National Business Group on Health®

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

June 5, 2019

The Honorable Lamar Alexander
Chairman
Senate Committee on Health, Education,
Labor and Pensions (HELP)
Washington, DC 20510

The Honorable Patty Murray
Ranking Member
Senate Committee on Health, Education,
Labor and Pensions (HELP)
Washington, DC 20510

Dear Chairman Alexander and Ranking Member Murray:

The National Business Group on Health (the "Business Group"), an organization of 448 members, including many of the nation's largest employers, applauds your leadership and the efforts of the HELP Committee to propose solutions to address some of the obstacles to better, more affordable health care in your draft legislation, "the Lower Health Care Costs Act." Employers have a vested interest in improving the efficiency and effectiveness of health care delivery and in keeping health care affordable for employees and their families while also keeping it financially sustainable for employers.

We appreciate this opportunity to comment on the following titles: Ending Surprise Medical Bills and Improving Transparency in Health Care. While we do not comment here on Reducing the Prices of Prescription Drugs, we support H.R. 938, The Blocking Act of 2019, a bill in the House similar to your Section 205 preventing the blocking of generic drugs and we strongly encourage Section 206, which requires the FDA to provide education on biological products for health care providers, patients, and caregivers.

The Business Group commends the HELP Committee's efforts to find a comprehensive solution to the growing problem of surprise billing. We strongly support the provision (Section 102) that would protect patients by banning balance billing for emergency care, post-stabilization out-of-network care where reasonable notice is not provided and informed consent is not obtained, and for care at in-network facilities, assuring that they would pay no more than in-network amounts. We believe this is the right thing to do.

TITLE I: ENDING SURPRISE MEDICAL BILLS

Beyond this, however, **we believe that there are two other requirements that are needed to completely protect patients.** Some proposals would build in inflationary pressure on patient and plan participant premiums from charges reflecting the undue market leverage of specific facility-based physicians by establishing benchmark payment rates that are too high or setting up an arbitration scheme that tilts to their advantage. Legislation that does this also risks encouraging more physicians to go out-of-network in hopes of securing higher payments, thereby undermining the financial protection and potentially the quality reassurance that provider networks offer. Both actions not only hurt patients, they also make it harder for employer plans to maintain affordable coverage and weaken a major tool to drive quality and

efficiency, particularly as the private sector, Medicare and Medicaid are moving toward higher performing networks, ACOs and other network-based arrangements. **That is why we do not favor Option 2 in Section 103.**

Finally, it is critical to reduce the number of situations in which surprise bills can occur. Requiring facility-based physicians to either contract with the same insurers that facilities they practice in do, or by prohibiting separate billing for ancillary services apart from the facilities, will significantly reduce the number and frequency of surprise bills. **This requirement, which is Option 1 in Section 103, called "network matching," will also strengthen networks by guaranteeing to patients that when they are at in-network facilities, the care is truly in-network and will be billed as such. We strongly support this provision and believe that any legislation that does not include it is woefully incomplete.**

Therefore, it is critical that as you consider legislation, comprehensive and complete protection must be carefully crafted to include provisions addressing <u>each</u> of the following:

- **Protect patients from balance billing when they have no choice of provider;**
- **Reduce the incidence of surprise bills from occurring in the first place; and**
- **Assure effective, equitable payment that does not undermine network participation nor raise health care premiums.**

The success and comprehensiveness of any legislation will be measured by <u>all</u> the following:

- Patients should be protected from extra charges beyond their in-network payments in emergencies or when they seek care at in-network facilities.
- Neither patient premiums, nor plan costs should increase due to any benchmark payment levels or payment dispute resolution processes established by legislation.
- The rate and number of physicians and other providers participating in networks should not decrease on account of the legislation. Physicians should not be disincentivized from network participation by benchmark payment levels or payment dispute resolution processes established by legislation that puts in-network providers at a financial disadvantage.
- The percentage and number of surprise bills should decrease significantly after the legislation takes effect. The network matching provision will be critical here.

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 support the following provisions:

Protect Patients from Surprise Medical Bills (Section 102)

The goal of any federal surprise balance billing legislative solution is to protect patients in situations in which they lack a choice of providers. Patients often lack any meaningful choice of provider when they obtain care in out-of-network emergency rooms, or when they receive services at in-network facilities from out-of-network professionals, particularly with respect to a small number of provider specialties. According to a recent National Business Group on Health survey of large employers, the most prominent drivers of surprise billing are from the following specialties that people usually assume are part of the services provided in-network by an in-

network facility: emergency physicians (96%), anesthesia (88%), surgical assistants (67%), pathology (58%), and radiology (58%).[1] Another frequent source of surprise bills are ambulance services, both ground and air ambulance, as detailed below. What these services have in common is that patients very rarely chose them. They are either provided by the facility or in the case of ambulance services, the first to respond.

- **To protect consumers and families, federal legislation must ensure that patients' cost sharing is limited to in-network amounts for emergency services performed at out-of-network facilities 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").

Reduce the Incidence of Surprise Billing

Two ways to reduce the rate and total number of surprise bills are increasing the facility disclosure and transparency requirements and requiring "network matching."

Disclosure and Transparency

At a minimum, though it is often infeasible and difficult to establish effective disclosure and informed consent in many health care situations, particularly when patients are already at facilities or in the middle of transition from emergency situations to post-stabilization care, stronger notice and disclosure requirements may inform some patients and avoid some surprise billing.

- For surprise balance billing that occurs at in-network facilities and follow-up care after stabilization from emergency treatment at out-of-network facilities, **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 informed decisions and schedule procedures when in-network professionals are available.
- **Facilities 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 patients may be seen by out-of-network providers.** Much of the surprise over unexpected balance billing can be eliminated by providing this information up front.
- 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.

[1] National Business Group on Health. Quick Survey Findings: Surprise Billing for Out-of-Network Medical Claims Data. January 2019

Network Matching (Section 103 Option 1)

Either of the following would significantly reduce the incidence of surprise billing at in-network facilities and thus eliminate the need to use legislated payment rates or mandated processes to resolve payment disputes.

- **Requiring facilities to require facility-based physicians and other ancillary providers to also contract with the same insurers they contract with would go a long way toward eliminating surprise billing when patients select in-network facilities for health care services.** Many health systems include this provision in contracts with providers of ancillary or emergency services at their facilities. Many hospitals also require it to protect the community from extra charges. Moreover, it is a common-sense approach that resonates with patients and the general public. When patients go to hospitals or other facilities in their insurance networks, they do not expect that ancillary services that may be needed as part of their overall treatment, such as imaging, anesthesia for surgery, or lab work, services that are provided by the hospital, would be done by out-of-network providers. If they are, patients do not expect that ancillary providers would bill separately. After all, these providers are not generally chosen by patients, unlike the surgeons who operate on them or the doctors who perform their primary procedures, and these ancillary services are generally viewed by the public as part of the facility services. This approach allows facility-based providers the ability to negotiate appropriate payments independently with payers while patients are shielded from charges beyond in-network amounts.
- **Alternatively, requiring facilities to include all ancillary services provided by facility-based providers they contract with into a single bill would accomplish the same result.** Payments would be determined by contracts between payers and facilities as they currently are in many cases. Specific ancillary provider payments would be governed by the contracts they have with facilities. This is currently how many hospitals and other facilities handle such payments, keeping patients out of the middle.
- 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

While network matching will eliminate many instances where surprise bills could arise, there will still be occasions when they do happen, particularly in emergencies, but also at in-network facilities if in-network providers are not able to provide on-call coverage 100% of the time. For these occasions, as mentioned, it will be critical that lawmakers select benchmark rates that are not higher than negotiated in-network payment rates nor too high a percentage of Medicare if that is chosen for a benchmark. The providers who are the most frequent sources of surprise bills generally have captive consumers who did not chose them and once they are at a facility, have little if any choice. As a result, and as cited below, their charges often reflect the market dysfunction and are often significantly higher than Medicare reimbursement rates.

Benchmark Payment Levels (Section 103, Option 3) (Section 106)

- Out-of-network providers frequently bill well in excess of negotiated commercial rates and Medicare reimbursement for these services. A study by Ge Bai and Gerard F. Anderson, published in JAMA in 2017 comparing physicians across specialties found that anesthesiology had the highest median charge-to-Medicare payment ratio (5.8), followed by interventional radiology (4.5), emergency medicine (4.0), and pathology (4.0).[2]
- To ensure equitable payment for the services 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 out-of-network facilities at the median contracted rate or 125% of the Medicare rate, and (2) requires all providers at in-network facilities to accept in-network rates**.
- (Section 106) A significant concern to both patients and plans is the massive costs associated with non-participating ambulance and air ambulance services. According to GAO's analysis of the most complete data 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.[3] Ambulance, air ambulance, and emergency services are essential to ensure that patients receive the care they need in the most urgent of situations. **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.** Though it is currently missing for the draft legislation, we believe that this is a significant gap that needs to be addressed. Merely itemizing the charges for travel and the charges for emergency services and supplies does not help patients and their families stuck with huge bills that may take a lifetime to pay off. 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.

Arbitration is Not Optimal and Likely to Be Costly (Section 103 Option 2)

Some proposals suggest a "baseball-style" arbitration in which each party, providers and payers, submits their best and final payment, and an independent arbitrator would choose a rate that would be binding on both parties. For the reasons below, we believe that this approach is time- and resource-consuming and would lead to rates much closer to unreasonably high provider charges such as those cited above that are not bound by market discipline. This would be particularly true if arbitrators were not bound to heavily weigh competitively negotiated commercial rates in their decisions.

- **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.**

[2] Ge Bai and Gerard F. Anderson, "Variation in the Ratio of Physician Charges to Medicare Payments by Specialty and Region," Journal of the American Medical Association, January 2017
[3] US Government Accountability Office (GAO), Report to Congressional Committees: Air Ambulance Available Data Show Privately Insured Patients Are at Financial Risk, March 2019

- **Binding arbitration is an inefficient and ineffective approach to addressing surprise billing and should not be included as a legislative solution.** As the committee seeks to bring greater transparency to health care prices, a costly, complex and opaque arbitration process is a step in the wrong direction.

TITLE III: IMPROVING TRANSPARENCY IN HEALTH CARE

Increasing Transparency in Contracts between Plans and Providers (Sections 301 and 302)

Restrictive contracting practices by health systems and provider groups that have undue market leverage in localities can restrict price competition and leave patients and employer plans without critical information on prices for health care services. These practices include the following:

- Gag Clauses
- Anti-Tiering
- Anti-Steering Clauses
- All or Nothing Requirements
- "Most Favored Nation" Clauses

We support and applaud the inclusion of prohibitions on all of these in contracts between plans and providers in the draft legislation. Elimination of each of these anti-competitive contract restrictions will not only strengthen provider and health system competition, it will also give patients more complete information on the price and quality of providers in their plans and will populate consumer comparison tools with more accurate and complete information, particularly on prices in their plans. We also believe that employers, as plan sponsors, should not be pressured to agree to terms of contracts with health systems and other parties that they are not party to and cannot review. These can conceal anti-competitive contracting terms particularly in areas with dominant, "must have" health systems that plan sponsors are under pressure to include in their provider networks.

All-Payer Claims Database (Section 303)

The Business Group supports a national uniform repository, a "one stop shop," to collect, analyze, and report health care and pharmacy claims, and payment data and to permit authorized users, including employer plans to analyze the data to improve plan performance, for value-based plan design, alternative delivery models, for network evaluation, and other purposes designed to improve plan quality and reduce costs. While improving transparency, the provider-and facility-level data will comply with all current privacy and security protections and protect proprietary financial information, not disclosing contract terms between individual providers or facilities and specific plans. Plan sponsors would electronically submit claims data through their health plan administrator, pharmacy benefit manager, or other entity designated by the plan in a format and manner than minimizes the administrative burden.

The National Business Group on Health, representing 448, primarily large employers (including 72 of the Fortune 100) who voluntarily provide valued health benefits and other health programs to over 55 million American employees, retirees, and their families, looks forward to working with you on our shared goals for health care: lower costs, improved access, and higher

quality. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 558-3012, if you would like to discuss our comments in more detail or if we can provide additional information as the Committee continues its evaluation of surprise billing proposals and transparency of health care information as well as other ways to reduce health care costs without compromising quality.

Sincerely,

Brian J. Marcotte
President and CEO