

June 5, 2019

The Honorable Lamar Alexander
Chairman
Senate Committee on Health, Education, Labor
and Pensions
Washington, DC 20510

The Honorable Patty Murray
Ranking Member
Senate Committee on Health, Education,
and Pensions
Washington, DC 20510

Dear Chairman Alexander and Ranking Member Murray:

We applaud you for seeking a solution to surprise medical billing in your draft legislation, the “Lower Health Care Costs Act.” Reflecting the goal of employers to protect patients from surprise medical bills without undermining network participation or resulting in higher health care costs for all consumers, we urge you to reject independent dispute resolution (*Option 2*) as a means of resolving surprise medical billing. We call upon Congress to pass legislation ending surprise medical bills consistent with the following priorities:

Protect Patients from Surprise Medical Bills

- The goal of any federal surprise medical billing legislative solution is to protect patients in situations in which they lack a choice of providers. It is vitally important, however, that any legislative solutions not discourage network participation or result in higher health care costs for all consumers. Patients often lack any meaningful choice of provider when they obtain care at out-of-network emergency rooms, and when a patient receives services at in-network facilities from out-of-network professionals, particularly with respect to a small number of provider specialties.
- To protect consumers and families, federal legislation must ensure that patient cost-sharing is limited to in-network amounts for emergency services performed at an out-of-network facility or for treatment by out-of-network facility-based physicians performed at in-network facilities, and prohibit providers from imposing additional surprise medical bills in these circumstances.
- Congress should implement this change through an amendment to section 2719A of the Public Health Service Act (“PHSA”), which applies to both group and individual commercial insurance, and which would apply to insured and self-funded group health plans through section 715 of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”).

Disclosure and Transparency

- For surprise medical billing that occurs at an in-network facility and follow-up care from emergency treatment at an out-of-network facility, federal legislation must require disclosure of out-of-network professional costs at the time of scheduling. This disclosure will help ensure that patients can make informed decisions and schedule procedures when in-network professionals are available.
- Facilities such as hospitals should also be required to list prominently on their websites, whether they lack available providers who participate in networks in which the facility

participates – including what those specialties are, and the likelihood that a patient may thus be seen by an out-of-network provider.

- Much of the surprise over unexpected balance billing can be eliminated by providing this disclosure.
- Congress could implement this disclosure requirement directly on hospitals (through Medicare’s minimum requirements for hospitals under 42 USC § 1395x(e)(1)-(8)), or through an amendment to section 2718(e) of the PHSA, which requires hospitals to disclose standard charges for items and services provided by the hospitals.

Required Reimbursement

- Out-of-network providers frequently bill well in excess of negotiated rates and Medicare for these services, as opposed to the actual value of the service provided. A study by Ge Bai and Gerard F. Anderson, published in JAMA in 2017 comparing physician charge-to-Medicare payment ratios across specialties found that anesthesiology had the highest median (5.8), followed by interventional radiology (4.5), emergency medicine (4.0), and pathology (4.0).
- To ensure equitable payment for the services provided without discouraging network participation or resulting in higher costs for all consumers, legislation must set a reasonable federal reimbursement structure that (1) establishes a federal cap for emergency services at an out-of-network facility at the median contracted rate or 125 percent of the Medicare rate, and (2) requires all providers at an in-network facility to accept in-network rates.
- Conversely, without reasonable limitations on the reimbursement rates, out-of-network providers in surprise medical billing situations will have an incentive to bill even higher rates in order to achieve maximum payment through any binding arbitration mechanism. ***Binding arbitration is an inefficient and ineffective approach to addressing surprise medical billing and should not be included as a legislative solution.*** As the committee seeks to bring greater transparency to health care costs, a costly, complex, and opaque arbitration process is a step in the wrong direction.
- Requiring facilities to bundle medical services for covered procedures into a single payment also could help address this problem if structured properly. In the case of bundled services performed by out-of-network providers, the costs of those services within the bundle cannot exceed either the allowable in-network rate or 125 percent of Medicare. But, care must be taken to ensure that the contracted bundled payment is final and not merely a progress point toward further negotiation.
- Congress should implement this change through an amendment to section 2719A of the PHSA, which applies to both group and individual commercial insurance, and which would apply to insured and self-funded group health plans through section 715 of ERISA.

Ambulance and Outsourced Emergency Departments

- A significant concern to both patients and plans are the massive costs associated with non-participating ambulance, air ambulance, and emergency department services.

- According to the Government Accountability Office's (GAO) analysis of the most complete data identified for air ambulance transports of privately-insured patients, 69 percent of about 20,700 transports in the data set were out-of-network in 2017.
- Ambulance, air ambulance, and emergency services are essential to ensure that patients receive the care they need in the most urgent of situations. Subjecting patients in the most dire of circumstances to balance billing exposes patients to material liabilities in order to receive the care they need.
- Any legislative solution for surprise medical billing should also specify that ambulances and air ambulance services are considered emergency services for purposes of the statutory limitations on balance billing and reimbursement rates.
- Further, Congress should include provisions to eliminate problematic incentives in which an in-network facility could profit by allowing or encouraging an outsourced out-of-network emergency department to surprise bill in-network patients.
- Congress should implement this change through an amendment to section 2719A of the PHSA, which applies to both group and individual commercial insurance, and which would apply to insured and self-funded group health plans through section 715 of ERISA.

We look forward to working with you to address the burden of surprise medical billing.

Sincerely,

American Benefits Council
 Associated General Contractors
 Auto Care Association
 Central Penn Business Group on Health
 Corporate Health Care Coalition
 Council for Affordable Health Coverage
 Economic Alliance of Michigan
 Florida Alliance for Healthcare Value
 Food Marketing Institute
 Greater Philadelphia Business Coalition on Health
 HealthCare 21 Business Coalition
 Healthcare Purchaser Alliance of Maine
 Houston Business Coalition on Health
 Lehigh Valley Business Coalition on Healthcare
 Louisiana Business Group on Health
 Memphis Business Group on Health
 MidAtlantic Business Group on Health
 Midwest Business Group on Health
 National Alliance of Healthcare Purchaser Coalitions
 National Association of Health Underwriters
 National Association of Wholesaler-Distributors
 National Business Group on Health
 National Restaurant Association
 National Retail Federation
 Nevada Business Group on Health

NFIB

North Carolina Business Group on Health

Partnership for Employer-Sponsored Coverage

Retail Industry Leaders Association

Retailers Association of Massachusetts

Rhode Island Business Group on Health

Self-Insurance Institute of America, Inc.

Silicon Valley Employers Forum

Small Business & Entrepreneurship Council

Society of Professional Benefit Administrators

South Carolina Business Coalition on Health

St. Louis Area Business Health Coalition

The ERISA Industry Committee

WellOK, The Northeastern Oklahoma Business Coalition on Health

Wyoming Business Coalition on Health