



The ERISA Industry Committee

Driven By and For Large Employers

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Protecting Patients from Surprise Medical Bills

*Testimony before House Ways and Means Health Subcommittee
Washington, DC*

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Intro and About ERIC

Chairman Doggett, Ranking Member Nunes, and members of the Subcommittee, thank you for this opportunity to testify on the surprise medical billing crisis. I'm James Gelfand, Senior Vice President for Health Policy at The ERISA Industry Committee – ERIC for short – the only national association that advocates exclusively for large employers on health, retirement, and compensation public policies at the federal, state, and local levels. ERIC member companies are leaders in every sector of the economy, with employees in every state, and we represent them in their capacity as sponsors of employee benefit plans for their own workforce.

Each of you and your constituents likely engage with an ERIC member company when you drive a car or fill it with gas, use a cell phone or a computer, visit a bank or hotel, fly on an airplane, watch TV, benefit from our national defense, go shopping, receive or send a package, wear makeup, or enjoy a soft drink.

Our member companies offer comprehensive health benefits to employees, their families, and often retirees, too. On average, large employers pay around 85 percent of health care costs on behalf of our beneficiaries – that would be a gold or platinum plan if bought on an Exchange. But we don't buy or sell health insurance; these plans are self-insured. In other words, ultimately it is the company that is on the hook for the vast majority of the costs of our patients' care. There are about 181 million Americans who get health care through their job, and about 100 million of them are in self-insured plans like ours.

We offer these great health benefits to attract and retain employees, to be competitive for human capital, and to improve health and provide peace of mind. Large employers, like ERIC member companies, roll up their sleeves to improve how health care is delivered in communities across the country. They do this by developing value-driven and coordinated care programs, implementing employee wellness programs, providing transparency tools, and a myriad of other innovations that improve quality and value to drive down costs. These efforts often use networks to guide our employees and their family members to providers of higher quality and lower cost. Surprise billing undermines all of this and fundamentally frustrates the goals of providing quality, affordable employer-sponsored health benefits.

No doubt you have heard from your constituents about this. ERIC has also heard from our member companies about beneficiaries who have fallen victim to devastating surprise bills. We can provide

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examples upon request. Again, these are beneficiaries with some of the most robust insurance coverage available, and still they are experiencing immense hardship.

Often these employees do everything right. They look up in-network providers. They call ahead. They ask questions at the hospital. But still, they later receive enormous, unexpected bills. These horror stories of surprise bills have our beneficiaries afraid to go to the hospital at all – even with a platinum plan! They’re skipping care, they’re worried while at work, and we have no choice but to call for bold action from Congress to address what has become a surprise billing **crisis**.

This crisis is narrowly confined and straightforward to resolve. There is a bipartisan path forward. We commend Congress for rolling up its sleeves to look into why surprise bills are generated, and how you can stop them. For large employers this is not a question of who should pay, but rather how to stop these bills from ever being generated, because they are unfair in the first place.

Defining Surprise Medical Bills

We should start by clarifying that the vast majority of health care providers rarely or never generate surprise bills. It’s almost exclusively confined to specific and small subsets of the health system that the patient does not have the ability to choose or shop for. We’re willing to get very specific: Almost all surprise bills come from ancillary providers working in a hospital (such as pathologists, radiologists, anesthesiologists, assistant surgeons), from critical emergency care providers such as ER doctors, neonatologists, ambulances and air ambulances whose service the patient cannot refuse, or from surprise fees from the hospital itself.

To address this problem, we must start by developing a common understanding of what a surprise medical bill is. We believe there are three scenarios that give rise to a surprise medical bill:

- (1) A patient receives care at an in-network facility, and at some point during the course of care, (without the patient’s knowledge, or without presenting the patient with a meaningful alternative), the patient is treated by an out-of-network provider;
- (2) A patient requires emergency care, and the providers, facility, or transportation available are outside of the patient’s insurance network; and
- (3) A patient is transferred or handed off to care, but not properly informed that this care is out-of-network, and not offered sufficient alternatives.

Some have suggested that a surprise medical bill is when an individual receives care and doesn’t realize they have not yet hit their insurance deductible. Others have cited instances where an individual violates the terms of their plan, and goes to the emergency room for non-emergency care. Some provider groups are seizing on the opportunity to try and dismantle existing standards related to step-therapy and prior authorization, mental health parity rules, and formulary management, too. It is true that there are many situations that can potentially lead to bills for the patient, but most of these are not what the public is talking about in the national conversation regarding surprise medical bills.

There are those who are trying to use this debate about surprise billing to unravel the system of networks that has developed, but employers and insurers need networks in order to ensure beneficiaries obtain the highest quality care, to control costs, and to ensure access for our patients. We

urge you to remain focused on the crisis at hand, and avoid relitigating “network adequacy” or the rules established in the Affordable Care Act.

ERIC’s Solutions to Surprise Medical Bills

ERIC, along with many other groups representing employers, believes that Congress can, and should solve this problem – and that the best solutions will be simple, straightforward, transparent, and based on common sense.

Chairman Doggett, thank you for your leadership on this issue – you were four years ahead of the curve on this. You introduced the “*End Surprise Billing Act*” back in 2015, which would require notice for patients, and most critically, it would hold the patient harmless in these situations – which is exactly where the conversation about solutions has to begin. We strongly support your efforts. And we believe that comprehensive legislation to end surprise billing starts with the concepts you pioneered.

We propose three core policy changes to decisively end the surprise billing crisis. Here’s how to do it:

- (1) “***In-network matching rate guarantee.***” This is a simple concept – if a patient goes to an in-network facility, every provider they see should be required to accept in-network rates as payment in full. This one change would eliminate any instance of surprise medical billing for a patient going to an in-network facility.
- (2) “***An emergency, last-resort, benchmark backstop.***” In most instances when a patient needs emergency care, and that care is out-of-network, the insurer or plan sponsor comes to an agreement on payment with the provider. When they cannot, a benchmark is needed to determine an appropriate payment amount. The most straightforward solution would be to designate a percentage of Medicare – we suggest 125 percent of what Medicare would pay that provider, in that market, for that service.

If Congress prefers to set a benchmark based on private markets, rather than Medicare, another option would be to look at the average contracted rate in a given market – rates mutually agreed to between insurers and doctors, without government involvement. But if the benchmark rate is equal to or higher than the average... then the average provider will make more money out-of-network. So we suggest something like 80 percent of the average. That would ensure fair payment to providers, while encouraging network participation.

- (3) “***Require informed consent.***” When a transfer or handoff takes place, Congress can require the provider to tell the patient if the care will be out-of-network. If so, they should offer the patient an in-network alternative whenever possible.

Enacting a variation of these three policies would wipe out the vast majority of surprise medical bills, while ensuring patients’ access to care, and guaranteeing fair reimbursement to providers. There is still more Congress could do, including cracking down on abusive behavior by outsourced, medical staffing firms, banning certain kickback agreements, and the like. But just the three policies described above would be an incredibly effective start.

Most importantly, the Ways and Means Committee has the power to make this happen. With jurisdiction over the Medicare program, this Committee can require providers and hospitals to follow

these new rules, as a condition to participate in Medicare. As a result, they will **all** follow suit. No new taxes or spending needed, no complicated insurance rules, just a simple opt-in. Providers will vote with their feet.

Legislative Snipe Hunts

ERIC recognizes that Congress is under immense pressure from parts of the health industry to maintain the status quo which, while bad for patients, is beneficial to the bottom line for certain providers, hospitals, and Wall Street investors. Those interests are attempting to send Congress on a series of snipe hunts – or wild goose chases – designed to slow down and ultimately co-opt legislative momentum to end the surprise billing crisis. We urge you to focus on measures that will prevent surprise bills from being sent in the first place – not simply rearrange who pays the bills.

- (1) **Arbitration:** The first, and certainly most bandied, of these snipe hunts is a call for mandatory binding arbitration. Playing on the fear that making changes to the health system will cause ... change... some have suggested that Congress not specify how to solve the problem. Instead, punt to arbitrators. Those arbitrators will listen to both sides and pick a winner – one side’s proposal without modification. Unfortunately, employers know that this proposal is a distraction: it simply will not work.

Binding arbitration is attractive to those who want to deflect or defer tough decisions away from Washington, out to communities where patients are sent surprise bills. One outcome is certain - arbitration will raise costs for patients. When employers determine health insurance premium costs, we will have to build in expected costs to pay arbitrators, pay for facilities, pay for the costs and claims that will fluctuate as providers attempt to game arbitration thresholds, and in worst case scenarios, pay the exorbitant “list prices” demanded by providers when we inevitably lose at “baseball-style” arbitration. And if providers find that they can make more by taking insurers and plan sponsors into arbitration, rather than getting in-network, patients will pay a heavy price.

- (2) **Transparency alone:** Some advocates are focused on transparency measures as a way of addressing the surprise billing crisis. We are in favor of transparency – the health system needs a lot more of it. However, transparency alone will **not** solve this problem. We are dealing with a market failure, and in some cases, with *de facto* monopoly powers. Informing a patient that they will be seeing the only anesthesiologist on duty, who happens to only accept cash and not insurance, does not really help the patient. Likewise, giving them advance notice of just how expensive the balance bill is going to be, still won’t offer them a meaningful choice, or protect them from a bill that could result in financial ruin. So while transparency is important, and a step in the right direction, Congress needs to make policy to solve this problem.
- (3) **Change is bad:** Some have warned Congress, if you legislate on surprise billing, you risk creating winners and losers. To this we respond: Well, obviously. The current system is not a carefully, perfectly balanced, well-designed one. There are losers in the current system – and those losers are the patients falling victim to surprise medical bills. If we give those patients a little more leverage, that’s an improvement, not a problem. Right now the scales are tipped significantly against patients, as well as the insurers and plan sponsors who negotiate on their behalf and pay for their care. A realignment should be considered a feature, not a defect. The idea that deep

inequities in the current system can be solved without changing anything... is another snipe hunt.

- (4) Let the market figure it out: Some say the free market will solve the problem. It won't. It hasn't. And surprise billing is getting worse, not better. These provider groups say that if Congress legislates on surprise bills, especially if a benchmark backstop is created, it's "big government" interfering in a free market. This couldn't be further from the truth. Ultimately, nearly all health insurance payments are based one way or another on a percentage of Medicare. And virtually every provider or hospital is engaged with various government payments and programs, be it Medicare, Medicaid, Disproportionate Share Hospital payments, discount drug programs, payments for graduate medical education, and an array of other government funding sources. Enacting a last-resort benchmark backstop will ensure that all parties are treated fairly – it will not pave the way for a government takeover. What it **will** do, is create an incentive for insurers and providers to agree to fair network rates.
- (5) State action: Lastly, some have advocated that surprise billing is already being addressed by the states, so just let them handle it. We disagree, and believe that Congress has to act, for two reasons: First, many states either have not acted, have enacted only half-measures, or have actually made things worse. And second, even if every state enacted a comprehensive solution, 100 million Americans would be unprotected. That is because states may not, and should not be permitted to, regulate self-insured plans, which are governed by federal law under the Employee Income Retirement Security Act, or "ERISA". ERISA ensures that large employers follow a single set of rules, rather than a patchwork of conflicting and disparate state and local rules. To fix the problem for the 100 million Americans in ERISA plans, Congress must take on surprise billing directly.

Conclusion

In conclusion, thank you for this opportunity to share our views with the Committee. The ERISA Industry Committee and our member companies are committed to working with Congress toward a bipartisan, comprehensive solution that protects patients' access to care, ends the surprise billing crisis, ensures fair provider compensation, and does so without driving up health insurance costs. We look forward to helping craft and pass bipartisan, comprehensive legislation, and getting it to the President's desk to be signed into law.