May 28, 2019

Chairman Frank Pallone
Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

Ranking Member Greg Walden
Energy and Commerce Committee
2185 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pallone and Ranking Member Walden,

On behalf of the National Association of Health Underwriters, representing 100,000 licensed agents and brokers who are engaged in the sale and service of health insurance and other ancillary products and serving employers and consumers around the country, we commend you for taking on the issue of surprise billing and we are pleased to offer our comments on the bipartisan discussion draft, the *No Surprises Act*.

The members of NAHU work daily to help consumers navigate a labyrinth of healthcare coverage options that work best for them, but they also expend an extraordinary amount of time assisting consumers who use their benefits, particularly around claims adjudication. It is not uncommon for an agent to spend many months working to resolve billing issues. Our agents have found offers to negotiate to 125% of Medicare are routinely refused. The time expended on these negotiations between the carrier and provider can be lengthy for even amounts as small as $300. One agent reported that 66 touches with the billing office were made on one issue. Some claims have required as many as 115 or more contacts over several months. However, one agency reported some success in negotiating down the bills, saving consumers over $2.1 million in 2018. This reflects the amount those consumers would have paid if the agency had not taken action regarding these surprise bills.

What we found is a system stacked against the consumers, who have no leverage with the provider or hospital that typically does little to negotiate or assist the insured. Patients are asked to sign paperwork that allows such billing with vague and ambiguous language, sometimes under duress, during an emergency. Often the patient is asked to sign these papers while actively preparing for a procedure. If you are in the unfortunate situation of not being conscious at the beginning of care, you may find that you have received almost all of your care from out-of-network providers, from the ambulance to ER doctor and hospital. In many cases this results in collection action and a damaged credit report.

We support the Committee's bipartisan approach to protecting consumers from preexisting conditions by prohibiting balance billing for all emergency services and requiring that consumers only be held responsible for the amount they would have paid in-network. We also believe that patients receiving scheduled care should be given written and oral notice at the time of scheduling about the provider's network status and any potential charges they could be liable for if treated by an out-of-network provider. These notices need to be provided in language that can be easily understood by patients that also provides them with information on how to seek a provider in network to prevent any access charges by an out-of-network provider especially in circumstances when patients cannot reasonably choose their provider.

This practice must come to an end, and we are encouraged by the bipartisan language provided in the *No Surprises Act*. We welcome the opportunity to respond to the Committee's specific request for feedback in the following areas:

Increasing Transparency for Consumers

We appreciate the concern for consumer protections and the caution given to require notices to patients in non-emergency settings to inform them that they may not be treated by an in-network provider. However, in the setting in which non-emergency patients are signing a form acknowledging they are aware they will be treated by out-of-network providers, we question whether patients understand the consequences of what they are signing, and whether it is reasonable for the provider to check with each patient's insurance company to look for an in-network provider option. We worry about network transparency and the ability of health plans to keep these records up-to-date, especially with little state or federal enforcement to do so. In the case that there is no option for the patient to transfer to an in-network provider, we suggest the health plan pay at the in-network level. If there is truly no other choice for the patient, the insured should not be penalized for the lack of providers participating in the network. This would also provide another manner in which providers could be incentivized to join networks.

Ensuring Network Adequacy

We recognize that network adequacy can be a barrier to access of care, but is not a direct correlation with surprise billing. Network adequacy is larger overseen by state regulators, and the NAIC has worked tirelessly to continue to modify their *Network Adequacy Model Act* which has been adopted in some iteration by several states. However, states and carriers need to work diligently to ensure that these provisions are truly being enforced, that information regarding provider participation in networks is being continuously updated, and that plan designs are not being approved if they do not provide adequate access to a range of healthcare providers. The needs of networks are specific to each state, and regulation of these networks should be reserved for state regulators who have the most intimate knowledge of the needs of their healthcare consumers.

Encouraging the Development of State All-Payer Claims Databases

Many states have already implemented all-payer claims databases with the goal of creating more transparency in the health insurance market. However, these databases include data from fully insured plans regulated by the state, and do not include information from self-insured plans that are governed by federal ERISA laws. Imposing any requirements that ERISA plans comply with the existing state all-payer databases could result in extreme administrative burden for both states and employers. Alternatively, if the desire of the Committee is to collect this data, we would suggest that a federal claims database for self-insured ERISA plans that would include a single point-of-entry for uploading this information, and be made available to employer plan sponsors for their utilization of plan development and design.

Protecting Consumers from Surprise Bills from Air and Ground Ambulances

We agree that there is a need for solutions to surprise medical bills from ground and air ambulances, and we encourage the Committee to address these in separate legislation. As the committee recognizes, consumers being served by air ambulances are often in critical condition, and the service provided in many cases is life-saving. However, there is a difference in how air ambulances are covered by insurance carriers that often leaves patients recovering not only from near-fatal physical ailments, but also from exorbitant bills from air ambulances that were either not in the consumer's carrier network or in no carrier network at all. The difference in how air ambulances

are covered results in many consumers with health insurance facing large amounts of debt they never thought possible because they did what they thought was responsible by enrolling in health insurance only to find out that most air ambulances are not covered by carrier networks.

Establishing a market-based benchmark to resolve out-of-network payment disputes between providers and insurers

We recognize there are several suggestions being offered to determine how to simplifying the calculation used to determine the maximum amount an emergency out-of-network provider can be reimbursed. Many look to the average cost of care by similar providers in a similar geographic area, and in some cases engaging the data from all-payer claims databases to assist in setting that benchmark. This practice rewards providers for being out-of-network by taking several measures into account from geographic location to average provider reimbursement to a percentage of cost sharing. Instead we suggest using some percentage above Medicare rates to determine the amount. Medicare reimbursement rates are a widely used standard, easier to understand and calculate and easier to administer. Using Medicare rates as a starting point would not only simplify the determination of reimbursement in these cases, but may also have a ripple effect to simplify other aspects of administration of health plans.

Examples of Balance Billing

To aid the Committee in providing examples of this issue, we have compiled a number of surprise-billing stories that traverse the United States. We believe these stories will be useful to the Committee as you examine this important issue. The stories we present here are a fraction of the stories we have and represent a wide range of balance-billing situations from lower dollar amounts to balance billing that reaches 7,000% above the usual and customary commercial rates. The next two stories come from a health insurance agent's recent testimony in Colorado.

Hospital and out-of-Network Equipment

The first claim is from a scheduled surgery where the insured did its due diligence and made sure the hospital (Sky Ridge), the surgeon, the anesthesiologist and anyone else who was going to be involved in the surgery was in-network. About a month after the surgery, the insured received three out-of-network bills --one from the surgeon, one from a company that provided technical equipment in the operating room, and one from a provider that was not in the surgical room to monitor the technical equipment. The surgeon, whom the agent confirmed was in the network, has two tax IDs, one for regular working hours (in-network) and one for outside of regular working hours (out-of-network). Of course, the surgery was scheduled during the out-of-network hours and resulted in total billed charges of $26,161 from the surgeon. If the surgeon had billed within the network, he would have been reimbursed roughly $3,500. The technical equipment had its own tax ID (out-of-network). The billed charges for the equipment were $258,400. If costs had been billed in the network, the company would have been paid around $1,000. The physician to monitor the equipment (out-of-network) billed $154,250. If charges had been billed in-network, the provider would have received around $1,000. To recap the numbers, the total out-of-network claims billed to the insured, which the carrier had to pay in total because of out-of-pocket limits, was $438,811. Had these services been in the network, the paid charges would have been approximately $5,500. When carriers are required to pay these abusive and usury charges, they are passed along to all of our premiums in future years.

The second claim resulted from an insured being taken by ambulance, after a bicycle accident, to an out-of-network hospital emergency room (Boulder Community Health). There were eight different billed charges, including two different hospital miscellaneous fees totaling $15,721, and an emergency room fee of $11,174. The eight total billed out-of-network charges were $53,968. If costs had been billed within the network, the reimbursement would have been approximately $5,050.

The carrier has tried to negotiate but the hospital will not budge on the out-of-network charges. The carrier is only responsible for paying usual and customary when negotiations breakdown and therefore the insured is being balance-billed roughly $48,000. The consumer has retained an attorney and this is still pending.

Laboratory

This story comes from Lutz, Florida, where an insured experienced a surprise bill after going to an in-network emergency room and being admitted to the in-network hospital. Laboratory tests were ordered, including advanced imaging. The reading and review of the tests were completed by out-of-network radiologists. The patient had no control over which doctors saw her or read the results of her tests. The agent attempted to go through the carrier to see if it could assist with getting this claim reprocessed, but an appeal was the only next step. With the insured's permission, the agent submitted a member first-level appeal on behalf of the insured and the appeal was upheld.

In another case, a five-year-old who was severely dehydrated and was taken by her mother to the closest emergency room to their home, Inwood Emergency Room. The total bill was $8,476.36. The bill was presented to the carrier for processing, which allowed $2,325.84 minus an emergency room copay of $450 and $817 to the deductible, plus coinsurance of $217.76, for a total payment of $841.08. After paying the legitimate cost-sharing expenses of $1,484.76, the insured was balanced-billed $6,150.52.

Hospital Specialists

This case involved an insured who went in for a pancreatic biopsy. His primary care provider was an in-network doctor who referred him to a network specialist. The specialist scheduled a test at a network hospital. The procedure went through without a hitch, and the insured was very satisfied with the care, but then the bills came and he learned that the hospital sent the tissue sample out to a non-network lab, and the lab was billing the insured for $5,800 in cancer screenings, of which the insured said the insurance company paid approximately $800 because some of the tests done were deemed experimental by the carrier. The insured was livid because: 1) he had no choice of the lab chosen, 2) he did not know what tests were being done and or if the tests indeed were experimental (had he known he would have declined them up front) and 3) he had no idea what the fee schedules were going to be once the out-of-network lab received the sample.

The insured complained to the hospital. The hospital pointed that, in the admitting paperwork, it was disclosed" "We may use out-of-network labs/contractors during your care and we can't be held responsible," and it was signed by the insured. (Of course the insured had no choice but to sign the paperwork or the procedure would not get completed as scheduled.)

ER

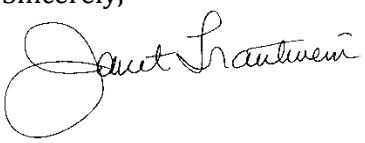
In Tennessee, two carriers are fighting over out-of-network emergency room charges, and the patients are losing. Agents report that people with real emergencies are now receiving $50,000+ outstanding emergency room bills due to balance-billing.

Anesthesiologist
A baby born in a hospital in Georgia and the mother had health coverage. After two days in labor and an unscheduled C-section, the mother was discharged with a healthy baby. The bad news is that the anesthesiologist was not a contracted in-network physician at the in-network hospital where the delivery occurred. The result was a balance of $8,000 for anesthesia. The agent made several calls to the provider's office and assured the carrier would pay more. It didn't, and the provider would not negotiate. Anesthesia services rendered should be mandated that an in-network hospital is considered as in-network and the carrier should negotiate these fees on behalf of patients. The provider claimed he had to stay at the hospital 24/7 to monitor the patient and the fee was reasonable. At the very least, hospitals should be required to disclose the in- or out-of-network status of anesthesiologists practicing at the hospital.

Pediatric Anesthesiology in Alabama
Agents have had issues with clients in Birmingham, Alabama, with pediatric anesthesiologist services at Children's hospital that are not a participating provider with the same providers as the hospital. This issue prevents patients going to this hospital because they know the hospital is participating in their network, they later find out with a surprise bill that the anesthesiologist group is non-participating, and they have a large bill to pay. The same goes for an anesthesiologist group in Auburn, Alabama.

We sincerely appreciate the opportunity to provide the Committee with our feedback on the *No Surprises Act* discussion draft. If you have any questions about our comments, or if NAHU can be of assistance as you move forward, please do not hesitate to contact me at either (202) 595-0639 or jtrautwein@nahu.org.

Sincerely,



Janet Stokes Trautwein
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