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February 11, 2020

The Honorable Richard Neal  
Chairman  
Committee on Ways and Means  
House of Representatives  
Washington, DC 20515

The Honorable Kevin Brady  
Ranking Member  
Committee on Ways and Means  
House of Representatives  
Washington, DC 20515

Dear Chairman Neal and Ranking Member Brady:

On behalf of our members and all older Americans nationwide, AARP thanks you for holding a hearing to mark up H.R. 5826, the Consumer Protections Against Surprise Medical Bills Act of 2020. We are supportive of enacting safeguards to protect consumers against surprise bills from non-network providers who provide services without the consumer's knowledge or consent in an otherwise in-network setting, and we believe this bill takes steps in the right direction to address the problem of surprise billing.

Cost is often a key determinant when 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.

Throughout the debate to end surprise billing, AARP has urged Congress to 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 full and fair 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 group, 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 are pleased that H.R. 5826, the Consumer Protections Against Surprise Medical Bills Act, follows these principles and would essentially end the practice of surprise billing.

Furthermore, we are encouraged by the inclusion of additional protections to ensure consumers are treated fairly. For instance, as we transition to a ban on surprise billing, AARP supports counting surprise medical bills toward an individual's medical expense deduction on their income tax returns. We further reiterate the need to make the medical expense deduction permanent at the 7.5% threshold for all tax filers. AARP is also encouraged by the effort to proactively give consumers advance notice of the costs they are likely to face when seeking care, as well as other provisions to help make consumers aware of their options.

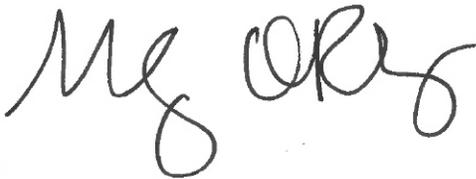
AARP has also been concerned about the shortcomings of insurance plan provider directories, including their lack of availability, confusion as to which directory applies to which plan, outdated information, and lack of standardization among plan directories. Your bill requires continuous updates and regular audits of provider directories by insurance carriers. However, we are concerned about the "response protocol" laid out in your bill. As written, it allows for a health plan to respond to a customer's phone call by sending a written response the next day – either electronic or paper. While we support the choice of electronic or paper communications, in this scenario, a person calling the plan with a question about the provider directory should be able to speak to a live person fairly promptly or, at a minimum, receive a call back the same day. If the individual is choosing to initiate contact via phone, the plan should use the medium of the consumer's choosing. Similarly, while we support including consumer assistance information on the health insurance membership card, there should be both a telephone number and website, not one or the other.

It is essential that individuals have clear, concise, and full information on their rights and responsibilities related to potential surprise medical bills. The Consumer Protections Against

Surprise Medical Bills Act includes solid notification requirements, yet we believe it could be further strengthened. The bill relies frequently on notices to be provided to participants, beneficiaries, and enrollees, but needs to be consistent that providers and plans must ask individuals how they want to receive these disclosures – electronic or paper – and provide them in the preferred format. In addition, on any form on which a signature is required, the enrollee must be provided an identical copy of the signed form. The bill should more clearly specify who provides notices; that all plan information will not only be updated on public websites, but also on all required plan documents; how and when participants will be notified of the availability of disclosures; and specify how long documents must be retained by both plans, providers, and participants. The bill also should clearly state that covered former employees and dependents of employer-sponsored plans have full rights to all information, updates, and disclosures.

We thank you again for your bipartisan leadership on this issue. We appreciate the opportunity to provide feedback in advance of the markup and look forward to continuing to work together to protect consumers and make health care more affordable. If you have any questions, please contact me or have your staff contact Andrew Scholnick ([ascholnick@aarp.org](mailto:ascholnick@aarp.org)) or Brendan Rose ([brose@aarp.org](mailto:brose@aarp.org)) on our team.

Sincerely,

A handwritten signature in black ink, appearing to read "Megan O'Reilly". The signature is fluid and cursive, with the first name "Megan" and the last name "O'Reilly" clearly distinguishable.

Megan O'Reilly  
Vice President, Government Affairs  
Federal Health and Family