case that a plan beneficiary has access to an in-network mode of medical transportation, but is steered instead to another transportation provider in the profit interest of the hospital or transportation company. This includes exclusivity agreements for hospital helipads, referral agreements, or any other mode of kickback.

Is there a state model that has worked well at protecting patients?

As ERIC member companies are not subject to state insurance laws, we do not have direct experience to share. However, we applaud states that have taken efforts not to simply re-route, but instead to end balance bills. It is our understanding that aspects of both California's and Maryland's laws have been (or likely will be) successful in this regard. A successful legislative effort will create a backstop that serves to bring providers and payers to the table, build more robust networks, and prevent surprise bills from ever being generated.

Any state law that causes payers to be forced to pay some portion of charges should be considered a failure. This kind of result will only encourage providers to go out-of-network, which will simply lead to even more surprise bills – and if those bills are required to be paid by third parties such as the plan or plan sponsor, it will simply raise costs for everyone and add to the unsustainable nature of costs in the U.S. health care system.

What is the rate of out-of-network claims?

ERIC member companies did not present this data to us, and as such we will rely on data provided by groups representing our third-party administrators. But we do note that it only takes one massive, unnecessary, and unconscionable surprise bill to financially devastate a family. **The surprise billing crisis is not based upon the volume of balance bills, but rather, it is based on the staggering destruction that they can cause a family, and the widespread fear and trepidation they cause to the vast number of plan beneficiaries who have NOT received a surprise bill**.

These surprise bills are frustrating the objective of plan sponsors in providing (at great cost) generous health benefits. If even families with robust health insurance benefits are afraid to make use of those benefits, then the goal of providing peace of mind (and indeed, of shielding patients from financial ruin due to medical bills) will be impossible to achieve.

We know that some provider groups are downplaying the impact of surprise bills, or attempting to project an image of a health care system so complicated, that any attempt to make changes will disrupt a delicate balance, and cause damage so great that no change should be attempted. ERIC and our allies reject this worldview. Congress can, and should, take action. And the current system is not balanced – the Tier 1 and Tier 2 providers are exercising *de facto* monopoly and monopsony power against both patients and plans/plan sponsors. This *lack of balance* is an open invitation for Congressional intervention.

What percent of balance bills are more than $750?

ERIC is aware that some provider groups have urged Congress to set a threshold, above which all out-of-network "surprise billed" claims will go to binding arbitration. We oppose this for a number of reasons.

First, Congress would inadvertently be creating a "safe amount" to surprise bill. Providers would know that based upon this threshold, plans and plan sponsors would be likely to simply accept and process certain claims in order to avoid the costs of binding arbitration. Further, amounts below this threshold might be manipulated in order to exceed it, or stay below it, for reasons related to the providers' economic interests. This is not in the best interest of the patient.

Second, providers have a high level of discretion when it comes to medical billing, up-charging, and characterizing care. As such, creating a monetary threshold may incentivize providers to change billing practices in a way that makes the costs of care more opaque, rather than more transparent. Picture, for instance, a provider who chooses to break down one $800 charge into two $400 charges, or vice-versa. Or providers choosing to no longer engage in bundling of care or accountable care operations. This also is not in the patient's best interest.

Third, the creation of a threshold is not a "middle ground" between a reasonable benchmark and a new binding arbitration regime. A threshold will still require plans to deal with all of the problems associated with binding arbitration, and it will still require Congress to carefully structure binding arbitration rules in such a way that prevents providers from obtaining windfall profits by inflating charges. So, while a threshold may seem to be a compromise position, it actually entails all of the same problems and adds a new layer of complication.

There are many examples in the media of surprise bills amounting to tens of thousands of dollars. Even one of those is too many. We urge Congress to address the root cause of the problem and not apply arbitrary thresholds.

Conclusion

ERIC commends Congress for moving forward boldly to address this pressing problem, despite intense resistance from entrenched medical interests. We hope to continue to be partners in advancing the goal of protecting all patients from surprise medical bills and reforming the health care system into one that focuses on value.

Thank you for considering these comments. Please do not hesitate to contact us with any questions, or if ERIC can serve as a resource on these critical issues.

Sincerely,

James Gelfand
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