COMMITTEE ON EDUCATION
AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES
2176 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6100

October 1, 2018

The Honorable R. Alexander Acosta
Secretary
U.S. Department of Labor
200 Constitution Ave NW
Washington, DC 20210

Dear Secretary Acosta:

Access to affordable, quality coverage remains a top concern for millions of individuals across the country, especially as the cost of living continues to rise and wages remain stagnant. Unfortunately, a growing number of consumers are being hit with "surprise bills"—higher than expected out-of-pocket costs from out-of-network providers. Patients incurring surprise bills may either face higher deductibles or coinsurance for out-of-network providers or balance billing, where patients are asked to pay the portion of the out-of-network provider's charges for services left unreimbursed by their plan.

Often patients incur these high expenses unknowingly. Nearly 70 percent of patients hit with unaffordable out-of-network medical bills were unaware that their health care provider was out-of-network at the time they received health care services.[1] Furthermore, many consumers cannot avoid being treated by providers outside their health plan's network—for example, in the case of an out-of-network emergency department physician. Even where patients used in-network facilities, about 15 percent of admissions resulted in a bill from an out-of-network provider.[2] These unexpected costs can come as a significant financial burden for patients. For example, a 2011 New York Department of Financial Services study of more than 2,000 surprise medical bill complaints found insurers paid, on average, only $1,794 of the $13,914 billed by out-of-network assistant surgeons.[3]

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[1] Liz Hamel, Mira Norton, Karen Pollitz, Larry Levitt, Gary Claxton and Mollyann Brodie, Kaiser Family Foundation, *The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey* (January 5, 2016), available at https://kaiserfamilyfoundation.files.wordpress.com/2016/01/8806-the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey.pdf

[2] Gary Claxton, Matthew Rae, Cynthia Cox and Larry Levitt, Kaiser Family Foundation, *An analysis of out-of-network claims in large employer health plans* (August 13, 2018), available at https://www.healthsystemtracker.org/brief/an-analysis-of-out-of-network-claims-in-large-employer-health-plans/

[3] New York State Department of Financial Services, *An Unwelcome Surprise: How New Yorkers Are Getting Stuck with Unexpected Medical Bills from Out-of-Network Providers* (March 7, 2012), available at http://www.statecoverage.org/files/NY-Unexpected_Medical_Bills-march_7_2012.pdf

As added by the Affordable Care Act (ACA), Public Health Service (PHS) Act section 2707(b) limits annual consumer spending for out-of-pocket costs, such as deductibles, copays, and coinsurance. Notably, this protection was also incorporated into the Employee Retirement Income Security Act (ERISA). Regulations issued by the Centers for Medicare and Medicaid Services (CMS) establishing network adequacy standards clarify that Qualified Health Plans (QHPs) that cover out-of-network services must count cost sharing for an out-of-network ancillary provider in an in-network setting toward annual cost-sharing limits. Alternatively, the QHP can provide timely, written notice to enrollees that out-of-network care may incur additional costs that do not count toward annual cost-sharing limits.[4] For patients covered under a large group plan, nearly 1 in 5 inpatient admissions result in an out-of-network bill—rates comparable for adults with Marketplace coverage.[5] In the absence of clear guidance from the Department, it is unclear whether these standards also generally apply to employer-sponsored plans that are subject to out-of-pocket limits.

Given these concerns, we request that you provide a response to the following questions by October 31, 2018:

1) Does the Department currently require employer-sponsored plans to count out-of-network costs incurred in an in-network facility toward annual out-of-pocket limits?

2) If not, does the Department believe it currently has legal authority to do so?

3) If it is the Department's position that it lacks legal authority, what statutory changes does the Department believe it needs to apply such a requirement on employer-sponsored plans?

We appreciate your prompt response to these questions. If you have any questions, please have your staff contact Udochi Onwubiko of the Committee on Education and the Workforce Democratic Staff at Udochi.Onwubiko@mail.house.gov or 202-225-3725.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Ranking Member

[4] 45 CFR § 156.230(e).
[5] Claxton, Rae, Cox and Levitt, *supra* note 2.