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Statement

of the

American Hospital Association

for the

Committee on Ways and Means

of the

U.S. House of Representatives

"Reduced Care for Patients: Fallout from Flawed Implementation of Surprise Medical Billing Protections"

September 19, 2023

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) writes to share the hospital field's experience with implementation of the No Surprises Act (NSA).

Hospitals and health systems support Congress' approach to protecting patients from unexpected medical bills. The NSA prohibits providers from sending patients certain types of balance bills and ensures that patients' cost-sharing responsibilities are limited to what they would have paid for in-network health care. Once the patient is protected, the provider and health plan are expected to work together to determine appropriate reimbursement. For instances where this approach fails to result in a mutually agreed upon reimbursement amount, Congress established an independent dispute resolution (IDR) process.

While we continue to support the underlying goals of the NSA, implementation of the statute has been uneven from both regulatory and operational perspectives. We appreciate the opportunity to provide feedback to the Committee, as we have previously shared this information with the agencies supervising the NSA — the Centers for Medicare & Medicaid Services, Employee Benefits Security Administration and Department of the Treasury.

OVERVIEW OF THE NSA

The NSA included critical patient protections against unexpected medical bills for certain types of health care services when provided by out-of-network providers. The AHA supports these patient protections. Through various provisions in the law, Congress intended for plans and other payers to appropriately reimburse providers for these services and included an IDR process should negotiations between the two parties fail. Patients are fully removed from this process, and the outcome has no bearing on their cost-sharing obligations. However, this does not mean that the IDR process will not affect patients. **Specifically, inappropriate reimbursement by payers can impact providers' ability to continue offering services or offering them in the timeframe or the quality that patients deserve.** A high-functioning IDR process is crucial for fully realizing the NSA patient protections.

Congress also incorporated the IDR process into the statute to curb inappropriate behavior by both payers and providers. However, the process only functions as a deterrent if both parties know that an unbiased third party will make a timely determination. If the process is weighted in favor of one party, that party has less of an incentive to act fairly in the initial claim billing and reimbursement process. Untimely decisions also limit the deterrent effect, as payers know that providers can only serve patients for a limited time with constrained cash flow. Delaying the reimbursement process can be an effective tactic for dissuading providers from disputing inappropriate payments even when their claims are strong.

Certain policy decisions and implementation challenges have undermined the unbiased and timely nature of the IDR process and contributed to the higher-than-anticipated volume of disputed claims. One of our primary concerns related to the overweighing of the qualifying payment amount (QPA) was validated by the U.S. District Court for the Eastern District of Texas. We continue to urge the regulatory agencies to comply with the court's ruling and refrain from placing any constraints on IDR entities that were not authorized by Congress. In addition, we have identified the following recommendations to improve the open negotiation and IDR process.

POLICY AND OPERATIONAL CHALLENGES AND RECOMMENDATIONS

Regulations Concerning Batching and Bundling of Claims

The agencies have adopted an unworkably narrow definition of "item or service" for

purposes of batching claims for IDR disputes. Effectively, a claim for an episode of care that involves multiple line items on the bill cannot be submitted to the IDR as a single dispute. Take, for example, a claim for an emergency department visit to set a broken leg. This claim may include multiple line items to cover diagnostic scans, supplies, physician time, etc. Under the agencies' regulations, each of these items is its own "item or service" and must be separately adjudicated.[1] As such, these regulations effectively make batching of claims unavailable to facilities, resulting in substantial underpayment of providers as well as increased use of the IDR process.

Following is an example from an AHA member hospital. A hospital billed a health plan for an out-of-network Level 4 emergency visit that include 30 unique "items or services" (per the agencies' definition). The total value of the charges was $68,880. The health plan paid $1,614 on a single line item. Under the current rules, this hospital must evaluate each underpaid line item and determine which to adjudicate. To select one item or service to dispute leaves the hospital significantly underpaid for the totality of services already rendered to a covered patient; but to initiate individual disputes for all unique items and services is extremely costly in terms of both money and time. In this instance, since only one of the items or services were paid, the provider would need to initiate 29 disputes to challenge the full reimbursement for this claim, and the administrative fees alone would have amounted to $10,150, not including the IDR fees.[2] This policy gives payers tremendous opportunity to abuse the system, as they have sole discretion over how to make an initial payment (i.e., whether they pay a single bundled amount, pay on each individual line item or a combination).

Other aspects of the batching rules also are driving the volume of disputes. Specifically, how the agencies have defined payer for purposes of batching severely limits providers' ability to batch like claims together. Under the law, claims may only be batched together if they meet certain conditions, including that the "payment for such items and services is required to be made by the same group health plan or health insurance issuer." Under the agencies' guidance, claims for individuals enrolled in employer-sponsored coverage may only be batched if the coverage is from the same employer. Yet, in most cases, it is the employers' third-party administrators (TPAs) that both determine the initial payment amount and reimburse the provider. In addition, it appears that most TPAs are using the QPA, which they are calculating based on all their TPA business in the same market. The TPA's initial payment is the same regardless of an individuals' employer, and yet providers may not batch these claims. This policy is further complicated as the provider generally does not know which employer the patient is associated with as their insurance card, as well as the remittance, may only indicate the TPA information. This double standard in the definitions disadvantages providers and

[1] On August 3, 2023, the U.S. District Court for the Eastern District of Texas vacated the batching provisions of the NSA regulations. Further guidance from the agencies is forthcoming.
[2] This claim occurred when the administrative cost per IDR filing was $350.

drives unnecessary utilization of the IDR process, thereby increasing the costs and burden for all parties. We strongly urge the agencies to revise the guidance to allow batching at the TPA level for employer-sponsored insurance (ESI) claims.

Recommendation: Revise the batching and bundling guidance to allow for a more rational process for facilities to dispute inappropriate reimbursement.

Excessive Administrative Fees

The agencies increased the non-refundable administrative fee to $350 from $50 effective Jan. 1, 2023. This 600% increase for initiating an IDR dispute is cost prohibitive for many hospitals and health systems, especially considering how facility claims must be disaggregated per the batching and bundling rules. As noted in the emergency department claim described above, the potential administrative costs for disputing the claim would amount to $10,150 in administrative fees to fully contest the payers' total reimbursement of $1,614 on a claim valued at $68,880. These fees create an inappropriate financial barrier to the IDR process and further tilts the process in payers' favor as they are aware that many providers will be unable to use the process due to the expense. Under a recent court decision challenging the increase, the administrative fee was once again set at $50, but only for claims filed after Aug. 3, 2023. Providers who filed between Jan. 1 and Aug. 3, 2023, will not receive a refund for the fees they have already paid for the dispute process. We encourage the agencies to maintain the lower administrative fee amount.

Recommendation: Continue to maintain the IDR administrative fee at $50, which otherwise makes the IDR process cost prohibitive for many facility claims when coupled with the batching and bundling policies.

Lack of Oversight of QPAs

Congress created the QPA for two purposes: 1) to calculate patient cost-sharing in a timely way, and 2) as a factor for consideration by the IDR entities. However, many health plans are using the QPA to set initial payment determinations, and there are reports from hospitals of payers offering very low rates based on their calculation of the QPA. In some cases, these rates are lower than what Medicare pays. We are unaware of any market for any service in which Medicare consistently pays above commercial rates. On its face, this suggests that some payers are not accurately calculating the QPA, likely by including "ghost rates" in their calculations. "Ghost rates" occur when a provider and plan technically have a dollar value for a service in their contract, but the provider does not offer the service and therefore does not negotiate on the amount. As a result, the rate could be $0 or otherwise low for the service since the reimbursement amount is irrelevant.

We continue to believe that the only way to enable providers to engage in the IDR process on equal footing with the plans, as well as to ensure arbiters have the information they need to make an informed decision, is to require payers to detail their QPA calculations. **Payers should be required to demonstrate to providers they are accurately calculating the QPA.** Otherwise, only one party enters the dispute process with the knowledge of how the QPA was calculated and whether it accurately represents a median contracted rate, while the arbiter and provider are unable to challenge this factor, which the agencies have consistently given outsized importance.

In addition to requiring that payers demonstrate to arbiters and providers that the QPA adheres to federal requirements, **the agencies also should conduct rigorous review of plans' QPA calculations.** More than a year into implementation, no public information has been provided to verify that such audits are occurring. Allowing payers' behavior to go unrestricted is likely contributing to their audacity in underpaying providers. We believe chronic underpayments could impact access to care. QPA oversight should therefore be one of the agencies' highest priorities.

Recommendation: Ensure greater transparency and oversight regarding the calculation of the QPA.

Failure by Health Plans to Negotiate

The NSA includes a 30-day open negotiation period, which we understand Congress intended to be used by providers and health plans to determine reimbursement in the vast majority of out-of-network cases. Unfortunately, a substantial number of health plans have been unwilling to negotiate with providers during the open negotiation period, leading providers to use the IDR process at rates that are higher than anticipated. The agencies have discussed including the open negotiation process as part of the federal portal, which we expect will encourage more payers to be willing to engage with providers in discussions regarding reimbursement and hopefully avoid many IDR claims.

Recommendation: Monitor and incentivize payer participation in the open negotiation process.

Information Sharing between Health Plans and Providers

Providers are hampered in the negotiation process due to incomplete or inaccurate information shared by plans. Reimbursement remittances often do not include the QPA (or a number identified as the QPA), nor do they indicate whether the claim is subject to the NSA (something only the payers will know definitively as health plan eligibility cards do not often indicate the exact form of coverage for the patient). At a minimum, **payers should be required to use the agencies' NSA-specific Remittance Advice Remark Codes (RARCs) when communicating information about claims to providers and**

facilities. These RARCs are a series of alert codes specific to the NSA that can be used on payers' remittances to convey NSA-related information to providers. For example, the RARCs include alerts as to when the NSA applies to a claim; that the cost-sharing is calculated according to the NSA; whether the initial, final and denial of the payment amount are made in accordance with the NSA; and whether notice and consent were obtained for the provider to bill out-of-network and whether the notice and consent obtained were in accordance to the NSA. Consistent use of the RARCs could greatly improve the processing of NSA claims and helping to determine whether such claims fall within the IDR process.

In addition, and as mentioned earlier, for employer-sponsored coverage, the health plan eligibility card will not indicate the employer but rather only their TPA. Without accurate information, providers may inadvertently initiate disputes on claims that are ineligible or batch claims that cannot be batched under current rules. Payers are the only party to know the definitive type of health plan, and they should be required to share it with the providers and facilities.

Recommendations: Mandate that payers use the agencies' RARCs when communicating information about claims to providers and facilities and require payers to include information on the patient's plan type at the time of initial payment or payment denial.

Timeliness of Payment

Contrary to the statute, a substantial number of claims subject to the NSA are not being paid within 30 days. One of our hospital systems reports that insurance plans have not responded to 40% of their out-of-network claims — neither remitting a payment nor issuing a denial. In reviewing their out-of-network claims in a single hospital market from June 2022, of the 2,361 claims filed, only 1,229 were paid or denied within June or July 2022; 796 were paid or denied over the subsequent six months; and 336 (14%) have received no response either way. **This represents a gross violation of the law, and the payers must be held accountable.** In these instances, providers have no recourse but to initiate an IDR dispute and, as a result, the failure by plans to provide any response to a claim is contributing to the substantial volume of disputes.

In addition, our hospital members report they are not being paid in a timely manner — if ever — when IDR entities decide in their favor, and often they are making multiple contacts with the insurance plans to attempt to receive payments. A review of this aspect of the IDR process is essential to ensure it is operating in a manner that is fair to providers.

Recommendation: Ensure plans are making payments in a reasonable period.

CONCLUSION

Thank you for your leadership to end surprise medical billing and for working with stakeholders to protect patients while addressing this important issue. We appreciate your ongoing reviews of NSA implementation process and look forward to continuing to work with you.