August 12, 2019

Mr. James Gelfand
Senior Vice President, Health Policy
The ERISA Industry Committee
701 8th Street NW, Suite 610
Washington, DC 20001

Dear Mr. Gelfand:

Thank you for appearing before the Subcommittee on Health on Wednesday, June 12, 2019 at the hearing entitled "No More Surprises: Protecting Patients from Surprise Medical Bills." We appreciate the time and effort you gave as a witness before the Subcommittee.

Pursuant to Rule 3 of the Committee on Energy and Commerce, members are permitted to submit additional questions to the witnesses for their responses, which will be included in the hearing record. Attached are questions directed to you from certain members of the Committee. In preparing your answers to these questions, please address your responses to the member who has submitted the questions using the Word document provided with this letter.

To facilitate the publication of the hearing record, please submit your responses to these questions by no later than the close of business on Friday, August 30, 2019. As previously noted, this transmittal letter and your responses will be included in the hearing record. Your written response should be transmitted by e-mail in the Word document provided with this letter to Josh Krantz, Policy Analyst with the Committee, at josh.krantz@mail.house.gov. You do not need to send a paper copy of your responses to the Committee. Using the Word document provided for submitting your responses will also help maintain the proper format for incorporating your answers into the hearing record.

Thank you for your prompt attention to this request. If you need additional information or have other questions, please have your staff contact Mr. Krantz at (202) 225-5056.

Sincerely,

Frank Pallone, Jr.
Chairman

Attachments

cc: Hon. Greg Walden, Ranking Member
Committee on Energy and Commerce

Hon. Anna G. Eshoo, Chairwoman
Subcommittee on Health

Hon. Michael C. Burgess, Ranking Member
Subcommittee on Health

Attachments—Additional Questions for the Record

Subcommittee on Health
Hearing on
"No More Surprises: Protecting Patients from Surprise Medical Bills"
June 12, 2019

James Gelfand

The Honorable Gus M. Bilirakis

1. The physician community supports a proposal from Rep. Raul Ruiz and Rep. Phil Roe that models a law from New York state. This would create a "baseball-style" arbitration process that incentivizes both parties to come to the table with reasonable offers to bring doctors in network. Georgetown put out a study that says the New York model has reduced out-of-network billing by 34%. As of October 2018, arbitration decisions have been roughly evenly split between providers and payers, with 618 disputes decided in favor of the health plan and 561 decided in favor of the provider. New York has a demonstrably fair process for dispute resolution, can the insurers show how any other solution would result in similar equity between providers and insurers?

ERIC Response: *ERIC does not represent insurance company interests; we represent the large employer plan-sponsors who pay 85% of health insurance costs on behalf of employees, families, and retirees. As you are no doubt aware, over 181 million Americans currently get health insurance through an employer, and this saves the federal government hundreds of billions of dollars per year.*

The Ruiz-Roe proposal, modeled off the New York surprise billing law, would mandate binding arbitration for the entire self-insured market. This would be much more disruptive, in many critical ways, compared to the results of the New York law, which was enacted in the unique legislative environment in the state. New York's health care markets are among the most expensive and highly regulated in the country, with different rules for hospitals, HMOs, and other actors than the rest of the county. As such, attempts to project the results of a New York law on to more than 110 million Americans in self-insured plans across the country, in 50 different states, are an "apples-to-oranges" comparison.

Regardless, the results of the New York law may show a somewhat even split between winners of arbitration. However, in the case of an insurer who loses an arbitration case, the New York law subjects that insurer to potentially unlimited costs. Because the law takes into account provider list prices, which are not market-based (indeed, they are simply invented by providers with no

requirement to have any basis on actual costs or economic conditions), any single arbitration loss could incur extreme costs to the insurer. This directly translates into costs for plan participants, causing premiums, deductibles, copays, and coinsurance to increase.

The Ruiz-Roe legislation would impose a similar system on all 110 million Americans in self-insured plans, as well as on anyone enrolled in a fully-insured plan in a state that does not currently have a comprehensive surprise billing law. It is no surprise that this is an approach favored by providers – it amounts to a government mandate to force insurers and employers to pay potentially unlimited amounts of new money into provider coffers. For this reason, the arbitration approach is highly favored by the private equity hedge funds that own most of the provider firms engaging in egregious surprise billing practices.

For those interested in controlling health care costs and truly protecting patients, a local market-based benchmark is the preferred approach. See ERIC's previously submitted testimony for further details.

2. Under the proposed benchmark, what would prevent insurers from dropping providers out of network and paying everyone that had been in contract above the median the lower benchmark rate? Wouldn't the median rate then drop, so the next year they could pay them even lower?

ERIC Response: *Short answer: market realities. Long answer:*

Employers do not sell health insurance; they provide benefits to meet the needs of beneficiaries – their employees and families. As such, we need robust networks that can handle the volume of care likely to be needed by our beneficiaries in a given plan year. A benefit without sufficient provider networks does not "work." Indeed, if patients cannot obtain care through the benefit, then the costs become incredibly wasteful for an employer.

Employers pay on average more than $15,000 for health care costs per beneficiary, every year. This cost is necessary in order to ensure that the patients receive the care they need, when they need it. If the benefit would not meet the needs of the beneficiaries, a large employer has the option of simply paying the ACA "shared responsibility" penalty, which is $2,000 per employee (and no penalties related to families/dependents or retirees).

Indeed, when an employer chooses an insurance carrier to serve as their self-insured plan's third-party administrator (TPA) and offer a provider network to our beneficiaries, one of the major selling points is the comprehensiveness of the network. Employers compare the networks of various TPAs, and make a selection based on ensuring patients have access to the best providers. An insurance company that emptied out its network in order to lower next year's benchmark would be at a disastrous market disadvantage, likely losing billions of dollars as employers pivot to TPAs that still have comprehensive networks that can handle their volume.

It's no different for fully-insured plans; neither a patient nor a business is likely to choose a plan

that cannot meet their needs with a sufficient provider network. The result would be a catastrophic loss of business for the plan attempting to game the system in this manner.

The hyperbolic allegation that employers, TPAs, and insurance companies will cut their own provider networks in half, in order to lower a benchmark rate in future plan years, is a scare tactic. It has been propagated by hedge fund-owned staffing firms, whose current business model is already to stay out of network, and surprise bill unsuspecting patients (who lack provider choice). Congress should not be taken in by these arguments.