American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

September 17, 2019

The Honorable Robert C. Scott
Chairman
Committee on Education and Labor
U.S. House of Representatives
Washington, DC 20515

The Honorable Virginia Foxx
Ranking Member
Committee on Education and Labor
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Scott and Ranking Member Foxx:

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 surprise medical billing legislation passed in July by the Energy and Commerce Committee, as we understand your Committee may be interested in considering a similar approach. We appreciate that this issue is a priority for your Committee, as it is for our field and our patients.

The Energy and Commerce Committee's "No Surprises Act" was contained in Title IV of an amendment in the nature of a substitute to H.R. 2328. While the AHA supports efforts to shield patients from the financial burden of unexpected medical expenses, we are concerned with this 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 should then be permitted to negotiate payment rates for services provided. We strongly oppose approaches that would impose arbitrary rates on providers, which could have significant consequences far beyond the scope of surprise bills.** 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 are as follows.

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 Energy and Commerce Committee has chosen to redefine what

constitutes emergency services and does not instead reference the Emergency Medical Treatment & Labor Act (EMTALA). In addition, the legislative text could be interpreted as extending protections to services that would not otherwise be covered in the patient's health plan: 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.** We also recommend that the Committee clarify that health plans (or administrators of health benefits in the case of self-funded products regulated under the Employee Retirement Income Security Act) must allow an enrollee to assign his or her benefits, or right to payment of benefits, to a health care professional or health care facility. There have been a number of concerning instances in which health plans or health benefit administrators have issued checks directly to patients for tens of thousands of dollars or more to pay for out-of-network care, and the patient is then responsible for conveying payment to the provider. This occurs because the ERISA statute allows plans to not recognize "assignment of benefits" through clauses in their contracts with enrollees. We believe this restriction violates the objective of keeping the patient out of the middle of negotiations between providers and insurance companies and burdens them with significant responsibility. We strongly urge the Committee to fully protect patients by clarifying that plans must accept assignment of benefits.

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.

The AHA opposes setting a rate in statute, given the risk it creates for setting rates too low and compromising patient access to care, and we ask the Committee to strike the benchmark rate language. 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? Incentives should be maintained 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.

Rate setting also would extend beyond just surprise billing scenarios by incentivizing insurers to depress in-network rates. **The Congressional Budget Office's (CBO) score of legislation on surprise medical billing passed in June by the Senate Health, Education, Labor and Pensions Committee (S. 1895), which tied the benchmark payment to the median in-network rate, states that more than 80% of the estimated budgetary effects (savings) – or about $19 billion - arise from changes to *in-network* payment rates.** As CBO notes, creating a method for reimbursing out-of-network rates that sets a benchmark rate would result in payments to providers, both inside and outside of networks, moving toward the median rates. **According to CBO, "The cost of surprise bills is a small portion of all health care spending, but policies to address surprise bills can have important consequences for the health care system because they affect negotiations between insurers and providers.**" **In an effort to solve the discrete problem of surprise medical billing, Congress must avoid harming the hospitals that actually provide the in-network care and the patients they serve.**

We also find the language regarding determination of the median contracted rate to be unclear as to which rates will be used to decide 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 is therefore not the most accurate inflationary index to be considered for this purpose.

ARBITRATION

The "No Surprises Act" was modified during the Energy and Commerce Committee mark up with an amendment that would allow providers and facilities to use the arbitration process for claims with median in-network contracted reimbursement rates of more than $1,250. The arbitration process is "baseball-style" and binding. Batching of certain claims would be permitted, although each individual claim must be above the $1,250 threshold. Arbiters would be instructed to take into account a limited set of factors. The Secretaries of the departments of Health and Human Services (HHS) and Labor would make public general information about the arbitration process and decisions.

The AHA believes that hospitals and payers generally should be left to negotiate reimbursement for out-of-network claims without government interference. However, there may be a role for an alternative dispute resolution process for physician claims. We believe that the instructions to the arbiters outlined in the

legislation are limited and skewed toward insurers. The factors should be expanded to include others, such as: market share held by the plan or issuer or the out-of-network health care provider; demonstration of good faith efforts (or lack of good faith efforts) made by the out of network provider or plan; prior negotiated rates, if applicable; and other relevant economic aspects of provider reimbursement for the same specialty within the same geographic area.

PROVIDER DIRECTORIES

The "No Surprise Act" 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 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, versus current law regarding Medicare Advantage and qualified health plans, which is far better for consumers, and 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) would likely be better served if a consistent provider directory process was required 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 is already aware of this. 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.

If new processes are pursued, we encourage the Committee to consider developing a single process that all health plans would have to follow so that enrollees would have a consistent process for identifying whether a provider is in their network and providers would have a consistent process for alerting health plans to any changes, as well as confirming with which plans they are in network. The legislation should be clear about how these rules do or do not apply to health plans that do not have networks, i.e., no-network plans that use reference-based pricing. We also encourage the Committee to consider requiring minimum network standards for all health plans.

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.** A preferred approach would be that the legislation direct health plans to identify in-network providers and allow the out-of-network provider to help coordinate patient communication with the health plan. Hospitals are already working 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 the hospital 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. It is unclear that such a provision is required in order to protect patients. Rather, providers who are unable to show that such notice was provided should simply be unable to balance bill. If maintenance of records is required, each provider should be responsible for their own paperwork.

PENALTIES

The "No Surprises Act" 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 a waiving of 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. In these instances, health plans – not the provider – should be responsible for reimbursing patients.

STATE ALL PAYER CLAIMS DATABASES

The "No Surprises Act" 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 HHS 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, including for 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. 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.

BILLING STATUTE OF LIMITATIONS

The legislation would prohibit billing a patient more than one year after a service was provided. While we strongly support timely billing, this provision fails to take into account delays due to other entities, such as health plans. Health plans often delay adjudicating claims, and providers cannot send accurate bills to patients prior to this occurring. The legislation should adopt a billing standard that starts 45 days from the point of health plan adjudication.

Thank you for your consideration of our comments on the "No Surprises Act." We look forward to continuing to work with the Education and Labor Committee regarding solutions to stop surprise medical bills.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President

cc: Members of the House Education and Labor Committee