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

February 10, 2020

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

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

Dear Chairman Neal and Ranking Member Brady:

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) thanks you for your efforts to protect patients from surprise medical bills. We appreciate that this issue is a priority for your Committee, as it is for our field and our patients.

We are pleased to support your legislation, the Consumer Protections Against Surprise Medical Bills Act of 2020, and commend you for your efforts to develop the most effective approach to surprise medical billing introduced to date.

We agree with the Committee that it is essential to prohibit balance billing in certain scenarios and to limit patients' obligation to their in-network cost-sharing responsibilities. We strongly support these provisions in the legislation. Once the patient is protected, hospitals and health systems should be permitted to work with health plans to determine appropriate reimbursement, as is outlined in your bill. We strongly oppose approaches that would impose arbitrary rates on providers, which could have significant consequences far beyond the scope of surprise medical bills and impact access to hospital care, particularly in rural communities.

We also would like to commend the Committee for not including in its legislation any references that are extraneous to the surprise medical billing issue, such as those related to privately negotiated contracts, which have been incorporated into other bills and would lead to narrower provider networks with fewer choice for patients.

As you move forward with the legislative process, we would appreciate your consideration of the following comments.

PREVENTING SURPRISE MEDICAL BILLS

The legislation prohibits providers from balance billing patients for emergency services or medical care the patient reasonably could have expected to be in-network, and does not allow patients to be charged more than the in-network cost-sharing amount. We applaud the Committee for protecting patients from surprise medical bills and for developing a workable approach for determining the patient's cost-sharing amount so they can be "taken out of the middle" of any discussions between the health plan and the provider regarding reimbursement. The Committee also has gone further than any other legislative efforts to remove patients from the reimbursement process by requiring that health plans accept when patients have assigned their benefits to the provider. This provision would require that plans reimburse providers directly, rather than sending reimbursement to the patient (who in turn must then compensate the provider).

We also appreciate that the Committee has taken into account state-based solutions to surprise medical bills. Not only does the bill defer to state law for state-regulated products, but it also recognizes the unique situation of states that either have all-payer rate mechanisms in place or allow self-funded plans to opt in to state surprise billing protections.

OUT-OF-NETWORK PAYMENTS

Out-of-network reimbursement would be determined either through a provider's acceptance of a health plans' initial payment, through a period of "open negotiation" or, ultimately, through a mediated dispute resolution process. The Consumer Protections Against Surprise Medical Bills Act enables providers and health plans an opportunity to directly negotiate fair and appropriate reimbursement, thereby minimizing the government's role in the process and reducing the risk that a federal legislative approach addressing surprise medical billing could cause wider market distortions. Recognizing that some negotiations may not resolve in a timely manner, the Committee established a mediated dispute resolution process. While we expect this option will rarely be used, we appreciate that the Committee has designed it in such a manner to allow for continued negotiation and enable providers and health plans to bring any information they deem relevant to the independent mediation entity.

We appreciate that the Committee has developed a thoughtful approach to calculating the median contracted rate, which could be used to determine patient cost-sharing, as a data point during negotiations and as a consideration factor for mediators. In particular, we are pleased to see that the calculation of the median contracted rate considers the facility type. We interpret this to mean that certain types of providers, e.g., critical access hospitals or academic medical centers, will be compared against like providers and not against other types of facilities that may have very different cost structures.

We support the dispute resolution approach articulated in the legislation, which will ensure that both parties put serious effort into developing reasonable offers**. However, we encourage the Committee to explicitly direct the mediator to a previously negotiated contracted rate between the health plan and provider, which will better reflect the unique circumstances of a particular payer/provider relationship. We also would ask that the mediator be directed to not consider public payer reimbursement rates, which are well known to be below the cost of providing care. And we request that the mediator also be explicitly pointed to other considerations, such as emergency department-only agreements, single case agreements and rental networks.**

We also support requiring that the non-prevailing entity pay the cost of mediation as a deterrent to overreliance on mediation. In addition, we support the concept of a "frequent flyer" penalty to further encourage health plans and providers to come to agreement on reimbursement during the open negotiation period and not abuse the mediated dispute resolution process, and would encourage the Committee to consider making this change to the legislation.

CONSUMER PROTECTIONS

Hospitals and health systems are committed to helping patients access the financial information they need to make decisions about their care. It appears that the text could be read that providers/health plans provide "good faith estimates" for all scheduled care, not just upon request. **We ask the Committee to clarify that the estimate is only required when requested by the patient.** We also ask that the estimate include targeted information that is most meaningful to the patient, as we are concerned that patients will struggle to decipher all of the different data elements currently required by the legislation. We recommend the estimate include only the patient's out-of-pocket costs (which would reflect where they are in their annual deductible and out-of-pocket cost limits) so the patient is able to easily find the information most important to them and to ease the administrative burden on providers and health plans.

We support the Committee's efforts to help patients understand their coverage by including critical information directly on their health plan benefit card. For example, we strongly support including the deductible amount, as well as out-of-pocket cost limits. However, we question whether it is feasible to incorporate on a card everything envisioned in the legislative text. For example, the legislation would require that plans state the cost-sharing obligation applicable for visits to emergency departments or urgent care facilities. While the basic structure of the cost-sharing may be included on a card, e.g., 20% coinsurance, it may not be able to provide the specific amount (unless the plan benefit structure uses a flat co-pay amount). We encourage the Committee to

either clarify the type of information that health plans would need to include or remove this requirement.

PENALTIES

The Consumer Protections Against Surprise Medical Bills Act outlines how civil monetary penalties (CMPs) can be assessed on hospitals for violations of the Act. Hospitals would be subject to a penalty for each instance in which either the facility or a contract provider working in the facility sent a balance bill to an out-of-network patient following an emergency without providing appropriate notice. **We ask the Committee to clarify that their intent is to impose CMPs on the provider who bills a patient in violation of the statute so a hospital is not subject to a penalty for action taken by an independent clinician.** We also note the absence in the legislation of specific penalties on health plans for their violations and ask the Committee to explain how they intend to hold plans accountable for their actions.

STABILIZATION

The AHA appreciates that the Committee recognizes there may be instances in which a stable patient could be alerted to the potential for out-of-network charges and be given the option to either be transferred to an in-network facility or accept higher out-of-pocket costs. We note that hospitals will not always be able to inform patients about which providers are out-of-network and what their estimated charges are. Hospitals do not maintain provider directory information and are not privy to the rates of non-contract providers.

PROVIDER DIRECTORIES

The legislation specifies a number of requirements on health plans to produce accurate provider directories, keep them up-to-date and provide this information to their subscribers. We agree that consumers should better understand their health plans and which providers are in their network. However, 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. We recommend the directories be updated every 30 days to be consistent with other statutory requirements.

Thank you for your consideration of our comments on the Consumer Protections Against Surprise Medical Bills Act. We look forward to continuing to work with the Ways and Means Committee regarding solutions to prevent surprise medical bills.

Sincerely,

/s/

Richard J. Pollack
President and Chief Executive Officer

cc: Members of the House Ways and Means Committee