ERIC | THE ERISA INDUSTRY COMMITTEE
Shaping benefit policies before they shape you.

JAMES GELFAND
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The Honorable Richard Saslaw
Chairperson
Senate Committee on Commerce and Labor
Pocahontas Building
900 East Main Street
Room 602-E
Richmond, Virginia 23219

Dear Mr. Chair:

On behalf of The ERISA Industry Committee (ERIC), thank you for this opportunity to submit testimony on the surprise medical billing crisis in Virginia. The ERISA Industry Committee, or ERIC, is 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.

Virginians are likely to engage with an ERIC member company when they 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 their beneficiaries – that would be a gold or platinum plan if bought on an Exchange. But employers don't generally 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 employees' care. There are about 181 million Americans who get health care through their job, and over 100 million of them are in self-insured plans like ours.

Employers 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 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.

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 employees and their families afraid to go to the hospital– 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 to address what has become a surprise billing crisis.

This crisis is narrowly confined and straightforward to resolve. There is a bipartisan path forward. ERIC commends the Virginia legislature 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 these surprise bills are unfair and should never happen.

About Surprise Medical Bills: Most 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. Primarily, these are ancillary providers working in a hospital (such as pathologists, radiologists,

anesthesiologists, assistant surgeons), emergency care providers such as ER doctors, neonatologists, ambulances and air ambulances whose service the patient cannot refuse or negotiate, or surprise fees from the hospital itself.

Patients are experiencing three scenarios that consistently 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 advance knowledge or consent, 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 medical transportation 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.

ERIC's Comments on S.B. 172 :

ERIC has significant concerns with S.B. 172, Senator Favola's legislation to address surprise billing. This legislation would ban balance billing patients in the event of an emergency and require health insurance plans to reimburse providers at benchmark rates based on the average of all paid claims, including out-of-network charges. These are not "fair" or market-driven rates, because they mandate highly inflationary reimbursement rates (using a "greatest of four" formula), creating windfall profits for providers, while employees and plan beneficiaries will experience skyrocketing premiums, co-pays, co-insurance, and deductibles as a result. Reimbursement rates should be based off real market value – meaning the median, negotiated in-network price, in a given geography, for a given procedure. By including inflated out-of-network bills in the calculation, this legislation encourages more gaming of the system, more surprise billing, and ultimately higher costs for patients.

ERIC encourages the committee to support S.B. 767, and oppose S.B. 172 for the following reasons:

ERIC commends Senator Barker for introducing S.B. 767 which creates a reasonable and fair market-based benchmark in surprise billing situations, taking the patient out of the middle, and providing certainty to plans, plan sponsors, patients, and providers. This is a middle-ground solution that does not inappropriately "tip the scales" in favor of one sector over another – even so, it addresses some of the deep iniquities currently present in the health care system. Those iniquities have resulted in a system in which, right now, there are winners and losers – and the losers are patients (along with the plans and plan sponsors negotiating and paying on their behalf). Senate bill 767 brings needed fairness and clarity where currently both are lacking.

Paying Providers Fairly

The legislation generates benchmark payments based on rates freely negotiated between the same kind of provider in the same geography. When a person receives emergency services from an out-of-network health care provider, or receives out-of-network services at an in-network facility, the employer or plan will pay said provider the lower of either the market-based value for the service, or 125 percent of Medicare (and the vast majority of providers accept Medicare). If the provider determines that the amount to be paid by the health carrier does not comply with the set rates, and if a resolution is not reached within 30 days, either party can request the State Corporation Commission to review the disputed amount (this mirrors what we call the "audit provision" in federal legislation – it serves to

ensure that no payer "cheats" on the benchmark rates). This proposal leverages market forces to enhance and improve networks for patients, without harming providers' bottom lines.

Employers offering health plans for their workforce want high quality providers to be available to care for employees and their families, and recognize that providers should be compensated fairly. Market economics ensure that a benchmark based on fair, in-network negotiated rates will **not** lead to provider or access shortages. And evidence from California, where a similar policy has been in practice for more than a year, shows that networks are growing in size, while provider reimbursement continues to increase.

National Uniformity for ERISA Plans

It is critical that the Committee's legislation distinguishes between fully-insured health plans and those that are self-insured and thus governed exclusively by federal law – the Employee Retirement Income Security Act (ERISA) - as self-insured plans are not, and should not be, subject to state law. Senate bill 767 explicitly states that it does not apply to self-insured plans, however, such entities may elect to be subject to the provisions of the bill, similar to a provision in New Jersey's surprise billing law. We are actively pursuing a federal solution that will apply to the 110 million Americans in self-insured plans. However, as Congress continues to debate, states should step in to protect consumers in fully-insured, state-regulated plans, with market-based solutions like S.B. 767.

Conclusion:

Therefore, ERIC urges legislators to enact a reasonable market-based benchmark solution like that envisioned in S.B. 767, and oppose legislation mandating inflationary rates that do not reflect a fair market value and will increase costs for both patients and plan sponsors, like the provisions in S.B. 172.

In conclusion, thank you for this opportunity to share our views with the Committee. We look forward to working with the Committee to enact legislation to end the surprise billing crisis. If you have questions concerning our comments, or if we can be of further assistance, please contact us at (202) 789-1400.
Sincerely,

James P Gelfand

James P. Gelfand
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