June 5, 2019

Chairman Lamar Alexander
Committee on Health, Education, Labor and Pensions
428 Senate Dirksen Office Building
Washington, DC 20510

Ranking Member Patty Murray
Committee on Health, Education, Labor and Pensions
428 Senate Dirksen Office Building
Washington, DC 20510

Dear Chairman Alexander and Ranking Member Murray:

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 of The Lower Health Care Costs Act. Our comments will focus primarily on Title I: Ending Surprise Medical Bills and Title III, Sec. 308: Disclosure of direct and indirect compensation for brokers and consultants to employer-sponsored health plans and enrollees in plans on the individual market.

Title I: Ending Surprise Medical Bills

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 that offers to negotiate are routinely refused. The time expended on these negotiations between the carrier and provider can be lengthy, even for amounts as small as $300. One agent reported that 66 touches with the billing office were made on one issue alone. Some claims have required as many as 115 or more contacts over several months. Although one agency reported some success in negotiating down the bills, saving consumers over $2.1 million in 2018, others have not been able to shave much from these over-inflated bills.

After consultation with our members, what we found is a system stacked against the consumers, who have no leverage with providers or hospitals. Patients are asked to sign paperwork that allows balance-billing from non-network providers with vague and ambiguous language. Often they are asked to do this when under duress, during an emergency or while actively preparing for a procedure. Some who were in the unfortunate situation of not being conscious at the beginning of care find that they have received almost all of their care from out-of-network providers, from the ambulance to ER doctor and hospital. The amounts billed are so high in many cases that the result is collection action and a damaged credit report.

Sec. 101. Protecting Patients against out-of-Network Deductibles in Emergencies

We support the Committee's bipartisan approach to protecting consumers 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 and 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.

Sec. 102. Protecting against Surprise Bills

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 be treated by an out-of-network provider. We also believe they should receive this information for scheduled admissions in time to research availability of in-network providers for the treatment of their condition. 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.

Sec. 103. Resolution
Subtitle A-Option 1: In-Network Guarantee

Our members have repeatedly worked with clients that have gone to an in-network facility only to be treated by an out-of-network provider, resulting in a surprise bill. Although we recognize that requiring all providers treating patients to be in-network for that facility may not be a reasonable expectation for the contracting of the providers, we do agree with the committee that if providing care in an in-network facility any out-of-network providers should be held to the reimbursement rates of the providers contracted with the in-network facility.

Subtitle B-Option 2: Independent Dispute Resolution

Our members are cautious when considering arbitration procedures to resolve balance-billing disputes. Although the system the Committee suggests would allow for a third-party arbiter to gauge the suggested level of payment by both the patient and the healthcare provider, the fact that this decision is binding could still result in patients being responsible for exorbitant costs from out-of-network providers. We are also concerned that this could lead to increased use of the arbitration system and burden consumers with the cost and efforts of hiring an attorney to represent them. Further, in states that currently engage in this "baseball-style" arbitration, the system does not apply to self-funded plans. Self-funded plans may choose to opt in to being regulated by this policy, which leaves an uneven playing field in terms of the markets where arbitration can occur.

Subtitle C-Option3: Benchmark for Payment

We recognize there are several suggestions being offered to determine how to simplify 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, 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 of simplifying other aspects of the administration of health plans.

Sec. 106. Simplifying Emergency Air Ambulance Billing

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.

Title II: Reducing the Prices of Prescription Drugs

We support the Committee's actions to reduce the prices of prescription drugs. We believe updates to both the "Purple Book" and the "Orange Book" will allow more transparency in the availability of biological products as well as provide up-to-date information on drug patents that could ultimately lead to lower costs to the consumers. We also support the limitations being placed on market exclusivities, and the Committee's dedication to education on biological products as well as biological product innovation and biologic similars These innovations do come with a caveat, as some patients may be sensitive to the specific makeup of a biosimilar vs. a brand product Access to the appropriate drug for each patient must also be considered.

Title III: Improving Transparency in Health Care

Sec. 308. Disclosure of Direct and Indirect Compensation for Brokers and Consultants to Employer-Sponsored Health Plans and Enrollees in Plans on the Individual Market

NAHU supports transparency in the health insurance market and applauds the Committee for compiling a package that seeks to do so by combatting surprise billing, lowering the cost of prescription drugs, improving access to patient health information, and emphasizing the need for patient-centered healthcare.

However, we do have concerns regarding Sec. 308. Requirements for disclosure of compensation for agents and brokers already exist across the states. State regulation of insurance provides for oversight of agents and brokers, including licensure laws that require a disclosure of compensation to the client, as well as additional laws that further specify the details of those disclosures. These requirements have been adopted encompassing the National Association of Insurance Commissioners' Producer Licensing Act.

In fact, some states have separate licensing laws for agents who wish to charge a fee to their clients instead of earning a commission on the products in which they are enrolling their clients. This provides further consumer protections by requiring an additional consulting license that also includes specific regulations on how the fee agreement must be disclosed to the consumer. In these cases, regulations already require fees to be completely transparent to the consumer.

Further, under ERISA, insurance carriers providing plans for groups over 100 must provide information about agent compensation in what is called a "Form 5500." Any additional federal requirements for agent compensation disclosure would be duplicative and burdensome on agents and employers. Individuals and employers alike benefit from working with agents and brokers to find the best plan design for their needs at the lowest premium for their budget. Layering additional disclosure requirements on what is already a very detailed and regulated process will limit the ability for agents to serve their consumers and continue their work in driving down health insurance costs.

The disclosure process outlined in Sec. 308 is also not compatible with the way agents and brokers earn compensation. Often agents are not aware of the level of compensation they may earn at the point of enrollment; it is only at the end of the plan year that an accurate assessment can be provided. This further proves the point that agents and brokers are working in the best interest of their client to find the best plan at the lowest price since agents are not always privy to the final compensation package that they may be receiving at the point of sale. Brokers also work on a "broker of record" (BOR) system where a client selects the broker to work on their behalf. The BOR system is very competitive and if a broker fails to find the best plan at the lowest price, the client is easily able to sign a BOR with another broker who will. The incentive here is to act in the best interest of the client, not the interest of the broker compensation.

In the small-group market, compensation for brokers is virtually standardized, with plans paying commissions that vary very little. In this market, the commissions are also "baked in" to the premiums so consumers are paying the same for a plan regardless of whether they are working with a broker. However, consumers who work with brokers statistically pay less in premiums because they are being assisted by a licensed professional who is trained in matching the consumer with the best plan for their health and budget needs.

We support the current state and federal disclosure requirements that are in place, and caution that additional requirements could be a financial burden on insurance carriers and employers, as well as agents and brokers. The compliance tools needed to fulfill further disclosure requirements could only lead to rising health costs and a decrease in consumer access to agents and brokers who are the professionals that consumers need most when faced with trying to select the best plan at the lowest cost.

Title IV: Improving Public Health

NAHU commends the Committee in proposing improvements to public health. We believe that disease prevention can serve as a means to lower healthcare costs. We applaud the Committee for committing to education on vaccinations, increasing access to medically underserved areas, and focusing on a broad range of services for women's health.

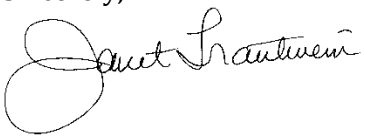
Title V: Improving the Exchange of Health Information

The Committee has committed to putting the patient first in lowering healthcare costs and expanding access to health insurance claims data will assist consumers in determining expecting costs of treatments while providing a chronicle of their past care. We support the provisions to examine ways in which cybersecurity and HIPAA privacy and security rules can be altered to allow for safe and effective access to health information by both the patient and healthcare provider.

Conclusion

We sincerely appreciate the opportunity to provide the Committee with our feedback on The Lower Health Care Cost Act discussion draft. We look forward to working with the Committee to further the goals of transparency for consumers in the health insurance market, and welcome the opportunity to discuss the best way to promote transparency for agent and broker compensation without sacrificing the service they provide to identify the lowest healthcare options for consumers in all health insurance markets. 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
CEO
National Association of Health Underwriters