June 12, 2019

The Honorable Anna G. Eshoo
Chairwoman, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Michael C. Burgess
Ranking Member, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Chairwoman Eshoo and Ranking Member Burgess

On behalf of the members of the American Federation of State, County and Municipal Employees (AFSCME), I ask that this letter be included in the record for the subcommittee's June 12, 2019 legislative hearing on the "No Surprises Act." The health and financial security of working families rests upon solid health care coverage, but coverage alone is not enough when individuals face surprise medical bills. We applaud the subcommittee for working to tackle this problem. The draft "No Surprises Act" is a key step towards protecting patients against punitive balance bills while keeping overall health care costs in check. We appreciate the opportunity to urge further improvements to the bill.

"Surprise medical bills" result from unexpected charges from an out-of-network provider. These bills can be tens of thousands of dollars, leaving working families with huge medical debt and a heavy financial burden. They usually happen with an emergency room visit. In an emergency, patients do not choose the emergency room, treating physicians, or ambulance providers. Surprise medical bills also happen with planned care from an in-network provider (such as a hospital or ambulatory care facility), but other treating providers brought in to care for the patient are not in the network. Typically, anesthesiologists, radiologists, pathologists, surgical assistants, and others may be out-of-network providers at an in-network facility. Like in an emergency, the patient seeking planned care in not in control of who treats at their in-network facility.

Hold Individuals Harmless for a Broad Range of Unexpected Medical Bills

We support that the bill works to hold individuals harmless but urge the subcommittee to expand the scope of services covered to hold individuals harmless

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against unexpected bills for air and ground ambulances when an individual is not in control of the decision to use the service. In rural areas, geography and hospital closures mean severely injured or ill individuals must rely upon air ambulance services and face surprise bills of $30,000 to $80,000. Air ambulance surprise bills also affect individuals in urban and suburban areas. For example, an individual seriously injured in a highway car crash may need this type of high-cost emergency transportation to be airlifted to a specialized trauma care medical center. The "No Surprises Act" should also cover air and ground emergency medical transportation.

We also urge the subcommittee to clarify in the legislation that hold harmless protections also apply to a patient transitioning from emergency to non-emergency treatment at a non-network facility. The scope of the bill should not leave these patients vulnerable to surprise bills, especially for those admitted to a hospital.

We also encourage the subcommittee to extend surprise billing protections to certain non-emergency services or items originating from the office of an in-network physician or other medical professional, even if that office falls outside the definition of health care facility described in proposed 42 U.S.C. Sec. 300gg–19a(e)(2)(B). For example, we encourage that the subcommittee clarify the bill's identification of health care to ensure hold harmless protections also apply in cases where a physician directs blood or other samples taken in the physician's office to a third-party, non-network laboratory.

Ensure that "No Surprises Act" Protections Wrap Around State Laws

The "No Surprises Act" defers to state surprise billing laws in instances in which a state law provides a method for determining the payment amount. We ask the subcommittee to ensure the "No Surprises Act" protects individuals in cases where the state surprise billing law is less comprehensive and not coextensive with federal law. For example, if a state surprise billing law applies only to specified categories of nonparticipating providers, federal law should still apply with respect to all other nonparticipating providers otherwise covered by the federal requirements.

Base Payment Rates for Out-Of-Network Providers on Medicare Rates

With the patient held harmless for the surprise medical bill, payment for the bill shifts to a resolution between the insurer and the out-of-network providers. Payment rates for out-of-network providers must not lock in soaring prices or increase health care costs. Americans already pay high health care prices even for in-network care. Using median contracted rates, as the "No Surprises Act" proposes, would not correct for the problem of already excessive contracted rates.

The most effective and efficient way to provide for adequate, non-escalating payments would be to link the new payment to Medicare rates plus a percentage for the same or similar services or items provided by a provider in the same or similar specialty in the same geographic region.

A recent analysis found that average contracted rates for emergency physicians and anesthesiologists are 306 percent and 344 percent of Medicare rates, respectively; in comparison, the average contracted rate for all physicians is just 128 percent of Medicare rates. Using Medicare rates as the reference price would correct for the market failures that result in these excessive in-network rates while also addressing surprise medical bills. *See* *https://www.brookings.edu/research/state-approaches-to-mitigating-surprise-out-of-network-billing/*

We urge the subcommittee to revise the "No Surprises Act" to use reference prices based on Medicare rather than negotiated rates for surprise billing claims because negotiated rates for providers most frequently involved in surprise billing (e.g., emergency room physicians, radiologists and anesthesiologists) are already inflated compared to negotiated rates for other providers.

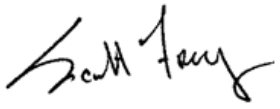
The minimum rate could be set at Medicare rates plus a percentage, such as Medicare plus 25 percent. Oregon uses this basic method for setting adequate rates in some circumstances. Oregon law sets maximum rates that can be paid by the state's Public Employees' Benefit Board and the Oregon Educators Benefit Board for certain hospital claims as a percent of the amount paid by Medicare, with a lower rate paid to out-of-network hospitals than in-network hospitals and hospitals reimbursed under this method barred from balance billing patients. *See* Or. Rev. Stat. § 243.256 and § 243.879 (as amended in § 31, Ch. 746, Or. Laws 2017) (applies to plan years beginning after July 1, 2019).

Network Adequacy Is Important but Not a Surefire Way to Protect Against Surprise Medical Bills

Some suggest improving network adequacy to protect individuals against surprise medical bills. Surprise billing and network adequacy are different problems. Addressing network adequacy will not solve the surprise billing problem. We note, for example, that individuals already covered by broad networks, including many AFSCME members, are still vulnerable to surprise bills.

Again, we thank the subcommittee for its work in protecting individuals against surprise medical bills.

Sincerely,



Scott Frey
Director of Federal Government Affairs

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