THE ERISA INDUSTRY COMMITTEE
Shaping benefit policies before they shape you.

No More Surprises: Protecting Patients from Surprise Medical Bills

Written testimony in support of HB 388 before the House Finance Committee
Columbus, Ohio

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Intro and About ERIC

Chairman Oelslager, thank you for this opportunity to submit comments on the surprise medical billing crisis in Ohio. The ERISA Industry Committee, or 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. 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.

Ohioans are likely to engage with an ERIC member company when they 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.

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 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 the Ohio legislature 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.

ERIC's Comments on HB 388

ERIC applauds Representative Holmes on his thoughtful and effective legislative draft to address the surprise billing crisis. HB 388 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). HB 388 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.

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 a median in-network benchmark will **not** lead to provider or access shortages. It will also solve 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.

ERIC also notes that some provider representatives have suggested that legislatures should merely stay silent on the resolution of surprise bills – they say legislatures 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. We are actively pursuing a federal solution that will apply to the 110 million Americans in self-insured plans. However, as Congress continues to debate, states should step in to protect consumers in fully-insured, state-regulated plans, with market-based solutions.

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. As such, this choice should be considered less

attractive to legislatures than its supporters claim, because it does not actually shield legislatures 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.

- Data from New York, where a binding arbitration regime has been imposed, show that health care costs are exploding, with plans being forced to pay 88 percent of provider's fake list prices. Patients will suffer as premiums gradually increase, due to providers knowing they can impose any list price they wish, and force plans to pay. Ohio's solution protects patients from unexpected surprise bills, as well as from health insurance premium increases.

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.

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 Ohio 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.