PARTNERSHIP FOR EMPLOYER-SPONSORED COVERAGE

STATEMENT FOR
U.S. HOUSE OF REPRESENTATIVES
ENERGY & COMMERCE COMMITTEE
HEARING ON
NO MORE SURPRISES:
PROTECTING PATIENTS FROM SURPRISE MEDICAL BILLS
JUNE 12, 2019

The Partnership for Employer-Sponsored Coverage is an advocacy alliance of employment-based organizations and trade associations representing businesses of all sizes and the over 181 million American workers and their families who rely on employer-sponsored coverage every day. We are committed to working to ensure that employer-sponsored coverage is strengthened and remains a viable, affordable option for decades to come.

Employer-sponsored coverage has been the backbone of our nation's health system for nearly eight decades. Employers of all sizes contribute vast resources to employees and their families through the employer-sponsored system. Employers have a vested interest in health care quality, value, and system viability. Employers have been on the leading edge of health delivery innovation and modeling for decades.

The Partnership for Employer-Sponsored Coverage applauds the Committee for holding this hearing and working on bipartisan solutions to address surprise medical billing. As the Committee continues its work on *No Surprises Act*, we would like to reiterate our support for protecting patients from surprise billing and enacting a minimum payment standard to resolve out-of-network claims disputes instead of an arbitration system. Attached are our full comments on the draft legislation submitted to the Committee last month.

PARTNERSHIP FOR EMPLOYER-SPONSORED COVERAGE

May 28, 2019

The Honorable Frank Pallone (NJ)
Chairman
U.S. House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Greg Walden (OR)
Ranking Member
U.S. House Energy & Commerce Committee
2322 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Pallone and Ranking Member Walden:

As members of the Partnership for Employer-Sponsored Coverage, we write to commend you on your efforts in drafting the bipartisan *No Surprises Act* to address surprise medical billing in our nation's health care system. We welcome the opportunity to provide you with feedback as you continue your work toward formal introduction of this legislation.

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Employer-sponsored coverage has been the backbone of our nation's health system for nearly eight decades. The employer-sponsored coverage system provides health coverage for over 181 million hardworking Americans and their families every day. Employers of all sizes contribute vast resources to employees and their families through the employer-sponsored system. Employers have a vested interest in health care quality, value, and system viability.

As you know, benefits offerings and coverage plans in the employer-sponsored system are as diverse as employers and employees themselves. With self-insured coverage under the Employee Retirement Income Security Act (ERISA), employers tailor coverage to meet their workforce's specific needs across state lines, pay all health claims and bears the financial risk, and utilize a third-party administrator (insurance carrier) for daily plan management. Through the fully insured state-regulated insurance market, employers purchase a prescribed benefit insurance product sold in a state from an insurance carrier and do not bear the full financial risk of claims.

As you work to formally introduce the *No Surprises Act*, we would like to provide you with the following comments for your consideration. The Partnership for Employer-Sponsored Coverage has been working alongside other stakeholders in the employer and plan coverage community on this important issue and our comments below reflect shared policy opinions.

Protecting Patients from Surprise Medical Bills

First and foremost, we strongly agree that patients should be protected when put in a situation in which they lack a choice of providers. We support the draft proposal to prohibit balance billing for all emergency services. We also support the draft proposal to prohibit balance billing from providers that patients cannot reasonable choose in situations in which there was scheduled care with an in-network provider, but associated care was charged at an out-of-network rate.

Increasing Transparency for Consumers

Navigating the health care system for a consumer is most often mindboggling, frustrating and emotionally draining. We support the draft proposal to require providers to give patients receiving scheduled care written and oral notice

at the time of scheduling about the provider's network status and any potential charges for out-of-network care. Transparency of this information is critical to ensuring patients are better consumers of their health care and protected from surprise medical bills.

Additionally, it is important to note that employer plan sponsors are already required to provide enrollees with benefits guides and materials and devote a lot of time and resources to produce this information in ways that are innovative and interactive such as through web portals and clickable .pdfs. As you continue to identify ways to improve transparency in the system, please call upon employers to provide you with real-world examples about the types of communications they transmit to their employees.

Resolution of Out-Of-Network Payment Disputes

We welcome the draft legislation's recognition that a minimum payment standard should be set to resolve out-of-network claims disputes. We greatly appreciate that the draft legislation does not utilize an arbitration system to settle payment disputes. An arbitration system would be an administrative nightmare to self-insured employers who would have to directly contest claims in court as they are the plan sponsor. For smaller and mid-size employers who self-insure, the legal costs of arbitration could potentially be devastating.

While we do believe that the draft legislation's proposal of a market-based median contracted rate for the geographic area in which the service was delivered is a step in the right direction, we are in support of establishing a federal cap for emergency services at an out-of-network facility at 125 percent of the Medicare rate for the service. Additionally, we support the proposition that all providers in an in-network facility must accept the in-network rate. This will greatly reduce potential consumer confusion as well as the incidence of surprise billing.

Network Adequacy

For talent retention and recruitment reasons, employers are committed to providing robust provider networks that address all of their employees' health care needs. Employers have been at the forefront of developing and implementing high value provider networks at the lowest possible cost, including telehealth, on-site and near-site health centers, utilizing centers of excellence, direct contracting, provider transparency initiatives and wellness programs. Any legislation to address surprise billing should be crafted in a way that ensures these employer innovations and other value-based network initiatives are not hindered. Additionally, we agree that provider directories must be kept up to date. Providers play a key role in keeping these directories current.

All-Payer Claims Database

As you know, current all-payer claims databases in individual states collect data from fully insured products regulated by the state and not from self-insured ERISA plans governed under federal law. While there is understanding that transparency of claims costs and utilization of services through the establishment of all-payer claims databases can help with overall system reforms and plan designs, the administrative details of these databases could have potentially devastating effects on multi-state self-insured employers.

We recommend you proceed cautiously with applying the current fully insured state database model to ERISA self-insured plans. We oppose any effort to preempt ERISA and require self-insured employers to adhere to individual-by-individual state claims databases. Should legislative proposals establish a federal claims database for self-insured ERISA plans, we urge it to 1) include a single federal point-of-entry for uploading this information, and 2) be made available to employer plan sponsors for their utilization of plan development and design.

Air and Ground Ambulance Services

We are very concerned about the non-participatory status of many air and ground ambulance services. It is unfathomable to think that the travel to a hospital in an air or ground ambulance could impoverish a patient. We believe legislation should prohibit the balance billing of patients for these emergency services and encourage in-network participation by air and ground ambulance providers. We also support applying provider price transparency requirements to air and ground ambulance companies. Further, while we understand there are issues governing air ambulance services under the Federal Aviation Administration (FAA) that complicate the committees of health care jurisdiction from implementing robust policy, we call upon Congress to resolve these issues so patients are no longer subject to exorbitant charges.

Conclusion:

As a coalition representing businesses of all sizes, the Partnership for Employer-Sponsored Coverage has the unique ability to provide operational input across the full spectrum of the employer system – from the smallest family-owned business to the largest corporation. Employers have a great stake in the development and implementation of health care policies, and we look forward to working with you and your colleagues in a bipartisan manner throughout 116th Congress.

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