



# AMERICAN BENEFITS COUNCIL

May 28, 2019

The Honorable Frank Pallone, Jr.  
Chairman  
Committee on Energy and  
Washington, DC 20515

The Honorable Greg Walden  
Ranking Member  
Committee on Energy and Commerce  
Washington, DC 2051

Dear Chairman Pallone and Ranking Member Walden:

The American Benefits Council (“the Council”) applauds your commitment to crafting a bipartisan solution to address the problem of surprise medical billing. We, too, seek to protect patients from these unexpected and costly medical bills that are leaving families across the country with crippling amounts of debt.

The Council is a Washington D.C.-based employee benefits public policy organization. The Council advocates for employers dedicated to the achievement of best-in-class solutions that protect and encourage the health and financial well-being of their workers, retirees and families. Council members include over 220 of the world’s largest corporations, as ranked by Fortune and Forbes. Collectively, the Council’s members either directly sponsor or administer health and retirement benefits for virtually all Americans covered by employer-sponsored plans.

Employers are deeply concerned about the burden that unexpected medical bills from out-of-network providers place on employees and their families. We view the effort to protect patients from surprise bills within the broader context of the effort to lower health care costs. As such, we urge Congress to develop legislation addressing surprise billing that protects these patients without undermining access to high-quality, high-value networks or increasing health care costs for individuals and employer providers of health coverage. **Accordingly, we applaud the committee for crafting legislation that establishes a market-based benchmark to resolve out-of-network payment disputes between providers and payers through a transparent and non-inflationary mechanism.**

Council member companies are taking steps to limit the incidence of surprise billing in the first place through, for example, enhanced communications to employees about the potential for balance bills from out-of-network providers. Our members understand the stress and financial devastation surprise medical bills can bring to their employees and provide assistance in multiple ways. This assistance may take the form of contracting with third parties to negotiate the bill with the provider on the employee's behalf. Some employers provide balance bill legal defense services for employees to contest balance bills themselves. Despite the efforts of plans to prevent unexpected balance billing or help employees faced with such a bill, the underlying problem continues.

While a number of states have sought to address this problem through insurance regulation, over 60 percent of employer-sponsored coverage is offered to employees through self-funded group health plans. The Employee Retirement Income Security Act of 1974 (ERISA) exempts self-insured plans from state insurance regulations to ensure that national employers can offer uniform health benefits to employees residing in different states. Accordingly, the problem of surprise billing cannot be left to the states to solve.

Adequately addressing this problem in a way that limits the financial burden on all consumers necessitates a federal solution. We are very concerned that federal legislation enshrining a reimbursement rate for out-of-network providers that is in excess of in-network rates – whether directly or through an arbitration process – will eliminate what remains of plans' negotiating leverage to avoid or reduce the incidence and amount of surprise billing and increase costs for all consumers. Instead, we seek legislation that takes aim at the root cause of surprise medical bills and the market distortions that allow certain specialties to take advantage of the patient's lack of meaningful choice in their selection.

Thank you for asking the Council to provide feedback on the questions you have posed. The discussion below addresses those questions and offers comments on the draft legislation. We commend you for crafting legislation directed at addressing the problem of surprise billing at its root and in a nationally uniform manner. The market-based benchmark approach based on median contracted rates set forth in your draft legislation is greatly preferred to arbitration, which is costly, complex, and unpredictable. The draft "No Surprises Act" is an important step forward in providing lower-cost and higher-value health care to the 181 million Americans with employer-sponsored coverage.

#### **1. ESTABLISHING A MARKET-BASED BENCHMARK TO RESOLVE OUT-OF-NETWORK PAYMENT DISPUTES BETWEEN PROVIDERS AND INSURERS**

We agree that payment disputes between providers and insurers must be resolved

in a manner that takes the patient out of the middle, is transparent and does not increase federal healthcare expenditures. The committee requests feedback on how to adequately provide payment in these situations through a transparent, non-inflationary mechanism. We support committee seeking a transparent and non-inflationary mechanism through which to provide adequate payment. Providing feedback on this critical point requires examining the drivers of surprise medical billing – a lack of meaningful patient choice in choosing certain providers and the resulting market distortion.

### **‘Surprise’ bills arise from lack of meaningful patient choice.**

These “surprise” balance bills arise in situations where a patient has a limited ability to know whether the provider is in or out-of-network. These scenarios include (1) emergency treatment at out-of-network hospitals and follow-up care, (2) ambulance and air ambulance services provided by out-of-network providers, and (3) treatment provided by out-of-network providers working at an in-network facility. Importantly, in all cases, the patient lacks a meaningful choice between receiving treatment from a provider who is in their health plan’s network, and thereby subject to contracted cost and quality requirements, or one who is outside of the network. The common theme of all three is that patients lack the true ability to avail themselves of a network provider, leaving the patient without knowledge or choice with respect to out-of-network providers and the fees they charge.

In the case of emergency services provided by out-of-network facilities and ambulance and air ambulance services, the patient – simply put – has no choice. Assuming that the patient is conscious, the emergent nature of the condition requiring the medical treatment presents the dilemma of identifying an in-network facility or provider in lieu of receiving the most expeditious stabilizing care. Such a choice is, in fact, no choice at all.

A study by Zack Cooper, Fiona Scott Morton and Nathan Shekita (the “Cooper study”)<sup>1</sup> explains that a “fundamental problem” in emergency medicine in the United States is that emergency department physicians face inelastic demand from patients when they are practicing at in-network hospital emergency departments. As a result, these hospital-based physicians need not set their prices in response to market forces, as noted in the study:

Because they are part of a wider bundle of hospital care and cannot be avoided once the hospital choice is made, emergency physicians (and other specialist physicians like radiologists, pathologists, and radiologists) face inelastic demand from patients and will not see a reduction in their patient volume if they fail to negotiate contracts with insurers.

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<sup>1</sup><https://www.nber.org/papers/w23623.pdf>

The problem of surprise balance bills will not be solved by shifting the cost of a balance bill for out-of-network emergency care from patients to employers and other commercial payers. Doing so merely masks the underlying driver of these balance bills – a market failure by virtue of the fact the emergency physicians experience “inelastic demand from patients.” The Cooper Study found that out-of-network emergency physicians charge, on average, 637% of what the Medicare program would pay for identical services, which is 2.4 times higher than in-network payment rates. The spread between Medicare rates, in-network rates and out-of-network billing suggests that more than recouping any purported negative profit margins is at play. An examination of the distribution of out-of-network billing for emergency care in hospitals across the U.S., which found that out-of-network billing is concentrated in a small number of hospitals, further supports such a conclusion. While 50% of hospitals have out-of-network billing rates below two percent, 15% of hospitals have out-of-network billing rates above 80%.

In the third scenario, where patients seek care at in-network facilities from in-network providers, patients generally lack the information necessary at the time of scheduling to determine whether care from an ancillary (but necessary) service provider like an anesthesiologist, radiologist or pathologist is also in-network. On the day of surgery, is the patient really going to question the network status of the anesthesiologist? A patient receiving treatment at an in-network hospital should justifiably expect that ancillary, but necessary, services performed by facility-based physicians such as anesthesiologists, radiologists, emergency medicine physicians, and pathologists, would be covered by their health plans as in-network charges. However, when these facility-based physicians choose not to participate in the network, an unexpected balance bill to a patient can threaten the financial security of working families. Again, the patient is left with effectively no choice at all. Despite the patient’s efforts to select an in-network facility and in-network surgeon, patients are exposed to the threat of balance billing because it is not disclosed to the patient that necessary, but ancillary, providers who are engaged by the hospital do not participate in the same networks as the patient. As discussed below, market distortions have allowed out-of-network providers of ancillary services to receive all the benefits of in-network status, *i.e.*, increased utilization, while exacting much larger reimbursements by remaining out-of-network.

A study by Ge Bai and Gerard F. Anderson, published in the Journal of the American Medical Association in 2017 comparing physician charge-to-Medicare payment ratio across specialties, sheds light on the drivers of surprise billing. Data from 429,273 individual physicians across 54 medical specialties were included. The physician charge-to-Medicare payment ratio ranged between 1.0 and 101.1 across individual physicians, with a median of 2.5. Among the 54 specialties studied, anesthesiology had the highest median (5.8), followed by interventional radiology (4.5), emergency medicine (4.0), and pathology (4.0). In other words, anesthesiologists were

charging more than 5 times the Medicare rate. The ratio also varied across states. The study concluded that: “Physician excess charge was higher for specialties in which patients have fewer opportunities to choose a physician or be informed of the physician’s network status (e.g. anesthesiology).”<sup>2</sup>

A recent report by the USC-Brookings Schaeffer Initiative for Health Policy drew a similar conclusion about why surprise out-of-network bills happen, stating that:

For most physicians in most geographic areas, it is not possible to maintain a practice without entering some insurer networks because few patients are willing to bear the higher costs associated with seeing an out-of-network physician. However, for some types of physicians, that basic dynamic does not apply. For ED physicians, patient volume is driven by patients’ choice of hospital and is unlikely to be affected by whether the physician is in-network or not; hospitalists and neonatologists face a similar dynamic.<sup>3</sup>

The ability of such specialties to set billing rates in this environment when patients have no meaningful choice in their selection serves as a powerful incentive to remain out-of-network, which, in turn, generates surprise balance bills. Clearly, this constitutes a market failure that limits the benefit of networks in controlling costs for patients and plans and necessitates legislative intervention.

**Use of a median contracted rate as set forth in the draft legislation is a transparent and non-inflationary market-based approach.**

To protect patients and families, federal legislation should prohibit balance billing of patients for emergency services provided at an out-of-network facility, for treatment by an out-of-network provider at an in-network facility, and out-of-network ambulance and air ambulance providers. Federal legislation should ensure patient cost-sharing is limited to in-network amounts in these instances.

Legislation addressing surprise balance billing must protect patients without undermining access to high-quality, high-value networks or increasing health care costs for consumers and employer providers of health coverage. Reimbursing out-of-network providers in excess of in-network rates would discourage network participation, worsen the market distortions that are fueling surprise billing and be inflationary. Health plan networks promote better quality and lower cost for consumers. Undermining high-quality, high-value networks removes the greatest leverage plans have to lower health care costs.

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<sup>2</sup><https://jamanetwork.com/journals/jama/fullarticle/2598253>

<sup>3</sup>[https://www.brookings.edu/wp-content/uploads/2019/02/Adler\\_et-al\\_State-Approaches-to-Mitigating-Surprise-Billing-2019.pdf](https://www.brookings.edu/wp-content/uploads/2019/02/Adler_et-al_State-Approaches-to-Mitigating-Surprise-Billing-2019.pdf)

Provider networks are an important, if not essential, tool in our health care delivery system. They allow participants to access quality care at affordable rates for the plan, as well as reduced premium and cost-sharing for the participants. **By way of example, one Council member company with almost 130,000 covered lives estimates that without networks, premiums would increase by \$8,000 – a 45% increase.** The resulting premium increase also makes plans more likely to trigger the looming “Cadillac Tax,” the 40 percent excise tax on employer-sponsored health plans that cost above a certain level.

Merely shifting the burden of balance billing from the patient to the plan or employer will no doubt result in higher premiums and increased costs for all consumers, and will do little to eliminate the underlying source of the issue.

We applaud the committee for crafting legislation that instead seeks to address the underlying root of the problem. By prohibiting balance billing and establishing a benchmark payment rate based on the median contracted rate for the service in the geographic area, the draft *No Surprises Act* would remove the incentive for certain providers of emergency services and those practicing at in-network facilities to remain out-of-network. In so doing, the legislation would both protect patients from surprise bills and be non-inflationary for all consumers.

Federal legislation should require in-network facilities to accept in-network reimbursement rates for all care performed at the facility by all providers associated with the facility. When a plan contracts with a hospital, it stands to reason that essential services performed at the facility – emergency, anesthesiology, radiology and pathology – would be included in the network. No one would purchase a car without a steering wheel or tires. Yet, these are the very specialties that – by virtue of their necessity – are unhampered by competitive market forces in setting their rates or electing not to participate in a network.

Setting the reimbursement rate at a percentage of Medicare or below in-network rates could go further in reducing health care costs more quickly. However, the *No Surprises Act* would be a significant improvement over the current situation. It would protect patients and their families from the financial pain of surprise medical bills. It would also be an important step forward in the effort to lower health care costs. The Council is also very supportive of an “in-network guarantee” approach as set forth in draft legislation recently released by the Senate Health, Education, Labor and Pensions committee. Under such an approach, an in-network facility is required to guarantee to patients and health plans that every practitioner at that facility will be considered in-network.

The Council is very pleased that the committee draft does not adopt a payment mechanism that would require employer-sponsored plans to reimburse providers in excess of in-network rates, thereby driving health care costs higher. We are also

concerned that using any reference to billed charges as a payment benchmark would undermine participation in high-value networks and drastically increase costs for all consumers. Any attempt to characterize billed charges by facility-based physicians as reflective of market value is belied by the fact that the “market” itself is distorted. When patients have fewer opportunities to choose a physician or to be informed of the physician’s network status, the marketplace for these services is not functioning.

**Binding arbitration is an, inefficient, ineffective and inflationary approach to addressing surprise billing.** We have serious procedural and substantive concerns with federal legislation mandating binding arbitration. For large companies with nationwide operations, a binding arbitration model would be administratively complex, costly and time-consuming. Baseball-style arbitration would create incentives for providers to remain out-of-network and increase rates in an effort to increase the final reimbursement they receive. As the committee strives to bring greater transparency to health care costs, arbitration is a step in the wrong direction. However artfully the legislation is crafted, arbitration brings unpredictability and the individual bias of the arbitrator into the equation. Congress needs to fix the problem of surprise medical billing at its root and in a uniform manner, not add more cost, risk and opaqueness to it. For policymakers concerned about federal rate setting, binding arbitration is not the answer. A federal market-based benchmark brings competition and balance in a more efficient and effective way to foster a market-based solution to surprise billing.

## **2. THE IMPORTANCE OF HIGH-QUALITY, HIGH-VALUE NETWORKS**

The committee notes that consumers deserve adequate networks that offer the right care at the right time. The committee seeks feedback on ensuring that networks are sufficiently meeting the needs of individuals. Health plan networks play a critical role in employer efforts to lower the cost and improve the quality of health care for employees and their families. Understanding the importance of networks in driving better health care value is at the foundation of understanding the surprise billing problem and developing an effective solution.

Plans are continually striving to bring high-value providers into their networks both to foster increased choice and options for enrollees, but also to help manage plan costs (and related premiums) and improve quality. As plan sponsors, employers take great care to provide their employees and their families access to networks of providers that: (1) provide high quality health care services, (2) provide those services at reasonable and predictable costs to both plans and patients and (3) control the aggregate cost of health care services. Patients generally face higher out-of-pocket costs under the terms of the health plan when using an out-of-network provider as an incentive to utilize network providers. However, because there is no contractual agreement in place between the out-of-network provider and the plan (or its third-party administrator), there is no ability for the plan to either predict patient costs or prevent any liability

owed to the provider outside of the plan. There is also no ability to require the provider to comply with quality improvement initiatives. The implications of this lack of a contractual agreement – and, critically, the reasons for it – are at issue.

Federal policy should facilitate and incent building provider networks that deliver high quality and high value health care to consumers. To protect access to high quality and high-value care, providers should be encouraged to participate in such networks. **Network adequacy should not be used to deflect attention or otherwise distract from the underlining drivers of surprise billing – a choice by certain specialty providers not to participate in networks. Neither should network adequacy be used to prohibit exclusion of poor-performing providers from a network.** As discussed in a recent report the USC-Brookings Schaeffer Initiative for Health Policy, standard network adequacy laws are designed to solve a different policy problem, are “poorly suited to addressing the problem of surprise out-of-network billing,” and are not designed to guarantee that a particular clinician is in-network.<sup>4</sup> The report concludes that “a network adequacy standard for facility-based clinicians would not do anything to address the market failure that leads to surprise out-of-network billing.” The report goes on to state that “Network adequacy regulation would strengthen the incentive for insurers to bring these providers into their networks, but surprise bills arise because of the incentives that providers (not insurers) face.” Because ancillary and emergency providers are guaranteed a flow of patients without regard to their network status, these providers “have a lucrative opportunity to remain out-of-network that is not available to their peer physicians in other specialties.” Addressing the problem of surprise billing requires addressing this market failure.

### 3. PROTECTING CONSUMERS FROM SURPRISE BILLS FROM AIR AND GROUND AMBULANCES

The *No Surprises Act* does not address the issue of surprise medical bills from ground or air ambulances. We thank the committee for recognizing the need for solutions in these areas and seeking feedback on how to provide relief to consumers burdened with unexpected ambulance bills. Any legislative solution to surprise medical billing must address this problem.

A lack of patient choice defines the massive costs associated with non-participating ambulance and air ambulance services. According to GAO’s 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.<sup>5</sup> This imbalance reflects the incentives that balance billing creates for providers to remain

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<sup>4</sup><https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/05/10/the-relationship-between-network-adequacy-and-surprise-billing/>

<sup>5</sup><https://www.gao.gov/assets/700/697684.pdf>



out-of-network. As with emergency services, ambulance and air ambulance services are essential to ensure that patients receive the care they need in the most urgent of situations. By subjecting patients in these most dire of circumstances to balance billing, it exposes patients to material liabilities in order to receive the care they need.

Accordingly, we strongly urge the committee to amend the *No Surprises Act* to specify that ambulances and air ambulance services are considered emergency services for purposes of the statutory limitations on balance billing and reimbursement rates.

#### **4. INCREASING TRANSPARENCY FOR CONSUMERS**

The committee notes that our health care system is confusing for even the most educated consumers. The committee is interested in feedback on ways to help consumers better understand their health plans and which providers are in their network.

A 2016 Kaiser Family Foundation survey<sup>6</sup> of medical debt found that among individuals who faced out-of-network bills they could not afford to pay, nearly 7 in 10 did not know the provider was out of network at the time they received care. Combatting surprise medical billing is rightfully part of Congress' broader focus on enhancing health care cost transparency.

Legislation can help take the "surprise" out of surprise billing by requiring hospitals and other providers to disclose upfront information to patients about pricing and out-of-network care. Patients should be informed about out-of-network care and cost at the time of scheduling non-emergency care at an in-network facility and follow-up care from emergency treatment at an out-of-network facility. Disclosing greater upfront information to consumers from providers about the service to be received and the pricing would provide the consumer better knowledge of whether their providers (all providers in the continuum of care) are in-network and whether a balance bill will occur, as well as their estimated financial obligation.

#### **5. STATE ALL-PAYER CLAIMS DATABASES**

The committee has requested feedback on how to aide states in developing robust all-payer claims databases.

We note that self-funded plans are not subject to state all-payer claims database reporting requirements. We ask policymakers to consider facilitating a national

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<sup>6</sup> <https://www.kff.org/private-insurance/issue-brief/surprise-medical-bills/>

all-payer claims database for self-funded plans. We strongly recommend that policymakers prevent the administrative burden associated with conflicting state requirements that arise from any federal mandate for reporting to 50 state all-payer claims databases. Congress could consider the creation of a single nationwide repository using existing authority or providing federal funding for a pilot program for a non-governmental (or quasi-governmental) entity or entities to serve as a national all-payer claims database.

## 6. ENSURING UNIFORMITY FOR ERISA SELF-FUNDED PLANS

We note for the committee that self-funded plans are not subject to state laws relating to surprise billing, as ERISA preempts those state laws. Our members rely on the ERISA framework to offer health benefits in a uniform manner nationwide. With respect to the “recognized amount,” the language refers to “in the case of such item or service furnished in a state that has in effect a State law that provides for a method for determining the amount of payment that is required...” The legislation needs to make clear that self-funded plans are not subject to the state laws. To ensure application to ERISA self-funded plan with respect to the recognized amount, the legislation should specifically incorporate the PHSA amendments to self-funded plans, and specify that the federal rule (not any state rule) applies. Section 715 of ERISA should be amended to add the following subsection (c):

“(c) Prohibitions on Balance Billing.—

- (1) Notwithstanding subsection (a), the provision of section 2719A of the Public Health Service Act, as amended from time to time, shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart.
- (2) In the case of a self-insured group health plan, for purposes of meeting the requirements under sections 2719A(b) and (e) of the Public Health Service Act, the recognized amount (as defined in section 2719A(b)(2)(H) of the Public Health Service Act) shall be at least the median contract rate (as defined in section 2719A(b)(2)(E) of the Public Health Service Act).”

Additionally, in Section (c) – Civil Monetary Penalties – on Page 14, Line 20, the word “group” should be added before “health plan” to ensure application to self-funded group health plans. The word “group” should also be added before “health plan” on Page 16, Line 18.

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The Council shares the committee's concern with surprise medical bills and the financial pain they inflict on patients. We look forward to working together on a solution that cures this problem, not merely masks its symptoms. With this goal in mind, we applaud the committee for its bipartisan proposal to address surprise billing. The draft legislation can bring relief to patients burdened by surprise medical bills and all consumers seeking lower cost and better quality health care.

Sincerely,

A handwritten signature in black ink that reads "Ilyse Schuman". The signature is written in a cursive, flowing style.

Ilyse Schuman  
Senior Vice President, Health Policy