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

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December 1, 2020
The Honorable Bob D. Hackett
Chairman
Senate Insurance and Financial Committee
1 Capitol Sq
1st Fl
Columbus, OH 43215

Dear Chairman Hackett:

Thank you for this opportunity to submit comments on the surprise medical billing crisis in Ohio. 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.

Ohioans 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.

ERIC applauds Representative Holmes on his thoughtful and effective legislative draft to address the surprise billing crisis. HB 388 creates a reasonable, 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 fair 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 employer plan sponsors working and paying on their behalf). HB 388 brings needed fairness and clarity where currently both are lacking.

Paying Providers Fairly

The legislation creates a benchmark payment rate based on median prices that have been agreed to under contract by providers and insurers in a given geographic region. This proposal leverages market forces to enhance and improve networks for patients, without harming providers' bottom lines. Because the benchmark is based on rates agreed to by both sides of the interaction, without government involvement, any suggestion that this constitutes "price-setting" is simply untrue. 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 fairly compensated.

Economics ensure that a median in-network benchmark will not lead to provider or access shortages. It will also solve much of the "joint venture scam" in which in-network hospitals team up with private-equity-owned outsourced medical staffing firms to charge patients outrageous fees by generating surprise bills. Patients who enter in-network facilities, including the emergency room, have every reason to expect that in-network providers will care for them, at in-network rates.

ERIC also notes that some provider representatives have suggested that legislatures should merely stay silent on the resolution of surprise bills – they say legislatures need only take the patient out of the middle, and the free market will solve the problem. What they fail to clarify is that the resolution for this will be undertaken in courts of law, costing thousands or millions of dollars, on a case-by-case basis, and creating a patchwork of precedents in different areas. This may work in favor of providers seeking to maximize revenue, but it will harm patients who ultimately will face higher health care costs to account for increased litigation and other administrative costs.

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 by federal law – the Employee Retirement Income Security Act (ERISA) - as self-insured plans are not, and should not be, subject to state 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.

Mandatory Binding Arbitration: Just Say "NO"

The Committee thus far has resisted significant pressure from the provider community to punt on solving the surprise medical billing crisis, and instead impose a binding arbitration regime. For this, we salute you. The employer community stands unified in opposition to binding arbitration schemes, for the following reasons:

• These "solutions" do not end surprise billing – they merely change who is subject to paying the surprise bill. As such, binding arbitration enshrines the current strategy of certain medical providers to eschew networks and generate surprise bills. Some particularly egregious proposals put forth would require plans and plan sponsors to promptly pay reasonable market rates to providers who generate surprise bills, but then reward the provider by allowing them to take the plan into arbitration and demand more money;

• Arbitration raises costs, requiring payments to arbitrators, lawyers or other representatives to the parties, and facilities. In "baseball style" arbitration, sometimes the plan or plan sponsor must pay excessive "billed charges" that no competent fiduciary would ever agree to pay. These costs will be passed on directly to patients. ERIC has seen estimates such as a minimum of $1,000 per hour for representation in an arbitration proceeding, a $1,500 filing fee for each party to an

arbitration dispute ($3,000 minimum per arbitration), and more. This is a recipe for the incineration of health care dollars by directing funds toward administrative and legal costs, rather than the provisioning of care;

• In order to avoid out-of-control costs, binding arbitration would still require a benchmark payment rate for the arbitrator to consider. As such, this choice should be considered less attractive to legislatures than its supporters claim, because it does not actually shield legislatures from deciding about backstop payments. Instead, it merely obfuscates this decision, adding in layers of administrative costs, creating a slower and less transparent process, enshrining the current dynamics that have led to the crisis, and burdening the health care system further; and

• Data from New York, where a binding arbitration regime has been imposed, show that health care costs are exploding, with plans being forced to pay 88 percent of providers' fake list prices. Patients will suffer as premiums gradually increase, due to providers knowing they can impose any list price they wish, and force plans to pay. Ohio's solution protects patients from unexpected surprise bills, as well as from health care cost increases.

Arbitration is a backdoor way of forcing third-party payers to pay providers based on fake prices: providers' "billed charges" are no different than a branded prescription drug's "list price" or the "sticker price" at an auto dealership. Reasonable people would never agree to pay these prices, nor would the sellers expect them to – it is no different in health care, especially with the out-of-control increases in health care costs every year. Even if we could develop a method of arbitration that eliminated the vast administrative waste likely to occur, it would still be crucial to ensure that "billed charges" were not taken into account and could never be the mandated outcome in a dispute.

For these reasons, ERIC urges the Committee to continue standing strong against demands to implement a binding arbitration or other quasi-judicial regime, rather than directly solving the surprise medical billing problem.

Conclusion

In conclusion, thank you for this opportunity to comment on HB 388 and urge its full passage through the Committee. The ERISA Industry Committee and our member companies are committed to working with Ohio 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. ERIC is standing by to help if you have any questions, or if we can be a resource in any way as the bill continues through the legislative process. Please contact me at sbelmont@ERIC.org or 202-627-1914.

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