



**MEMORANDUM**

**June 12, 2019**

**To: Subcommittee on Health Democratic Members and Staff**

**Fr: Committee on Energy and Commerce Democratic Staff**

**Re: Hearing on “No More Surprises: Protecting Patients from Surprise Medical Bills”**

On Wednesday, June 12, 2019, at 10 a.m. in the John D. Dingell Room, 2123 of the Rayburn House Office Building, the Subcommittee on Health will hold a legislative hearing entitled, “No More Surprises: Protecting Patients from Surprise Medical Bills.” On May 14, 2019 Chairman Pallone and Ranking Member Walden released a discussion draft of the No Surprises Act. The text of the discussion draft and a section-by-section explanation are attached.

**I. BACKGROUND**

Surprise billing, also referred to as balance billing, is when a patient receives a bill from a provider (other than the cost-sharing required under their insurance) for any difference between the amount the provider charged and the payment from the patient’s insurance plan for that service. This occurs because the provider and the insurance plan have not contracted for a rate which the provider will accept as payment in full for the contracted services (i.e. the in-network rate). When a patient is treated by a provider outside of their plan’s network, the plan may only be required under the terms of the plan to pay for a portion of the service or may not be required to pay for any out-of-network services. Under current law, providers are permitted to bill privately-insured patients for the balance not paid by the insurance plan.

Surprise bills occur primarily in two scenarios; when an individual receives emergency services and therefore has no ability to ensure they are treated by in-network providers, or when an individual goes to an in-network hospital but certain providers at that same hospital, that the patient may not have been aware would be involved in their care, are out-of-network. For example, patients usually have little ability to choose certain “facility-based” providers such as anesthesiologists, pathologists, radiologists and emergency providers. As described by the National Association of Insurance Commissioners (NAIC), services by these providers are typically arranged by the facility as part of the facility’s general business operations and the insurance plan or patient generally “does not specifically select or have a choice of providers from which to receive such services within the facility.”<sup>1</sup> Surprise bills also occur in situations

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<sup>1</sup> National Association of Insurance Commissioners, *Health Benefit Plan Network Access and Adequacy Model Act* ([www.naic.org/store/free/MDL-74.pdf](http://www.naic.org/store/free/MDL-74.pdf)).

where a person uses emergency transport such as a ground ambulance or air ambulance. Surprise billing occurs across all insurance plan types, even those with larger more generous networks.<sup>2</sup> Research has found that around one in five emergency department visits and about nine percent of elective inpatient care at in-network facilities results in a surprise bill.<sup>3</sup>

#### **A. Existing Patient Protections**

Individuals covered by federal healthcare programs are largely protected from surprise medical bills. Federal law, however, does not prohibit balance billing in the private insurance market.<sup>4</sup> For example, in the Medicare program, non-participating providers (only about four percent of providers in the program) are permitted to balance bill, but the bill cannot exceed 15 percent of Medicare's established payment for that service.<sup>5</sup>

Section 2719A of the Affordable Care Act (ACA) required plans to cover emergency services without prior authorization and regardless of whether a provider is in the network of the plan.<sup>6</sup> The ACA also required that for emergency services, a patient's cost sharing be equivalent to what the patient would be responsible for in-network. However, the ACA did not prohibit balance billing or specify how much a health plan is required to pay out-of-network providers for emergency services. In 2015, the Department of Health and Human Services, the Department of Treasury, and the Internal Revenue Service finalized the "greatest of three" rule as part of their implementation of Section 2719A. The rule states that for emergency services, the insurer must pay the provider the greatest of 1) the in-network negotiated rate; 2) a method the plan generally uses to determine the cost of out-of-network care ((such as usual, customary, and reasonable (UCR) charges)); or 3) the Medicare rate for that service.

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<sup>2</sup> The Commonwealth Fund, *Americans' Experiences with ACA Marketplace Coverage: Affordability and Provider Network Satisfaction, Exhibit 8* (July 2016) ([www.commonwealthfund.org/sites/default/files/documents/\\_\\_\\_media\\_files\\_publications\\_issue\\_brief\\_2016\\_jul\\_1883\\_gunja\\_americans\\_experience\\_aca\\_marketplace\\_affordability\\_v2.pdf#page=8](http://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2016_jul_1883_gunja_americans_experience_aca_marketplace_affordability_v2.pdf#page=8)).

<sup>3</sup> Christopher Garmon and Benjamin Chartock, *One In Five Inpatient Emergency Department Cases May Lead To Surprise Bills* (Jan. 2017) ([www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.0970](http://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.0970)).

<sup>4</sup> Loren Adler et.al., *Stopping Surprise Medical Bills: Federal Action Is Needed*, Health Affairs (Feb. 1, 2017) (<https://www.healthaffairs.org/doi/10.1377/hblog20170201.058570/full/>).

<sup>5</sup> AARP, *Medicare's Financial Protections for Consumers: Limits on Balance Billing and Private Contracting by Physicians* (Jan. 2017) ([www.aarp.org/content/dam/aarp/ppi/2017-01/medicare-limits-on-balance-billing-and-private-contracting-ppi.pdf](http://www.aarp.org/content/dam/aarp/ppi/2017-01/medicare-limits-on-balance-billing-and-private-contracting-ppi.pdf)).

<sup>6</sup> Katie Keith, *New Regulation Justifies Previous Position On Emergency Room Balance Billing*, Health Affairs (May 9, 2018) ([www.healthaffairs.org/doi/10.1377/hblog20180509.247998/full/](http://www.healthaffairs.org/doi/10.1377/hblog20180509.247998/full/)).

About half of states have some form of protections from surprise medical bills for patients in state regulated plans (i.e. fully insured plans).<sup>7</sup> However, states' ability to regulate surprise medical bills is constrained by the Employee Retirement Income Security Act of 1974 (ERISA). ERISA precludes states from regulating self-funded employer plans (which currently cover about 100 million Americans). Therefore, millions remain unprotected absent a federal solution even though a growing number of states have enacted surprise billing laws.

## **B. Air Ambulances**

Emergency providers sometimes deploy air ambulances to quickly transport patients in life-threatening situations. More than 550,000 patients in the United States use air ambulance services each year.<sup>8</sup> According to a study by the Government Accountability Office, in 2017 nearly 70 percent of air ambulance transports for privately insured patients were out-of-network with the median price charged by air ambulance providers around \$36,400 for a helicopter transport and \$40,600 for a fixed-wing transport.<sup>9</sup> The Airline Deregulation Act of 1978 (ADA) preempts states' ability to regulate air ambulance services. As a result, states currently have no ability to regulate the balance billing of patients enrolled in private insurance who receive air ambulance services.

The FAA Reauthorization Act of 2018 required the Secretary of Transportation to establish an advisory committee on air ambulance patient billing to examine options to improve transparency around air ambulance charges and protect consumers from balance billing.<sup>10</sup>

## **II. THE NO SURPRISES ACT (PALLONE-WALDEN DISCUSSION DRAFT)**

The No Surprises Act would prohibit balance billing and limit patient cost-sharing to the in-network amount for emergency services, and services provided by certain facility-based providers in the private insurance market. The draft would resolve the payment dispute between providers and insurers by requiring that the insurer pay at minimum the median in-network negotiated rate for the service in the geographic area where the service was delivered. For scheduled care, the draft legislation would require that patients receive notice and provide their consent to out of network care. If a patient does not receive adequate notice, then that provider could not balance bill the patient.

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<sup>7</sup> The Commonwealth Fund, *State Efforts to Protect Consumers from Balance Billing* (Jan. 18, 2019) (<https://www.commonwealthfund.org/blog/2019/state-efforts-protect-consumers-balance-billing>).

<sup>8</sup> National Association of Insurance Commissioners, *Air Ambulances* (May 28, 2019) ([https://www.naic.org/cipr\\_topics/topic\\_air\\_ambulances.htm](https://www.naic.org/cipr_topics/topic_air_ambulances.htm)).

<sup>9</sup> Government Accountability Office, *Air Ambulance: Available Data Show Privately-Insured Patients Are at Financial Risk* (Mar. 2019) (<https://www.gao.gov/assets/700/697684.pdf>).

<sup>10</sup> U.S. Department of Transportation, *Air Ambulance and Patient Billing Advisory Committee* (<https://www.transportation.gov/airconsumer/AAPB>).

**III. WITNESSES**

**Sonji Wilkes**  
Patient advocate

**Sherif Zaafran, MD, FASA**  
Chair  
Physicians for Fair Coverage

**Rick Sherlock**  
President & CEO  
Association of Air Medical Services

**James Gelfand**  
Senior Vice President, Health Policy  
The ERISA Industry Committee

**Thomas Nickels**  
Executive Vice President  
American Hospital Association

**Jeanette Thornton**  
Senior Vice President of Product, Employer, and Commercial Policy  
America's Health Insurance Plans

**Claire McAndrew**  
Director of Campaigns and Partnerships  
Families USA

**Vidor E. Friedman, MD, FACEP**  
President  
American College of Emergency Physicians