Dear Colleague:

There has been a significant focus in the media over the past 18 months on patients who have received high and unexpected medical bills resulting from gaps in their health coverage.

Policymakers have also taken note, and both Congress and the Administration have identified the issue of “surprise bills” as a priority for this year. In fact, it is one of the few areas of bipartisan interest in Congress. In addition, President Trump recently held a roundtable on the issue to gain insights from patients affected by such bills and mentioned surprise billing in fact sheets associated with his State of the Union address.

The last thing a patient should worry about in a health crisis is an unanticipated medical bill that unintentionally impacts their out-of-pocket costs, and undermines the trust and confidence that patients have in their caregivers.

Unfortunately, there are a variety of circumstances that can leave patients with surprise bills. For example: insurers controlling costs by relying on narrow and inadequate networks, and out-of-date provider directories that do not accurately reflect the provider status with the insurers’ contracts. Moreover, a separate issue is the increasing use of high-deductible health plans that create “surprise insurance” coverage resulting in higher expenses for patients. At the same time, underinsurance and the skyrocketing cost of prescription drugs further exacerbate the problem.

The American Hospital Association (AHA) is committed to working with policymakers to identify workable solutions that protect patients from surprise bills in certain scenarios. And key leaders in Congress and the Administration want our input. Hospitals and health systems need to be part of shaping this solution, and the AHA has been working to do this.

Earlier this year, the AHA Board of Trustees appointed a member Task Force to evaluate this and other issues related to price transparency. Their first task was to review various legislative proposals that have been put forth and develop a set of principles (see below) that the AHA can use to develop specific policy solutions related
to surprise billing. These principles were crafted with extensive feedback from the AHA’s policy development bodies. We held eight conference calls involving more than 200 members of our Regional Policy Boards, Councils, Committees and other leadership groups. They were endorsed by the AHA Board of Trustees on February 19. We thank everyone who contributed to their development.

The AHA – along with the Federation of American Hospitals, America’s Essential Hospitals, the Association of American Medical Colleges, Catholic Health Association of the United States and Children’s Hospital Association – today is sharing with key legislators a letter (see below) outlining our position using these principles as a guide. The letter will also be shared with the media and the public.

Surprise bills can cause patients stress and additional financial burden at a time of particular vulnerability: when they are in need of medical care. We believe it is critical to protect patients from surprise bills and support a federal legislative solution to do so.

If you have any questions, please contact AHA Field Engagement at 1-800-424-4301. We appreciate your continued partnership.

Sincerely,

Brian Gragnolati
Chairman, AHA Board of Trustees

Rick Pollack
AHA President and CEO

SURPRISE BILLING PRINCIPLES

America’s hospitals and health systems are committed to protecting patients from “surprise bills” and support a federal legislative solution to do so. These types of bills may occur when a patient receives care from an out-of-network provider or when their health plan fails to pay for covered services. The three most typical scenarios are when: (1) a patient accesses emergency services outside of their insurance network, including from providers while they are away from home; (2) a patient has acted in good faith to obtain care within their network but unintentionally receives care from an out-of-network physician providing services in an in-network hospital; or (3) a health plan denies coverage for emergency services saying they were unnecessary. In these situations, we believe it is critical to protect patients from surprise bills.

We have developed the following principles to help inform the debate regarding surprise billing in the scenarios outlined above. In the event a patient chooses to go out-of-network for care, these principles should not apply.
• **PROTECT THE PATIENT.** Any public policy solution should protect patients and remove them from payment negotiations between insurers and providers.

Patients, regardless of the type of health care coverage they have, should be protected from gaps in insurance coverage that result in surprise bills. Patients should have certainty regarding their cost-sharing obligations, which should be based on an in-network amount. Patients should not be “balance billed,” meaning they should not receive a bill from the provider beyond their cost-sharing obligations. Patients should not have to bear the burden of serving as an intermediary between health plans and providers, rather health plans should be responsible for paying providers directly.

• **ENSURE PATIENTS HAVE ACCESS TO EMERGENCY CARE.** Any public policy solution should ensure that patients have access to and coverage of emergency care.

This requires that health plans adhere to the “prudent layperson standard” and not deny payment for emergency care that, in retrospect, the health plan determined was not an emergency. Recent actions by some health plans to deny coverage of emergency services puts patients’ physical, mental and financial health at risk.

• **PRESERVE THE ROLE OF PRIVATE NEGOTIATION.** Any public policy solution should ensure providers are able to negotiate appropriate payment rates with health plans.

The government should not establish a fixed payment amount for out-of-network services. Health plans and providers take into account a number of factors when negotiating rates. Any rate or methodology sufficiently simple for national use would not be able to capture these factors. In addition, a fixed payment rate could undermine patients’ ability to access in-network clinicians by giving health plans less of an incentive to enlist physicians and facilities to join their networks because they can rely on a default out-of-network payment rate. Providers and health plans should be able to develop networks that meet consumers’ needs, and not be compelled to enter into contracts that could thwart the development of more affordable coverage options that support coordinated care.

• **EDUCATE PATIENTS.** Any public policy solution should include an educational component to help patients understand the scope of their health care coverage and how to access their benefits.
All stakeholders – health plans, employers, providers and others – should undertake efforts to improve patients’ health care literacy and support them in navigating their health coverage and the health care system.

- **Ensure Adequate Provider Networks and Greater Health Plan Transparency.** Any public policy solution should include greater oversight of health plan provider networks and the role health plans play in helping patients access in-network care.

  Patients should have access to easily-understandable provider network information to ensure they can make informed health care decisions, including accurate listings for hospital-based physicians in health plan directories and websites. Patients also should have adequate access to in-network providers, including hospital-based specialists at in-network facilities, rather than simply a minimum number of physicians and hospitals. Federal and state regulators should ensure both the adequacy of health plan provider networks and the accuracy of provider directories. Health plans should be responsible for an efficient and timely credentialing process to minimize the amount of time a physician is “out-of-network.”

- **Support State Laws That Work.** Any public policy solution should take into account the interaction between federal and state laws.

  Many states have undertaken efforts to protect patients from surprise billing, but federal action is necessary to protect patients in self-insured employer-sponsored plans regulated under the Employee Retirement Income Security Act, which cover the majority of privately insured individuals. Any federal solution should provide a default to state laws that meet the federal minimum for consumer protections.

**JOINT LETTER TO CONGRESSIONAL LEADERS**

February 20, 2019

Dear Congressional and Committee Leadership:

On behalf of our member hospitals, health systems and other health care organizations, we are fully committed to protecting patients from “surprise bills” that result from unexpected gaps in coverage or medical emergencies. We appreciate your leadership on this issue and look forward to continuing to work with you on a federal legislative solution.
Surprise bills can cause patients stress and financial burden at a time of particular vulnerability: when they are in need of medical care. Patients are at risk of incurring such bills during emergencies, as well as when they schedule care at an in-network facility without knowing the network status of all of the providers who may be involved in their care. **We must work together to protect patients from surprise bills.**

As you debate a legislative solution, we believe it is critical to:

- **Define “surprise bills.”** Surprise bills may occur when a patient receives care from an out-of-network provider or when their health plan fails to pay for covered services. The three most typical scenarios are when: (1) a patient accesses emergency services outside of their insurance network, including from providers while they are away from home; (2) a patient receives care from an out-of-network physician providing services in an in-network hospital; or (3) a health plan denies coverage for emergency services saying they were unnecessary.

- **Protect the patient financially.** Patients should have certainty regarding their cost-sharing obligations, which should be based on an in-network amount. Providers should not balance bill, meaning they should not send a patient a bill beyond their cost-sharing obligations.

- **Ensure patient access to emergency care.** Patients should be assured of access to and coverage of emergency care. This requires that health plans adhere to the “prudent layperson standard” and not deny payment for emergency care that, in retrospect, the health plan determined was not an emergency.

- **Preserve the role of private negotiation.** Health plans and providers should retain the ability to negotiate appropriate payment rates. The government should not establish a fixed payment amount or reimbursement methodology for out-of-network services, which could create unintended consequences for patients by disrupting incentives for health plans to create comprehensive networks.

- **Remove the patient from health plan/provider negotiations.** Patients should not be placed in the middle of negotiations between insurers and providers. Health plans must work directly with providers on reimbursement, and the patient should not be responsible for transmitting any payment between the plan and the provider.

- **Educate patients about their health care coverage.** We urge you to include an educational component to help patients understand the scope of their health care coverage and how to access their benefits. All stakeholders – health plans, employers, providers and others – should undertake efforts to improve patients’
health care literacy and support them in navigating the health care system and their coverage.

- **Ensure patients have access to comprehensive provider networks and accurate network information.** Patients should have access to a comprehensive network of providers, including in-network physicians and specialists at in-network facilities. Health plans should provide easily-understandable information about their provider network, including accurate listings for hospital-based physicians, so that patients can make informed health care decisions. Federal and state regulators should ensure both the adequacy of health plan provider networks and the accuracy of provider directories.

- **Support state laws that work.** Any public policy should take into account the interaction between federal and state laws. Many states have undertaken efforts to protect patients from surprise billing. Any federal solution should provide a default to state laws that meet the federal minimum for consumer protections.

We look forward to opportunities to discuss these solutions and work together to achieve them.

Sincerely,

American Hospital Association  
America’s Essential Hospitals  
Association of American Medical Colleges  
Catholic Health Association of the United States  
Children’s Hospital Association  
Federation of American Hospitals