



601 E Street, NW | Washington, DC 20049  
202-434-2277 | 1-888-OUR-AARP | 1-888-687-2277 | TTY: 1-877-434-7598  
www.aarp.org | twitter: @aarp | facebook.com/aarp | youtube.com/aarp

June 12, 2019

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

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

RE: No More Surprises: Protecting Patients from Surprise Medical Bills

Dear Chairwoman Eshoo and Ranking Member Burgess:

AARP, on behalf of our nearly 38 million members and all older Americans nationwide, would like to thank you for holding a hearing on June 12 to examine the issue of surprise medical billing. AARP strongly supports efforts to protect consumers from expensive surprise medical bills when they believe they are appropriately seeking care from in-network providers (facilities or professionals) or during an emergency.

Cost is often a key determinate as consumers decide what care to seek, as well as where to receive it. Unfortunately, there are times when an individual makes every effort to obtain affordable care under their insurance coverage, but is surprised to receive a bill from a non-network provider whom they did not choose or were not given the opportunity to choose. As we noted in our May 28, 2019, letter commenting on the draft *No Surprises Act*, we seek clarification on the following points:

- The draft bill does not appear to apply protections to non-facility based settings, such as physician offices. There are many instances of in-network, office-based providers using non-network labs to process tests, or consulting non-network providers, without the knowledge or permission of the consumer. We urge that the bill be clarified to apply to non-facility based settings as well.
- Allowing exceptions for nonparticipating providers at participating facilities to balance bill if they provide notification may remove the “surprise”, but it can still place an undue burden on consumers. Individuals visiting the facility may see multiple providers. Allowing different providers to bill under different rules creates

confusion and puts a burden on the consumer. Moreover, consent is not meaningful if there is limited or no choice of provider. Consumers may sign the acknowledgement form because they have no alternative.

Any final legislation must prioritize the consumer experience and follow these three principles:

1. Consumers must be held harmless

Individual out-of-pocket cost-sharing must be limited to the in-network amount when a consumer receives emergency care, chooses to receive care at an in-network facility, or has not elected to receive care from a non-network provider. This applies to any copay, coinsurance, or deductible under the individual's insurance coverage. Disputes about payment, once the in-network coverage obligation has been met, are between the provider and the payer. The consumer has fulfilled their responsibility and should not be subject to further bills or penalties. Furthermore, notifying an individual at an in-network facility that a provider or service is out-of-network does not provide sufficient protection. Notification may remove the "surprise", but it is not a substitute for meaningful choice.

2. Protections must apply to all sites of care and providers of care

An individual seeking care in a medical emergency should not be expected to research provider directories or check network status before calling an ambulance or going to the nearest emergency room. Likewise, we must not penalize consumers for making good choices, or when they are given no choice at all. An individual who does their due diligence, and seeks care from an in-network facility or an in-network provider's office, should not be saddled with a bill from a separate provider or lab for which they had no choice. Once at the facility or doctor's office, the discretion is with the provider – not the consumer – to consult specialists, order tests, and process images.

3. Protections must apply to all payers

Surprise balance billing must be prohibited across all payers – individual/small market, large employer, self-insured, and ERISA plans. This issue impacts all consumers, regardless of their type of coverage. While states should be allowed to have more protective laws, a federal standard or baseline is necessary to prevent loopholes and exceptions.

We also urge you to not overlook the Medicare program as you consider ways to protect consumers from surprise medical bills. There is a glaring absence of consumer protection in Medicare regarding the use of "observation status". Medicare beneficiaries who enter the hospital, spend multiple nights, and receive the same care as *inpatients* are being denied coverage for subsequent skilled nursing facility (SNF) care because they were classified as an *outpatient* under *observation*. We urge you to protect beneficiaries from paying possibly thousands of dollars more in surprise out-of-pocket

costs by counting the time a Medicare beneficiary spends in observation toward the three-day stay requirement for Medicare coverage of SNF care.

Thank you again for your bipartisan leadership on this issue. We appreciate the opportunity to provide feedback, and look forward to working with you to protect consumers from surprise medical bills and make health care more affordable. If you have any questions, please contact me, or have your staff contact Andrew Scholnick of our Government Affairs team at [ascholnick@aarp.org](mailto:ascholnick@aarp.org) or 202-434-3770.

Sincerely,

A handwritten signature in black ink, appearing to read "David Certner", with a stylized flourish extending to the right.

David Certner  
Legislative Counsel and Legislative Policy Director  
Government Affairs