



The ERISA Industry Committee

Driven By and For Large Employers

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No More Surprises: Protecting Patients from Surprise Medical Bills

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Intro and About ERIC

Chairwoman Eshoo, Ranking Member Burgess, 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 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 our patients' 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.

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.

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.

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 examples upon request. Again, these are beneficiaries with some of the most robust insurance coverage available, and still they are experiencing immense, and in our view, unnecessary 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 these surprise bills are unfair and should never happen.

About Surprise Medical Bills

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. 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.

It is true that there are other 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. For example, some have suggested that a surprise medical bill is when an individual receives care and doesn’t realize they have not yet reached 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. We urge Congress not to deviate from the core three scenarios above.

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 believe the best course of action is to work to directly address 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, and transparent. 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. 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.

About the “No Surprises Act”

ERIC applauds the Energy and Commerce Committee for being early out of the gate with a thoughtful and effective legislative draft to address the surprise billing crisis. The “No Surprises Act” 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 plan sponsors working and paying on their behalf). The “*No Surprises Act*” 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.

While the Committee deliberates on a benchmark payment rate, we ask that you consider ways to simplify and enhance this approach.

First, in cases of a provider practicing at an in-network facility, we urge the Committee to bypass any need for a benchmark, by simply enacting a “network matching” guarantee. This would completely remove the government from influencing prices in these scenarios, simultaneously protecting patients from most surprise bills, and complementing the Committee’s approach thus far. There is bipartisan interest in such an approach: it has been praised by the [Brookings Institution and the American Enterprise Institute](#), the [Manhattan Institute](#), and many others, including more than [40 business groups](#) who are united in supporting network matching.

Network matching preserves complete freedom of choice for providers who don’t like the rates in a given facility – they can simply work somewhere else. If sufficient volume and quality of providers cannot be obtained for a facility, then the network rate will necessarily increase. 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. Market economics ensure that network matching will **not** lead to provider or access shortages, and because it takes place completely between providers, facilities, and payers, it can protect patients from surprise medical bills with **no government price-setting** and **minimal government involvement**. It even solves 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.

Unfortunately, network matching cannot solve the problem in cases of out-of-network emergency care. For that scenario, the *No Surprises Act* nails it. ERIC and our member companies support the market-based benchmark approach, as well as others that can potentially save patients more money. For instance, most of the employer community has coalesced around proposals to set a benchmark at 125 percent of Medicare rates, which would vastly simplify the solution.

We also recently learned about proposals from the Council for Affordable Health Coverage (CAHC), and the Progressive Policy Institute (PPI), which have the potential to significantly reduce the deficit and reduce patients’ health care costs, while ensuring fair compensation for providers. Those proposals would cap all out-of-network rates at around 200 percent of Medicare, drawing down to 125-150 percent of Medicare over 5-12 years. This could potentially save billions of dollars and help to bend the health care cost curve.

ERIC also notes that some provider representatives have suggested that Congress should merely stay silent on the resolution of surprise bills – they say Congress 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 premiums 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.

Some advocates are calling for federal legislation to only take effect in states with no surprise billing laws of their own, whereas others are calling for a national “floor” – providing a baseline in all states, and giving those states the option to add even more comprehensive rules on top. This will have a profound effect on Americans enrolled in individual market plans, small employers, and families who get their insurance through a state- or local-government plan. This is because some states have enacted only half-measures, others have taken no action whatsoever, and a few have passed laws that are in fact worse than the status quo, raising costs for all patients.

In the case of self-insured plans and those governed by ERISA, it is critical that one uniform, national standard applies. These employer-sponsored plans should continue to be regulated exclusively at the federal level, unaffected by state policies and regulation. This should include the amount the plan is required to reimburse providers – while it may make sense to vary this amount based on geography, it should still be subject to one national standard. Employers with operations in many states, and their beneficiaries who work or live across the country, should be protected by the same federal standard that enables employers to sponsor nationwide health plans for their workforce. We believe this is the policy the Committee’s draft lays out, and urge Congress to maintain this common-sense approach.

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 it mandates that 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; and

- In order to avoid out-of-control costs, binding arbitration would still require a benchmark payment rate for the arbitrator to consider – just as the most prominent Senate arbitration proposals do. As such, this choice should be considered less attractive to Congress than its supporters claim, because it does not actually shield Congress from making a decision 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.

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's 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.

Emergency Medical Transport

ERIC and others in the business community urge Congress not to attempt to address surprise medical billing without including ground and air ambulances. Indeed, we believe that Congress will have done a disservice to patients if they only protect them from balance bills once they enter the hospital doors, but the patient might already be bankrupted from the ride there.

Emergency medical transportation that is out-of-network should be treated exactly the same way out-of-network emergency room care would be treated. These services should be reimbursed based on a benchmark tied either to Medicare rates, or to comparable in-network rates in that of a similar geographic area. Ambulance or air ambulance providers' participation in the Medicare and Medicaid programs should be conditioned upon their agreement to abide by reasonable billing practices – thus eliminating any Congressional jurisdictional concerns that may arise. If that is not feasible, insurers and group health plans should be prohibited from contracting with or directing payments to any ambulance or air ambulance provider that does not abide by said practices – providers will quickly adopt these rules in order to maintain access to third-party payment.

We note that some medical transportation providers have opposed Congressional efforts to protect patients from *their* surprise bills. Ground ambulance providers have suggested that because they are subject to state law, federal surprise billing restrictions should not apply. ERIC notes that **all health care providers** are subject to various state laws, and that the participation of ground ambulance providers in interstate commerce (through services provided to patients and group health plans) clearly subjects

them to federal jurisdiction – and that federal law can and should supersede any possibly conflicting state laws in this limited area of out-of-network billing practices. States and localities have imposed regulation on ambulances in light of a lack of consistent policy from the federal government; now is the opportunity to correct this gap, thus eliminating the need for much of this inconsistent regulation.

Air ambulance providers have stated repeatedly that they are increasingly joining insurance networks. ERIC applauds this evolution, but ERIC member companies continue to hear from beneficiaries who are saddled with devastating surprise medical bills from air ambulance providers. If more air ambulance providers are participating in networks, this should supply a robust data reference that can be used to ensure air ambulance providers are compensated fairly once they are subjected to in-network matching, or a median in-network benchmark. Increased network participation also means that federal legislation will impose minimal disruption for providers, as in-network providers already cannot generate surprise bills.

As such, the perceived impediments to including both ground and air ambulance in the Committee's surprise medical billing solution are quite surmountable – and final legislation should protect patients from surprise medical bills generated by both ground and air ambulances.

Safeguarding Against Shenanigans

ERIC notes that the Committee's draft includes a provision that allows providers at an in-network facility to continue their out-of-network strategy, so long as they obtain signoff from a patient at least 24 hours prior to treatment. We are concerned that this provision, clearly designed with the good intent of preserving access, could in fact undermine the overall goals of the legislation. One of the chief causes of surprise medical billing is monopolistic behavior in various markets; effective legislative solutions will null this behavior by subjecting relevant providers to standards mutually accepted by providers and payers in other markets, and in a specific market, by the facilities where they choose to practice, and by similarly situated providers.

ERIC urges the Committee to tighten language as necessary to ensure that under no circumstance can a patient be asked (or required) to consent to out-of-network billing during an in-network visit or procedure. Otherwise, if there is no available alternative, a provider can still gouge patients – whether they obtain consent weeks in advance, or on the spot at the facility. An extremely narrow exception may be necessary, but consent should be required well in advance of any scheduled procedure, and balance billing should be outright banned in cases of an already admitted patient.

Oppose Network Adequacy Subterfuge

In communities around the country many provider specialties have adopted a business strategy not to join networks or accept health insurance. This has created significant challenges for employers who seek to create plans that can provide patients with access to quality, affordable health care. ERIC understands that representatives of such provider specialties have called upon Congress to force insurance companies to add these providers to their networks. Seeing as these providers currently choose not to participate in networks on a large scale, this request should be seen as a transparent attempt to increase their leverage to force third-party payers to pay higher prices than are reasonable in the context of a given market. In these cases, it is not about network adequacy, but tipping the scales to maximize provider revenue.

As the Committee is no doubt aware, the issue of network adequacy was addressed a decade ago as part of the Affordable Care Act. States have varying network adequacy standards, and in some cases, states that have the most draconian network adequacy requirements simultaneously have the greatest surprise billing problems. The two are unrelated, do not correlate, and as such, need not be taken up together.

Instead, the Committee should avoid relitigating the network adequacy debate – especially during the process of addressing the surprise medical billing crisis facing the more than 100 million Americans in self-insured plans. Congress has rightly recognized that network adequacy standards might make sense for products sold on a government-sponsored exchange and purchased with government-provided tax credits, but self-insured plans are not selling insurance. These plans are designed to provide adequate protection for their beneficiaries, to build networks that can handle the volume of care likely to be needed by beneficiaries, and to ensure costs are controlled to the greatest extent possible while patients are given access to providers with records of high-quality treatment. The application of network adequacy standards to self-insured plans has the potential to undermine value-driven models, eradicate centers of excellence programs, and vastly inflate health insurance premiums for beneficiaries.

At the same time, ERIC notes that providers currently abide by no network adequacy standard of their own. As a result, many providers participate in no networks at all. If providers are interested in expanding network adequacy requirements, Congress should consider whether providers should be required to participate in at least one network, to ensure no gaming of the system takes place.

Empower Patients and Payers with an All-Payer Claims Database (APCD)

Numerous states are moving forward with efforts to aggregate health claims data in their markets, and those efforts should be commended. However, states will not be able to fully achieve this goal without access to data from entities which they have no ability to regulate – namely, federal government programs, and self-funded ERISA plans. Therefore, ERIC has endorsed the creation of a national APCD that aggregates large employer claims data, as well as state-level and fully-insured data, and Medicare data, giving employers as well as researchers the opportunity to get a comprehensive view of health care markets and trends.

As outlined earlier in this testimony, self-insured plans cannot be subjected to conflicting and inconsistent regulation by the various states, and indeed the U.S. Supreme Court has ruled in *Gobeille v. Liberty Mutual* that the states cannot compel self-insured plans to report health care claims data. We believe that a national database can strike the right balance -- respecting states' rights to design and administer their own databases, ensuring states get access to the multitude of data they currently do not have access to, and protecting the ability of ERISA plans to operate on a national, uniform level.

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 working with the Committee to enact legislation to end the surprise billing crisis.