

July 17, 2019

The Honorable Frank Pallone
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Greg Walden
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Pallone and Ranking Member Walden:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) is writing to comment on provisions of the Reauthorizing and Extending America's Community Health (REACH) Act, an amendment in the nature of a substitute to H.R. 2328.

We would like to express our support for the Medicaid disproportionate share hospital (DSH) program provisions included in Title III. This language would eliminate the Medicaid DSH cuts in fiscal year (FY) 2020 and FY 2021 and reduce the cuts to \$4 billion for FY 2022, with cuts for FY 2023-2025 remaining at \$8 billion for each of those fiscal years. We greatly appreciate your efforts to assist hospitals and urge you not to use hospital payments as an offset to the cost of eliminating the cuts when this measure moves to the House floor for consideration. Thank you for your efforts to preserve patient access to their community hospitals by supporting the Medicaid DSH program.

We also would like to share comments on Title IV, which contains provisions of the No Surprises Act. While the AHA appreciates your efforts to shield patients from the financial burden of unexpected medical expenses, we are concerned with the legislation's approach to determining reimbursement for out-of-network providers. **The AHA believes that once the patient is protected from surprise bills, providers and insurers then should be permitted to negotiate payment rates for services provided. We strongly oppose approaches that would impose arbitrary rates on providers.** It is the insurers' responsibility to maintain comprehensive provider networks, and a default payment rate would remove incentives for plans to contract with providers or to offer fair terms.

Our specific comments on the provisions follow.



PREVENTING SURPRISE MEDICAL BILLS

The legislation prohibits balance billing by out-of-network providers for all emergency services, as well as when the patient is treated in an in-network facility but cannot reasonably choose their provider, a position with which we agree. However, it is unclear as to why the Committee has chosen to redefine what constitutes emergency services and does not instead reference the Emergency Medical Treatment & Labor Act (EMTALA). In addition, the legislation could be interpreted as extending protections to services that would not otherwise be covered in the patient's health plan. In most of the bill text: there are references to "items and services" without clarification that these are "covered items and services." It is important to distinguish when patients would have to pay for procedures and services that are not covered by their health plan, and when they would be protected from balance billing in specific scenarios.

The No Surprises Act establishes a minimum payment standard for out-of-network emergency care and care provided by out-of-network ancillary providers during otherwise in-network care. The payment standard would be set at the median of the negotiated rates for the service in the geographic area the service was delivered, with an inflationary increase that references the urban consumer price index (CPI-U). States would have the ability to determine their own payment standards for plans they regulate.

We find the language regarding determination of the median contracted rate to be unclear as to which rates will be used to determine the median: are the plans limited to calculating the rates for a specific health plan, or should this be a comparison across similar plans? In addition, it is unclear as to why the 2019-2020 payment rate is based on "median negotiated rate" and the payments for 2022 and beyond are determined by the "median contracted rate." Finally, the inflationary adjustment of CPI-U is generally below medical inflation and hospital cost inflation, and is thereby not the most accurate inflationary index to be considered for this purpose.

The AHA opposes setting a rate in statute, given the risk this creates for setting rates too low and compromising patient access to care. Rate setting would be nearly impossible to get right and ignores the many factors that providers and health plans consider when deciding whether or not to enter into a contract. Factors that may be relevant to one provider may not be relevant to another provider, which means that the median contracted in-network rate may not be the appropriate payment level. Considerations include a provider's size or mix of services, such as whether a provider is the only hospital or health system in a community offering advanced trauma services, and whether a provider and payer have negotiated to enter into a value-based contracting arrangement. Providers also consider whether an insurer is a good business partner when determining when to contract. For example, does the insurer have a history of delaying prior authorization decisions or denying claims inappropriately? We should maintain the incentives on insurers to not only pay fairly but also to engage in good business practices. Rate setting creates a disincentive for insurers, as it removes

the need for health plans to form comprehensive networks and to contract and negotiate with providers.

PROVIDER DIRECTORIES

The legislation specifies a number of requirements on health insurance plans to produce provider directories, keep them up-to-date and provide this information to their subscribers both online and in printed formats. We agree with the Committee that consumers should better understand their health plans and which providers are in their network. However, it is unclear as to whether these provisions will improve provider directories or simply add significant burden to the system. There is a lack of consistency regarding requirements placed on the group health plans in this legislation: provider directory updates are required every 90 days; current law for Medicare Advantage and qualified health plans requires these updates to be made every 30 days. The legislation also would require each health plan to establish its own process for collecting and verifying information, while enrollees (and providers) likely would be better served if they encountered a consistent provider directory process across all health plans.

Certain requirements also are placed on providers to transmit provider directory information to each health plan. We are concerned that these requirements are duplicative of current operating procedures. And if the health plan and provider have a contract, the health plan already is aware of it. We question the need to establish a separate process for the provider to alert the health plan that they are coming in or going out of network.

PREVENTING CERTAIN CASES OF BALANCE BILLING/NOTICE REQUIREMENTS

The No Surprises Act requires hospitals to give patients both oral and written notice of any items or services they may receive from out-of-network providers, as well as the estimated cost of services and whether there are any in-network providers at the facility who may be able to furnish the services. **The AHA supports increased transparency with regard to both in-network provider status as well as potential costs patients will face. However, the primary responsibility for ensuring provider directories — the source of this information — are accurate lies with health plans.** Hospitals are willing to work on securing information for patients, but insurers and other providers should be required to work with facilities to ensure a timely result. The legislation also puts undue burden on hospitals by requiring that facilities retain for two years their own signed notices, as well as those of any non-participating providers who are delivering services at the facility.

PENALTIES

The legislation allows the imposition of civil monetary penalties of up to \$10,000 per violation to enforce its prohibition on surprise medical bills. In the exception section, there is provision for waiving penalties if a provider unknowingly violated any section of the bill. However, providers are required to reimburse, with interest, both patients and the plan in cases of erroneous balance billing. However, there are no accommodations made for situations in which the balance billing is the result of inaccurate information from the health plan, such as those related to covered services and benefits and/or errors in the provider directory.

STATE ALL PAYER CLAIMS DATABASES

The legislation provides \$50 million in grants for states to develop or maintain an all-payer claims database that would assist in determining a median contracted (in-network) rate, if the sponsor or issuer does not have sufficient information. The bill defers to the Secretary of Health and Human Services to create eligibility requirements for states, such as requirements around data collection and security.

The AHA supports price transparency innovations, such as all-payer claims databases. We recognize the value of collecting claims for a number of different purposes, such as quality improvement activities. We caution the Committee against considering all-payer claims databases as a comprehensive solution to price transparency. Specifically, adoption of these databases to-date is uneven, and it has been challenging to determine the correct data to collect, to secure all of the data from all payers in a state, and to determine how then to use the data. For example, only 18 states have set up these systems, and many have struggled with data completeness and accuracy.

There also are issues of privacy and security and questions regarding who receives access to the data and for what purposes. At this stage, we do not believe that the Committee should rely on all-payer claims databases for purposes of setting national policy. We instead encourage consideration of funding for studies on the best way to implement these data collection entities and support such efforts at the state level.

AIR AMBULANCES

The No Surprises Act includes language requiring air ambulances to report costs or air travel and emergency medical services to the health plans. We do not think the Committee has sufficiently addressed this issue and would ask that the legislation extend to air ambulance services similar consumer protections from out-of-network billing and include air ambulance services in network adequacy requirements.

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Thank you for your consideration of our comments on the REACH Act. We look forward to continuing to work with the Committee regarding relief on Medicaid DSH cuts and protecting patients from surprise medical bills while ensuring that there are not negative unintended consequences to patients and the health care system.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President