

May 21, 2019

The Honorable Lloyd Doggett  
Chair  
Subcommittee on Health  
Washington, DC 20515

The Honorable Devin Nunes  
Ranking Member  
Subcommittee on Health  
Washington, DC 20515

Dear Chair Doggett and Ranking Member Nunes:

We applaud you for holding a hearing examining surprise billing. Reflecting the goal of employers to protect patients from surprise medical bills without undermining network participation or resulting in higher health care costs for all consumers, we urge Congress to pass legislation consistent with the following provisions:

***Protect Patients from Surprise Medical Bills***

- The goal of any federal surprise balance billing legislative solution is to protect patients in situations in which they lack a choice of providers. It is vitally important, however, that any legislative solutions not discourage network participation or result in higher health care costs for all consumers. Patients often lack any meaningful choice of provider when they obtain care in out-of-network emergency rooms, and when a patient receives services in in-network facilities from out-of-network professionals, particularly with respect to a small number of provider specialties.
- To protect consumers and families, federal legislation must ensure that 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 “surprise” balance bills in these circumstances.
- Congress should implement this change through an amendment to section 2719A of the Public Health Service Act (“PHSA”), which applies to both group and individual commercial insurance, and which would apply to insured and self-funded group health plans through section 715 of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”).

***Disclosure and Transparency***

- For surprise balance billing that occurs at an in-network facility and follow-up care from emergency treatment at an out-of-network facility, federal legislation must require disclosure of out-of-network professional costs at the time of scheduling. This disclosure will help ensure that patients can make an informed decision and schedule procedures when an in-network professional is available.
- Facilities such as hospitals should also be required to list prominently on their websites, whether they lack available providers who participate in networks which the facility participates in – including what those specialties are, and the likelihood that a patient may thus be seen by an out-of-network provider.

- Much of the surprise over unexpected balance billing can be eliminated by providing this disclosure.
- Congress could implement this disclosure requirement directly on hospitals (through Medicare's minimum requirements for hospitals under 42 USC § 1395x(e)(1)-(8)), or through an amendment to section 2718(e) of the PHSA, which requires hospitals to disclose standard charges for items and services provided by the hospitals.

### ***Required Reimbursement***

- Out-of-network providers frequently bill well in excess of negotiated rates and Medicare for these services, as opposed to the actual value of the service provided. A study by Ge Bai and Gerard F. Anderson, published in JAMA in 2017 comparing physician charge-to-Medicare payment ratio across specialties found that anesthesiology had the highest median (5.8), followed by interventional radiology (4.5), emergency medicine (4.0), and pathology (4.0).
- To ensure equitable payment for the services provided without discouraging network participation or resulting in higher costs for all consumers, legislation must set a reasonable federal reimbursement structure that (1) establishes a federal cap for emergency services at an out-of-network facility at 125 percent of the Medicare rate, and (2) requires all providers at an in-network facility to accept in-network rates.
- Conversely, without reasonable limitations on the reimbursement rates, out-of-network providers in surprise balance billing situations will have an incentive to bill even higher rates in order to achieve maximum payment through any binding arbitration mechanism. Binding arbitration is an inefficient and ineffective approach to addressing surprise billing and should not be included as a legislative solution. The experience of the mediation process in Texas is instructive. According to a recent report, 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,
- Requiring facilities to bundle medical services for covered procedures into a single payment also could help address this problem if structured properly. In the case of bundled services performed by out-of-network providers, the costs of those services within the bundle cannot exceed either the allowable in-network rate or 125% of Medicare. But, care must be taken to ensure that the contracted bundled payment is final and not merely a progress point toward further negotiation.
- Congress should implement this change through an amendment to section 2719A of the PHSA, which applies to both group and individual commercial insurance, and which would apply to insured and self-funded group health plans through section 715 of ERISA.

### ***Ambulance and Outsourced Emergency Departments***

- A significant concern to both patients and plans are the massive costs associated with non-participating ambulance, air ambulance, and emergency department 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.
- Ambulance, air ambulance, and emergency services are essential to ensure that patients receive the care they need in the most urgent of situations. Subjecting patients in the most dire of circumstances to balance billing exposes patients to material liabilities in order to receive the care they need.
- Any legislative solution for surprise balance billing should also specify that ambulances and air ambulance services are considered emergency services for purposes of the statutory limitations on balance billing and reimbursement rates.
- Further, Congress should include provisions to eliminate problematic incentives in which an in-network facility could profit by allowing or encouraging an outsourced out-of-network emergency department to surprise bill in-network patients.
- Congress should implement this change through an amendment to section 2719A of the PHSA, which applies to both group and individual commercial insurance, and which would apply to insured and self-funded group health plans through section 715 of ERISA.

We look forward to working with you to address the burden of surprise medical billing.

Sincerely,

American Benefits Council  
 Corporate Health Care Coalition  
 Economic Alliance for Michigan  
 Florida Alliance for Healthcare Value  
 Food Marketing Institute  
 Greater Philadelphia Business Group on Health  
 Louisiana Business Group on Health  
 Midwest Business Group on Health  
 National Alliance of Healthcare Purchaser Coalitions  
 National Association of Health Underwriters  
 National Association of Wholesaler-Distributors  
 National Business Group on Health  
 National Retail Federation  
 Partnership for Employer-Sponsored Coverage  
 Retail Industry Leaders Association  
 Rhode Island Business Group on Health  
 Self-Insurance Institute of America, Inc.  
 Silicon Valley Employers Forum  
 St. Louis Area Business Health Coalition  
 The ERISA Industry Committee  
 Wyoming Business Coalition on Health