



AMERICAN BENEFITS COUNCIL

February 22, 2019

The Honorable Bill Cassidy
United States Senate
Washington, DC 20510

The Honorable Michael Bennet
United States Senate
Washington, DC 20510

The Honorable Todd Young
United States Senate
Washington, DC 20510

The Honorable Thomas R. Carper
United States Senate
Washington, DC 20510

The Honorable Lisa Murkowski
United States Senate
Washington, DC 20510

The Honorable Maggie Hassan
United States Senate
Washington, DC 20510

Dear Senators Cassidy, Bennet, Young, Carper, Murkowski and Hassan:

The American Benefits Council (“the Council”) applauds your effort to craft bipartisan, effective legislation to address surprise medical billing and your engagement of the private sector in this effort. We, too, seek to protect patients from costly surprise bills. Employers are deeply concerned about the burden that unexpected medical bills from out-of-network providers place on employees and their families. 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 (2) treatment provided by out-of-network providers working at an in-network facility.

The Council is a public policy organization whose 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.

Surprise medical bills bring financial stress to patients already dealing with the challenges of a medical emergency or serious health condition. 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.

We view your effort to protect patients from surprise bills within the broader context of your effort to lower health care costs and improve price transparency. 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.

Our member companies recognize the toll that surprise billing can take on working families. Although employers are not obligated to pick up the balance billing charges, many large employers currently do so in order to provide additional financial protection to their employees and families beyond the substantial cost the employers already bear as sponsors of the health plan. As a result, the surprise billing practice is a financial burden on employer sponsors as well as individuals. While many employers currently voluntarily absorb some or all of the cost of balance bills, the legislative and regulatory response to surprise billing must not require employers to do so. Mandatory imposition of these costs on employers would undermine the considerable effort that employers, with their health plan partners, undertake to negotiate for effective networks of high quality and cost conscious providers. Despite employer efforts to avoid unexpected balance billing and to help employees faced with such a bill, the underlying problem continues. While insurance carriers and third party administrators may be better positioned to respond to some of your specific data requests, we offer insights from the employer perspective on the following questions you pose.

Thank you for asking the Council to provide answers to several important questions you have posed. The discussion below addresses those questions. We also offer specific policy recommendations for federal legislation directed at addressing the problem of surprise billing at its root and in a nationally uniform manner. Crafting legislation in keeping with these recommendations and the [consensus principles put forth by a coalition](#) representing employers, consumers and carriers will provide higher-value health care to the 181 million Americans with employer-sponsored coverage.

- *What do you currently pay for out-of-network care on average, broken down by plan type (e.g. HMO, PPOs, etc) market type (e.g. individual, small group, large group, ASOs), and provider types. How do these rates compare to Medicare rates, average in-network rates, and provider charges?*

The landscape for out-of-network reimbursement is changing. This is the message of a 2018 Milliman white paper¹ (the “Milliman report”) and the experience of Council member companies. The paper reports that billed charge trends have consistently outpaced in-network reimbursement trends, and that “most billed charge trends are considered out of sync with costs and well above typical in-network reimbursement.” The paper further notes that for some markets, it is common to see hospital billed charge levels many times those of typical commercial in-network reimbursement rates with Medicare and other government payer charge levels usually much lower.

Another study by Zack Cooper, Fiona Scott Morton and Nathan Shekita (the “Cooper study”) focusing on out-of-network billing for emergency care found that physicians charge, on average, 637 percent of what the Medicare program would pay for identical services, which is 2.4 times higher than in-network payment rates.²

As the gulf between billed charges and in-network rates grows, the Milliman report observes that many payers – including some Council member companies – are redefining out-of-network reimbursement as a multiple of Medicare rather than based on a percent of billed charges. The Milliman report also describes another approach payers are taking to out-of-network reimbursement by paying the in-network level for the market, determined as an average for providers in the market, or the standard base schedule – or even below the network level for non-emergency care.

Council members see the increasing disconnect between billed and network charges and the pressure it places on both patients and the benefit plans they sponsor. Reimbursing out-of-network providers by reference to billed charges is unsustainable and will result in even higher health care costs and fewer in-network providers. As you seek to address surprise billing as part of your broader goal of lowering health care costs and improving price transparency, the finding that most billed charge trends are “out of sync” with costs and “well above” typical in-network rates is alarming. We urge you consider an approach that would narrow this gap, lower costs and enhance transparency – not widen this gap even further.

- *What percentage of your plans’ premiums is currently attributable to the following specialty groups: emergency care (ER) physicians, radiologists, anesthesiologists, pathologists, ambulance services, and laboratory services?*

¹ <http://us.milliman.com/uploadedFiles/insight/2018/changing-landscape-oon-reimbursement.pdf>

² <https://www.nber.org/papers/w23623.pdf>

A Kaiser Family Foundation analysis³ of medical bills from large employer plans found that a significant share of inpatient hospital admissions includes bills from providers not in the health plan's networks. Nearly one in five inpatient admissions includes a claim from an out-of-network provider. The analysis found that almost 18 percent of inpatient admissions result in non-network claims for patients with large employer plan coverage.

Even when enrollees choose in-network facilities, 15 percent of admissions include a bill from an out-of-network provider, such as from a surgeon or an anesthesiologist. For inpatient admissions, those that include an emergency room claim are much more likely to include a claim from an out-of-network provider than admissions without an emergency room claim. This is the case whether or not enrollees use in-network facilities.

As with inpatient admissions, outpatient service days with a facility claim that include a visit to the emergency room are much more likely to include a claim from an out-of-network provider, whether or not enrollees use in-network facilities. The analysis also found that enrollees with anesthesia or pathology claims are more likely to have an out-of-network provider claim, even when using in-network facilities.

A study by Ge Bai and Gerard F. Anderson, published in JAMA in 2017 comparing physician charge-to-Medicare payment ratio across specialties,⁴ sheds light on the drivers of surprise billing. Data from 429,273 individual physicians across 54 medical specialties were included. 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). 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)."

The Cooper study similarly 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 inside 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

³ <https://www.healthsystemtracker.org/brief/an-analysis-of-out-of-network-claims-in-large-employer-health-plans/>

⁴ <https://jamanetwork.com/journals/jama/fullarticle/2598253>

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.

The ability of such specialties to set billing rates in this environment serves as a powerful incentive to remain out-of-network and fuels the surprise medical bills patients are facing. Clearly, this constitutes a market failure which necessitates legislative or regulatory intervention.

Federal legislation to protect patients from surprise medical bills must begin with a ban on this practice. To protect consumers and families, federal legislation should prohibit balance billing of patients for emergency services provided by an out-of-network provider or for non-emergency treatment by an out-of-network provider at an in-network facility.

If a facility is in-network, all care delivered at the facility should be reimbursed at the in-network rate and all patient cost-sharing should be based on in-network amounts. Legislation should not enshrine the incentives and leverage that have given rise to out-of-network surprise billing in the first place. If properly crafted, legislation should resolve this fundamental market failure created within some facility-based specialties.

It is important to recognize that while the magnitude of the surprise billing problem may not be great relative to the plan's overall spend, for a patient receiving a surprise medical bill, it could impose substantial financial hardship.

RECOMMENDATION: Ensure 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 balance billing. Require in-network facilities to accept in-network reimbursement rates for all care performed at the facility by all providers associated with the facility.

- *Can you provide data and modeling to demonstrate the effect on premiums for the current draft text's proposed changes (e.g. median in-network rate or 125% of allowed in-network amount)? Can you also provide data and modeling to determine the effect on premiums if legislation were to use Medicare rates, as well as if it were to use 80th percentile of charges as payment benchmarks?*

Sifting the cost of surprise billing from patients to payers merely masks the underlying drivers of charges from out-of-network providers for emergency treatment or at an in-network facility. Health plan networks promote better quality and lower cost for consumers.

Federal legislation to address surprise billing should not further incentivize providers to decline network participation by guaranteeing them reimbursement rates higher than in-network rates or higher than existing applicable Affordable Care Act (ACA) requirements. Simply 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. A federal solution to surprise billing should serve to lower, not increase, premiums and costs for consumers and employer plan sponsors.

The Council is concerned that the standard set forth in the draft legislation for payment by employer-sponsored plans and issuers to providers for amounts in excess of cost-sharing are excessive, would discourage network participation and drive higher health care costs. We are also concerned that using the 80th percentile of 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 for these 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.

As noted above, out-of-network billing for emergency care found that physicians charge, on average, 637 percent of what the Medicare program would pay for identical services. This is price-gouging and should be prohibited rather than encouraged by federal legislation. Clearly, billed charges are out-of-sync with costs and “well-above” typical network rates. Setting the benchmark by reference to billed charges creates incentives to artificially inflate billed charges with a so-called “discount” rate that remains well above costs and in-network rates and discourages network participation.

Undermining high-quality, high-value networks removes the greatest leverage plans have to lower health care costs. Setting a federal benchmark at a level that discourages network participation would result in higher costs for consumers. **By way of example, one Council member company with almost 130,000 covered lives estimates that, without networks, premiums would increase by approximately \$8,000 – a 45 percent 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.

We urge you to consider a different method for determining out-of-network provider reimbursement rates that will provide clarity, but neither discourages network participation or results in higher costs for all consumers. **A federal benchmark that caps reimbursement based on a percentage of Medicare or in-network rates is a less harmful and more effective approach.** A number of Council members are already utilizing a percentage of Medicare for out-of-network reimbursement. Using a Medicare rate eliminates problems inherent in relying upon a method based on billed charges. This approach is clear and would facilitate competitive, balanced negotiation.

RECOMMENDATION: Set a reasonable federal benchmark that caps reimbursement of out-of-network providers for emergency services or at in-network facilities based on a percentage of Medicare or in-network rates, not billed charges.

- *For states using independent dispute resolution processes to address balance billing, what has been the effect of the dispute resolution process on premiums and payment rates to providers, both in and out-of-network?*

At the outset, we note that self-funded plans are not subject to state laws relating to surprise billing, including with respect to state mandatory binding arbitration requirements, as the Employee Retirement Income Security Act of 1974 (ERISA) preempts those state laws. Our members rely on the ERISA framework to offer health benefits in a uniform manner nationwide. Accordingly, our member companies do not have data to provide on the impact of state laws utilizing a dispute resolution process to address balance billing. However, we do 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.

The experience of the mediation process in Texas is instructive. According to a recent report,⁵ the Texas Department of Insurance received just 43 requests from consumers for mediation in 2013. In 2014, the number of requests grew to more than 600 and have climbed steeply ever since. There were 4,519 requests in 2018, creating a significant backlog, and regulators expect 8,000 during the current fiscal year. The Texas experience is illustrative of the administrative challenges of a nationwide mandated dispute resolution process. We are aware of the Cooper study finding that New York's law requiring mandatory arbitration reduced out-of-network billing by 34 percent, and also reduced the level of in-network emergency physician payments in the state by 9 percent. The authors of the study acknowledge that the New York State law is administratively complex and potentially costly and advocated for an alternative policy requiring that care provided in the emergency department would be included when the hospital contracted to be in-network.

For policymakers legitimately concerned about federal rate setting, binding arbitration is not the answer. A federal benchmark that is clear and brings competition and balance is a more efficient and effective way to foster a market-based solution to surprise billing. If federal legislation requires the use of binding arbitration to resolve disputes between payers and providers (which we do not support), at a minimum, policymakers should include sufficient protections to guard against increasing health

⁵ <https://www.texastribune.org/2019/02/12/texas-mediation-balance-billing-faces-massive-backlog/>

care costs and undermining value-based networks. For example, arbitrators should not be allowed to take billed charges into consideration.

RECOMMENDATION: Binding arbitration is an inefficient and ineffective approach to addressing surprise billing and should not be included as a legislative solution.

- *Do you have a process for identifying when providers send balance bills?*

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 recognize the stress and financial devastation surprise medical bills can bring to working families and provide assistance to their employees in multiple ways. This assistance may take the form of contracting with other entities 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. We are concerned that federal legislation enshrining a reimbursement rate for out-of-network providers in excess of in-network rates will eliminate what remains of plans' negotiating leverage to avoid or reduce the incidence and amount of surprise billing.

- *What specific recommendations do you have to facilitate network adequacy and encourage provider participation in health plan networks in the context of federal legislation to address surprise medical billing?*

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 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.

- *What role do you think hospitals should play in combatting surprise medical billing?*

We believe that hospitals must play a key role in combatting surprise medical billing. The market power that certain hospital-based physician specialties exert certainly drives surprise medical bills. However, the fact remains that hospitals can and must take responsibility for the physicians staffing their hospitals. 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.

RECOMMENDATION: When a plan contracts with an in-network facility, all services performed at the facility should be at the in-network rate.

Transparency, or a lack thereof, also lies at the root of surprise medical billing. A 2016 Kaiser Family Foundation survey⁶ 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.

RECOMMENDATION: 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 at the time of scheduling non-emergency care about out-of-network care and cost, well before the point of services.

RECOMMENDATION: A new CMS rule requires hospitals to post their price lists online in an effort to increase price transparency. This chargemaster data posting should include a reference to actual costs and Medicare rates and identify egregious outliers.

Your question warrants a closer examination of any contractual relationships that may exist between hospitals and providers under which in-network hospitals financially benefit from facility-based physicians remaining out-of-network. The role of hospitals in combating surprise medical billing should also be viewed in the context of the role that hospital and provider consolidation is playing in rising health care costs more broadly. Payment differentials for certain out-patient services create incentives for hospitals to artificially increase costs to patients by acquiring physician practices, thereby fueling greater market consolidation and less choice for payers and patients.

RECOMMENDATION: Support payment parity across site of service in order to decrease Medicare and commercial spending, and ensure patients receive the right care in the right setting. Support site neutral payment reform policies to remove payment differentials for certain outpatient services, thereby reducing the incentive for hospitals to artificially increase costs to patients by acquiring physician practices.

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

- *In your view, is there a state model that has worked particularly well at protecting patients from surprise medical billing?*

California's surprise billing law was signed into law in late 2016 and only recently became effective. It applies only to "covered services from a contracting [*i.e.*, in-network] health facility at which, or as a result of which, the enrollee receives services provided by a non-contracting [*i.e.*, out-of-network] individual health professional." Under California's law, the liability of the individual receiving treatment is limited to any copay, coinsurance, or deductible that would apply to in-network providers. The out-of-network provider cannot bill or collect more than the cost-sharing amount.

The California law also dictates the reimbursement rate for surprise bills. It provides that issuers must reimburse out-of-network providers the greater of the average contracted rate, or 125 percent of the Medicare payment for the same service in that geographic region. The "average contracted rate" is determined using a methodology determined by health plans and insurers based on rates for services delivered by out-of-network providers at in-network facilities. Those reimbursement rates will be adjusted by the Consumer Price Index annually. California's Department of Managed Health Care and Department of Insurance were tasked with developing a statewide methodology by January 1, 2019, based on data provided to them by plans and insurers.

Since implementation of the California law is so recent, data on its impact is not yet available. However, its structure holds promise as a potentially reasonable approach. While self-funded plans are not subject to state requirements addressing surprise billing, Congress could look to the California law as a possible federal standard.

In conclusion, we thank you for the opportunity to inform your work on this issue. We applaud and share your commitment to bringing relief from surprise medical bills to Americans; and to your broader goal of lowering health care cost and improving price transparency. By working together with other stakeholders and with this goal in mind, we can bring relief to patients from surprise medical bills and lower cost and better quality to all consumers.

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