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June 5, 2019

The Honorable Lamar Alexander  
Chairman, Committee on  
Health, Education, Labor & Pensions  
United States Senate  
Washington, DC 20510

The Honorable Patty Murray  
Ranking Member, Committee on  
Health, Education, Labor & Pensions  
United States Senate  
Washington, DC 20510

***RE: Discussion Draft Legislation on Reducing Health Care Costs***

Dear Chairman Alexander and Ranking Member Murray:

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) appreciates the opportunity to provide feedback on the Lower Health Care Costs Act of 2019, the Committee’s bipartisan discussion draft legislation. We applaud the efforts the Committee has taken to address this important issue.

The cost – and affordability – of health care in America affects all stakeholders, including patients and their families, employers, policymakers and care providers. And all stakeholders play a role in making care and coverage more affordable. Hospitals and health systems understand the importance of this issue and have been tackling it head on, taking steps to redesign care and implement operational efficiencies.

One important step we can take to address the affordability of care for patients is to end surprise bills. We commend your focus on this issue, and we look forward to continuing to work with you to find a solution to protect patients and remove them from the middle of any reimbursement disputes. Our preferred solution is simple: patients should not be balance billed for emergency services, or for services obtained in any in-network facility when the patient could reasonably have assumed that the providers caring for them were in-network with their health plan. Patients should have certainty regarding their cost-sharing obligations, which are based on an in-network amount. We strongly oppose the imposition of arbitrary rates on providers, along with untested proposals such as bundling payments, which would significantly increase complexity in the system



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and may, ultimately, be unworkable. We encourage the Committee to use this opportunity to help simplify the health care system rather than add more complexity.

We are pleased that the committee proposes making important investments in public health, including efforts to modernize the public health data system and improve maternal health outcomes. We also are supportive of provisions aimed at increasing competition in the prescription drug market and ensuring patient access to these drugs. We appreciate the Committee's focus on the importance of ensuring the privacy and security of patient health information and are pleased the draft legislation would incentivize strong cybersecurity practices.

However, we are concerned about several of the proposals that would allow the government to intrude into private commercial contracts between providers and insurers. For example, several of the provisions could undermine value-based purchasing arrangements aimed directly at improving the quality of care while reducing costs. We strongly urge the Committee to remove these provisions.

We appreciate the opportunity to provide these comments and support the Committee's efforts and attention to examining the cost of health care in America. We are committed to working with Congress, the Administration and other health care stakeholders to ensure that all individuals and families have the health care coverage they need to reach their highest potential for health.

Our specific comments on the discussion draft legislation are as follows.

Sincerely,

/s/

Thomas P. Nickels  
Executive Vice President

## **American Hospital Association (AHA) Detailed Comments on the Lower Health Care Costs Act of 2019**

### **TITLE I: ENDING SURPRISE MEDICAL BILLS**

Hospitals and health systems are deeply concerned about the effect of unanticipated medical bills on our patients, which could impact their out-of-pocket costs and undermine their trust and confidence in their caregivers. Protecting patients from surprise medical bills is a top priority for the AHA and our members. To that end, we have adopted the **attached set of guiding principles** to use as we evaluate legislative proposals, such as the one put forward by the Senate Committee on Health, Education, Labor and Pensions. We support a federal-level solution to protect all patients, including individuals who receive health care coverage through Employee Retirement Income Security Act of 1974 (ERISA) plans and those who live in states that have not yet enacted comprehensive legislation to address surprise medical bills. We also would like to acknowledge the work of the Senate Bipartisan Working Group led by Senator Cassidy to address surprise medical billing.

The AHA supports the committee's efforts to advance solutions to stop surprise medical bills by removing patients from the middle of reimbursement disputes. **Our preferred solution is simple: patients should not be balance billed for emergency services, or for any out-of-network services obtained in any in-network facility for which the patient could not be reasonably expected to have known the ancillary providers' network status. Furthermore, we believe that, in those situations, the patient should have certainty regarding their cost-sharing obligations based on an in-network amount.** We strongly oppose, however, approaches that would impose arbitrary rates on providers, along with untested proposals such as bundling payments, which would be unworkable and would do nothing to solve the issue of surprise billing. Below are our specific comments with regard to the discussion draft's provisions to end surprise medical bills.

#### **PROTECTING PATIENTS AGAINST SURPRISE BILLS – SEC. 102**

In general, we support the discussion draft's provision to hold patients harmless from surprise medical bills for all emergency services, for post-stabilization care, unless notice was provided, and in instances of out-of-network ancillary care provided at an in-network facility. We also are pleased to see that, not only will patient cost-sharing obligations be based on the in-network amount, but the discussion draft also would require that such cost-sharing for services count toward a patient's in-network deductible.

**Notice and Disclosure Prior to Post-stabilization Out-of-Network Service:** The committee's discussion draft would require that hospitals, prior to the provision of any out-of-network post-stabilization service, provide the patient the following: paper and electronic notification of out-of-network services with the option to affirmatively consent;

a list of in-network hospitals or practitioners with the option for referral, and the estimated amount such provider would charge for out-of-network services. It is important to note that most hospitals have some form of notice-and-disclosure protocols in place and many states have laws to require notification of network status, including requiring of estimates of fees for potential out-of-network care. While we believe that providing the patient such network status information is important, it is not in and of itself a solution to surprise medical bills. The nature of emergencies, and the legal requirements regarding how and when coverage may be discussed, make providing notice in some of these instances difficult. Notice may not be particularly effective in other scenarios as well. Additional paperwork can often be confusing for patients, especially in instances where they may not have another timely alternative for care. We, therefore, encourage the Committee to focus on fully protecting patients by prohibiting surprise bills and remove notice-and-disclosure requirements as part of the solution.

**Enforcement:** The discussion draft prohibits out-of-network facilities and practitioners from balance billing patients in excess of the in-network cost-sharing amount in the specific scenarios outlined. The discussion draft also includes an enforcement mechanism for facilities and practitioners in violation of these patient protections. Violators would be subject to civil monetary penalties of not more than \$10,000 for each violation. **The AHA believes that, once the patient is protected, resolution of the disputed claims should be left to the plans and providers. If a provider continues to balance bill the patient, then a penalty should be applied, and civil monetary penalties would be preferable to other approaches.**

### **PROPOSALS TO RESOLVE OUT-OF-NETWORK PAYMENT DISPUTES – SEC. 103**

The committee's discussion draft outlines three options to resolve payment disputes between providers and health plans. The committee is seeking stakeholder comments on which option to choose. The AHA, however, is pleased that the committee has stated affirmatively that any payment resolution they decide upon would apply to a broad range of health plans, including those regulated by the state and ERISA. In addition, the AHA supports the provision in the discussion draft that would permit states with patient protection laws in place to address surprise medical bills to continue with their existing state law or regulation. The AHA's comments on the three payment dispute resolution options are below.

**Subtitle A Option 1: In-Network Guarantee:** In this option, the discussion draft would require that in-network facilities guarantee to patients and health plans that every practitioner caring for the patient in the facility is considered in-network. Some health policy experts have described this approach as "network matching," where the facility-based practitioner would be required to contract with every plan for which the facility has a contract. The discussion draft includes two direct and indirect methods to ensure this "in-network guarantee" or "network matching." Practitioners and facilities would be considered to be in-network one of two ways:

1. Practitioners could participate in the same health plan networks for which the facility has an agreement.
2. If a practitioner chooses not to participate in the same networks as the facility, the practitioner would bill the health plan for services via the facility. The out-of-network facilities and practitioners would have 30 days to work with health plans on payment. If no payment agreement is reached within 30 days, the plan would pay the facility and/or the practitioner the median contracted rate for services in the geographic area.

**The AHA opposes Option 1 because it interferes with the fundamental relationship between hospitals and their physician partners and severely limits providers' ability to negotiate contract terms with insurers. We believe that 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. In addition, providers should be able to refrain from entering into contracts with health plans based on other considerations, such as whether the health plan is a fair business partner, which is described in more detail under Option 3 below.**

*Require Network Participation.* Option 1 raises certain antitrust concerns in that it would require that a hospital compel non-employed physicians practicing in its facility to participate in the same health plan networks. It is conceivable that some impacted physicians would threaten or bring suit against the hospital, charging that such compulsion violates federal or state antitrust laws that prohibit restraint of trade in certain circumstances.

*Require Hospital to Bill Plan for Non-participating Practitioner.* In addition to the antitrust concerns noted above, Option 1 raises other legal vulnerabilities through its requirement that a hospital bill the health plan on behalf of the out-of-network practitioner if the practitioner chooses not to participate in the hospital's network. This could create a situation of "ostensible agency," which refers to the relationship that exists between two parties that leads a person to believe that the first is an agent of the second, or vice versa. For example, ostensible agency could apply to a non-participating physician practicing in a hospital but employed by an outside contractor, such as a physician management company. In this case, the patient may believe that the non-participating practitioner is an employee of the hospital but, in fact, he is an "ostensible agent" who is employed by the physician management company. This requirement that the hospital bill on behalf of non-participating practitioners could create confusion in a malpractice action if a patient sues the hospital for the actions of the non-participating practitioner. Legal safe harbors would need to be included to protect hospitals against unintended antitrust and malpractice claims, if the committee chooses to move forward.

Lastly, this option suggests a "backdoor" approach to bundling non-participating practitioner payments. For practitioners that choose not to go in-network and have the

facility bill the health plan, this payment becomes a "bundled payment." This would be administratively burdensome for hospitals by requiring facilities to negotiate directly with practitioners and then negotiate their own rates with insurers to account for the practitioners' payment. Hospitals would be essentially taking on the traditional insurer role of contract negotiations, which employers and individuals contract with their insurers to do, as well as bearing the financial risk. In addition, it is not clear how the health plan would establish the facility portion of this practitioner "bundled payment." In the end, this approach would be too administratively burdensome for hospitals.

**Subtitle B Option 2: Independent Dispute Resolution:** This option would establish an independent dispute resolution process. In cases of payment disputes for claims above \$750, providers and health plans could elect to use an independent dispute resolution process established by the Secretaries of Health and Human Services (HHS) and Labor. Plans, facilities and/or practitioners would submit their best offer to the arbiter consistent with "baseball-style" arbitration. The arbiter can take into consideration information that would include the median in-network rate for services in the geographic area. The arbiter's decision would be binding and the losing party would pay the arbitration costs. Balance bills valued at \$750 or less would be paid at the median contracted rate for that service in the geographic area.

While the AHA believes that hospitals and payers generally should be left to negotiate reimbursement for out-of-network claims without government interference, there may be a role for an alternative dispute resolution process. Several states have passed laws to establish a dispute resolution process to mediate out-of-network claims primarily between physicians and health insurers. Prominent among these processes is "baseball-style" arbitration. New York is one such state that frequently is referenced as having a successful process. One study noted that the New York law reduced out-of-network billing by 34 percent.<sup>1</sup> A more recent study found that, "as of October 2018, IDR [New York's independent dispute resolution entity] decisions have been roughly evenly split between providers and payers, with 618 disputes decided in favor of the health plan and 561 decided in favor of the provider... Additionally, insurers and physicians appear to be making 'a real concerted effort' to work out their payment disputes before filing with IDR." The study also noted that, while it may be too soon to know if the arbitration process leads to higher out-of-network prices, there had not yet been an inflationary impact on insurers' annual premium rates.<sup>2</sup>

The AHA believes that, for arbitration to work within the context of a federal solution to surprise medical billing, it would need to be designed effectively and accommodate existing state programs. **The AHA appreciates the work of the Senate Bipartisan Working Group in S.1531 that would allow providers to initiate an independent**

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<sup>1</sup> Surprise! Out-of-Network Billing for Emergency Care in the United States; Zack Cooper, Fiona Scott Morton, and Nathan Shekita; NBER Working Paper No. 23623 July 2017, Revised January 2018.

<sup>2</sup> New York's 2014 Law to Protect Consumers from Surprise Out-of-Network Bills Mostly Working as Intended: Results of a Case Study; Corlette, S. and Hoppe, O.; Georgetown University Health Policy Institute – Center on Health Insurance Reforms; May 2019  
[https://georgetown.app.box.com/s/6onkj1jaiy3f1618iy7j0\\_gpzdoew2zu9](https://georgetown.app.box.com/s/6onkj1jaiy3f1618iy7j0_gpzdoew2zu9)

**dispute resolution process. The AHA, however, strongly opposes the imposition of arbitrary rates on providers, including as interim payments. We encourage the Committee to look at those features of S.1531 that focus on a prohibition on balance billing and a dispute resolution process as the solution for determining out-of-network reimbursement. This is consistent with our recommendation that the Committee pursue, with modifications, the approach laid out in Option 2. Specifically, we recommend that the committee incorporate the following key design elements into any dispute resolution process:**

1. Provide for an efficient process, such as “baseball-style” arbitration.
2. Place the responsibility to initiate the request for arbitration with the provider or health insurer, not the patient.
3. Allow state government appointment of the arbitrator to ensure better understanding of local markets.
4. Split the cost of arbitration between the two parties in dispute.
5. Establish fixed timelines to ensure expeditious handling of the process.
6. Follow established procedures for documentation and claims recommended by the American Arbitration Association to include processes to reduce costs, such as allowing batching of similar claims.
7. Arbiters should not be bound by a benchmark rate and should take into consideration the usual, customary and reasonable charges for a geographic area.
8. Require that the arbitrators’ decisions are confidential.
9. Apply arbitration to self-insured ERISA plans.

**Subtitle C Option 3: Benchmark Rate:** In this option, the health plan would pay the out-of-network practitioner and/or the facility based on the median contracted rate for services in the geographic area.

**We urge committee members to reject a legislative proposal like Option 3 that would have the government dictate rates between two private entities.** Health plans and hospitals have a longstanding history of resolving out-of-network emergency service claims, and this process should not be disrupted. We are particularly concerned that any attempt at setting a reimbursement standard in law will have significant consequences, including the creation of a disincentive for insurers to maintain adequate provider networks. Growth in the use of no-network, reference-based pricing models in the commercial market suggests this already is a growing strategy, and one that would accelerate if the insurer could simply point to a government-dictated rate or methodology.

The process of rate negotiation is a core function of managing a health plan. The process takes into account a number of factors that could not be accounted for in a single rate or methodology. For example, health plans and providers often consider their entire lines of business, volume, quality, partnerships on special programs or initiatives,

as well as other factors when setting rates. In addition, providers consider other elements besides reimbursement when negotiating contracts, such as a health plan's history with respect to prior authorization and payment delays and denials, as well as other administrative burdens imposed by a particular plan. Setting a default rate would not be able to capture the many factors that specific health plans and specific providers consider. While the committee's proposal to use a median contracted rate appears, on the surface, to suggest it reflects local market conditions, it is impossible to evaluate because the contracted rate data is in the domain of the health plans. In addition, we raise the question with the committee as to why the "median contracted rate" was chosen as opposed to the "average contracted rate," which was an approach taken in earlier legislation. This would certainly result in an arbitrarily lower overall payment rate. Lastly, this default rate approach would remove incentives for health plans to maintain comprehensive networks and follow fair business practices as a way of encouraging providers to enter into contracts. Health plans should not be absolved of the core function of establishing provider networks, including negotiating rates with providers.

#### **SIMPLIFYING EMERGENCY AIR AMBULANCE BILLING – SEC. 106**

The committee's discussion draft begins to address concerns regarding out-of-network billing for air ambulances; however, the draft only addresses issues regarding price transparency. The draft does not prohibit balance billing by these providers.

The AHA believes Congress has a real opportunity put forward a federal solution to address growing concerns over surprise billing for air ambulance services. The Federal Aviation Administration (FAA) regulates air ambulances, and federal law preempts states from regulating rates, routes and services of air carriers. This has limited state governments' ability to address air ambulance balance billing issues. The Government Accountability Office (GAO) recently released a report on air ambulance surprise bills that found that, between 2010 and 2014, the median price charged by air ambulance providers for helicopter transports doubled, and the number of air ambulance helicopters grew by more than 10 percent.<sup>3</sup> In addition, the agency found that, in 2017, about two-thirds of air ambulance transports for privately insured patients were out of network, insurers typically paid only a portion of the out-of-network services, and almost all of the consumer complaints involved balance bills greater than \$10,000. As required by the FAA Reauthorization Act of 2018, the Secretary of Transportation has formed an advisory committee on air ambulance patient billing. The advisory committee is directed to recommend ways to protect consumers from surprise air ambulance bills. **We encourage Congress to take this opportunity to address air ambulance service issues as it develops its legislative solutions related to surprise medical billing.**

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<sup>3</sup> GAO-19-292 Air ambulance [www.gao.gov/assets/700/697683.pdf](http://www.gao.gov/assets/700/697683.pdf)



## **TITLE II: REDUCING THE PRICES OF PRESCRIPTION DRUGS**

The AHA applauds the Committee's continued work to lower the price of prescription drugs for both patients and the providers who care for them, and supports the drug pricing proposals included in the Lower Health Care Costs Act. The evidence clearly demonstrates that increased competition in the prescription drug marketplace lowers prices, with significant decreases occurring after at least five generic competitors enter the market. Each of the proposals under Title II of the legislation seek to increase competition and protect access through appropriate market-based solutions.

Specifically, we support the inclusion of provisions aimed at restoring clarity and transparency to both the Purple and Orange Books. Abuse of patent and exclusivity law remains a significant barrier to lowering drug prices, and the Committee's proposals to restore transparency related to patent and exclusivity periods for biological products and small molecule drugs is a critical component of removing those impediments. Further, not only is ensuring the availability of up-to-date patent and exclusivity information important, but creating and protecting avenues for biosimilar and generic approval and market entry is key. We thank the Committee for its inclusion of several proposals focused on fostering increased competition, as well as ensuring patient access to affordable medicines on which they rely. In addition, we support the Committee's plan to facilitate the increased utilization of biosimilar products when appropriate by requiring that the U.S. Food and Drug Administration (FDA) establish educational tools for both biosimilar and interchangeable products. As biosimilar products become more readily available, educating providers, patients and other key stakeholders on their clinical value, including the role of interchangeability designations, will be necessary to establish a true market for those products.

Finally, we thank the Committee for its recognition of a longstanding issue concerning the drug approval process – abuse of the five-year New Chemical Entity (NCE) exclusivity. When originally enacted, the goal of the NCE exclusivity designation was to incentivize the development of drugs that were truly innovative. We recognize and appreciate the unparalleled clinical value those specific breakthroughs products offer; however, since the implementation of NCE exclusivity, pharmaceutical manufacturers have continuously skirted the law's intent, applying for and receiving new exclusivity periods for minor changes to the way in which an already approved drug is administered or for new uses of the already approved drug. These "updates" fail to reach the intended NCE exclusivity threshold, which is why we support the clarifying language proposed by the Committee. This proposal would rightfully establish a process to properly apply the NCE designation, granting exclusivity to only the most novel drugs that are developed.

### **TITLE III: IMPROVING TRANSPARENCY IN HEALTH CARE**

While we share the Committee's commitment to increase transparency in health care for consumers, we have serious concerns with some of the policies proposed. Our detailed comments on the proposed policies are included below.

#### **PROVIDER/HEALTH PLAN CONTRACT REQUIREMENTS – SEC. 301, 302 AND 309**

The discussion draft includes a number of new requirements that impact provider and health plan contracting. **We do not support these policies because they would unnecessarily increase costs for providers, discourage commercial health insurers from pursuing value-based care arrangements with providers and/or put consumers at risk of being subject to practices that would limit their access to care.** In addition, for some integrated delivery systems, some of the provisions would be wholly unworkable and would result in their dissolution, jeopardizing patient access to high-quality, integrated coverage and care delivery.

The provisions in Section 301 are perplexing; hospitals support providing consumers with tools to understand the extent of their coverage and payment obligations and so it is not clear what the actual issues are that the discussion draft seeks to address. With respect to HIPAA requirements, the underlying legislation and rules provide a consistent and largely workable framework for commercial health insurers or any other legitimate business associate to obtain the information needed to process claims and provide consumers with the services they require. Again, it is not clear what the actual issues are that the discussion draft seeks to address and how it would benefit consumers.

Conversely, a number of the provisions in section 302 would not benefit consumers and would harm hospitals and hospital systems, including those with integrated health plans. For example, preventing providers from declining unfair tiering and/or steering restrictions would undermine the basis for value-based care. Put another way, commercial insurers cannot be allowed to have it both ways – that is, enjoy the savings from providers shouldering financial risk under a value-based care arrangement while simultaneously encouraging those same patients to go elsewhere for care.

Likewise, it would be unfair, particularly to rural and urban hospitals, to allow commercial insurers to cherry-pick which hospitals in the system they contract with. There are enormous economic efficiencies and quality benefits associated with contracting with commercial insurers as a system. For example, to promote efficiency and maintain quality, many systems do not duplicate services at every site of care within the system. That means, excluding one or more of those sites would, at best, limit access to care. Moreover, allowing commercial insurers to decline to include system hospitals that serve vulnerable communities, which is one of the most likely scenarios, would put those already vulnerable communities at even greater risk by limiting access to care.

It is incumbent on those who support legislation in the area of private contracting to provide data to justify such intrusion by the government before the Committee adopts such significant change.

We also are deeply concerned about the provisions in Section 309 that would prohibit health plans from contracting with providers unless the provider agreed to provide enrollees their estimated cost-sharing amount at the time of scheduling or within 48 hours of a request. The AHA supports policies that encourage the continued development of out-of-pocket estimates, when appropriate, and is pleased to see so many of our members undertaking these endeavors on their own accord. However, restrictions on provider-health plan contracts are not the right approach, especially in light of the significant movement in this area by the field.

The AHA agrees that patients should have access to an estimate of their out-of-pocket costs, as we have discussed in a number of recent letters to the Administration (see [here](#) and [here](#)). However, there are a number of challenges to providing accurate and reliable out-of-pocket cost estimates, not least of which is the inherent uncertainty that exists within health care. Specifically, providers can often only give a high level of certainty for very discreet services and bundles of services for treatments that generally follow a common course and are agnostic to patient characteristics. Such items and services may include laboratory and other diagnostic tests, as well as routine procedures where a typical course of care can be reasonably assumed, such as a joint replacement. However, there are many services for which the services needed can change over the course of care, depending on how a particular patient responds to a treatment and the evolution of their disease or injury. Therefore, it is not always possible to provide estimates.

For those services for which estimates can be generated, hospitals and health systems have typically relied on financial assistance staff to help patients navigate their insurance benefits and develop out-of-pocket cost estimates. Increasingly, providers are working to develop the ability to provide these estimates in other ways, such as through their websites and other online applications. While significant progress has been made, the technology is still developing, and no provider can rely on a computer algorithm alone. Hospitals and health systems maintain (and often report increasing) staff to ensure the accuracy of these estimates and to be available to work directly with patients and insurers if complications or questions arise.

Finally, providers must work with payers to obtain all of the information necessary to generate an estimate. For example, providers need to know a patient's current eligibility, as well as their specific cost-sharing obligation and where they are within their deductibles. While electronic transaction standards already exist to share this information, we hear from our members that health plans often do not comply fully with these requests. We, therefore, appreciate that Section 501 would require health plans to provide providers with this information.

### **ALL-PAYER CLAIMS DATABASE – SEC. 303**

Section 303 of the discussion draft would require the U.S. Department of Labor to establish a national all-payer claims database (APCD) and provide \$100 million in grants to states to encourage implementation of their own APCDs. These databases are intended to promote transparency by requiring insurers to submit claims data, which are made available to researchers and policymakers for use in analysis. They also are intended to enable hospitals, health care providers and communities to benchmark their performance against that of others.

The discussion draft would require self-insured group health plans to submit all claims data to a private non-profit entity, which would be required to be a qualified entity under Medicare (to incorporate Medicare data) and have a governing board. Self-insured plans are currently exempted from state APCD reporting mandates because they are federally regulated under ERISA. States interested in using data from the national APCD may submit data from their own APCDs, or opt to have insurers covered under state mandates report directly to the national database. Data in the national database would then be made available to researchers, insurers, health systems and other providers, and regulators monitoring trends and variation in health care prices and spending.

The AHA recognizes the potential of APCDs to drive quality improvements and cost-containment, as well as helping to identify and track issues within the health care system. However, to guarantee the integrity of the data and insights that they yield, we strongly encourage that great care be taken to protect the privacy and security of the data, that data released be presented in its full context, and that relevant stakeholders be involved in the governance process. Therefore, we recommend the following.

*Protecting Privacy and Security.* Protecting the privacy of consumers' health information is of paramount concern for the AHA. In a national survey sponsored by the Institute of Medicine, 83 percent of consumers expressed trust in health care providers to protect their health information, and a smaller share, 69 percent, expressed trust in health services researchers to protect their health information<sup>4</sup>. Moreover, about 50 percent of respondents expressed concern that health services researchers had access to de-identified private health information.

The discussion draft addresses these concerns by establishing privacy and security requirements for receiving, storing and transmitting data. For example, the discussion draft requires the contractor to establish a process for providing data to authorized users in a secure manner, maintain security standards and keep proprietary financial information confidential. We fully support these principles and encourage further strengthening these requirements to protect consumers' private health information and the integrity of the database. The AHA recommends:

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<sup>4</sup> The Institute of Medicine. (2010). *Healthcare data as a public good: Privacy and security*. In Clinical Data as the Basic Staple of Health Learning: Creating and Protecting a Public Good: Workshop Summary.

- Requiring privacy and security training for staff and authorized users, including federal agency users; and
- In the annual report required under subsection (g), the APCD contractor should describe the privacy and security standards around receiving, accessing, storing and transmitting data, as well as any privacy or security incidents that have occurred.

*Ensuring that Data Released be Presented in Context.* Claims data are highly complex and do not always present a full picture of the care and services that providers offer. In order to draw meaningful conclusions from these data, it is important to understand what is and is not included in the data. This means having a clear understanding of any limitations or gaps in the data, as well as understanding what other factors not represented in the data may impact the findings of analyses.

For instance, the discussion draft specifies that the contractor would identify which data elements are required to be submitted. However, it does not specify which types of administrative data – such as information on prior authorization, utilization management, approval or denial rates, appeals – would be required for submission. It is also unclear whether other data that are critical to understanding the factors contributing to patient access to care and utilization, such as quality and outcome indicators, would be included.

To address these considerations, we recommend the following:

- Require that the Annual Report, as well as any publicly released research conducted by authorized users, describe regional, demographic or market-level data limitations or gaps in the database that may affect research findings.
- Require users, including those at federal agencies, to undergo training about the scope of the data.
- Establish minimum requirements for the scope of information required for submission.
- Include information about the insurance plans that submit data, such as type of health plan (e.g., high-deductible health plan, PPO, HMO, etc.), use of utilization management techniques (e.g., prior authorization, including approval/denial rates, decision timeframes, appeal rates and outcomes of appeals) and payment metrics (approval/denial rates, appeal rates and outcomes, etc.). These are important to understanding factors contributing to patient access to care and utilization.

*Governance.* The discussion draft requires the Secretary to convene an Advisory Committee (the “Committee”). The language requires the Secretary of Labor, in consultation with the Secretary of HHS, to appoint 11 members, including: a Committee chairperson, six federal government representatives, a representative from an employer

that sponsors a group health plan, a representative of an employee organization that sponsors a group health plan, and an academic researcher with expertise in health economics or health services research. The Secretary would make two additional appointments to the Committee.

The AHA strongly encourages the inclusion of dedicated Committee seats for health care providers. Health care providers could play a valuable role in translating the experience of providing care, and all that happens in a clinical setting that is not captured in administrative claims data. For example, providers can speak to how clinicians balance the competing administrative requirements of different insurers and plan administrators in providing care, and how that may be reflected in how claims are coded and filed. This voice is not represented in the Committee as currently composed. The AHA also recommends adopting an appointment process that is consistent with other existing federal advisory committees, such as the Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission, to which the Comptroller General of the U.S. makes appointments.

#### **PROVIDER NETWORK TRANSPARENCY – SEC. 304**

Section 304 of the discussion draft would require that health plans establish processes to ensure patients have the most current information on their health care provider's network status. The AHA believes that up-to-date provider directories play an important role in holding health plans accountable for adequate networks. The primary responsibility for ensuring provider directories are accurate lies with health plans, and the AHA is pleased that the discussion draft recognizes this dynamic. However, we are concerned that the discussion draft does not hold health plans truly accountable for errors in the provider directory. In fact, the discussion draft holds providers responsible for refunding patients when an error occurs, even though the health plan controls the accuracy of the directory. In addition, providers could be subject to civil monetary penalties for violations except for one safe harbor that would allow the provider to rescind the bill within 30 days of billing. This safe harbor time window could be too restrictive, however, in the event that the patient does not raise an issue with the bill within the allotted timeframe. **The committee should hold health plans accountable for the accuracy of provider directories rather than rely on the patient and the provider to figure out when mistakes are made.** That accountability should extend to civil monetary penalties for plan errors as well.

#### **BILLING REQUIREMENTS – SEC. 305**

Section 305 of the discussion draft would require providers to give patients a list of the services rendered during a health care visit at the time of discharge and bill the patient within 30 business days of the visit. It also would require providers to allow patients at least 30 days to pay their bills. Though AHA supports the goal of timely patient billing, we have a number of recommended changes to the proposed policy to address underlying issues. **Most critically, the AHA recommends basing the 30-day timeframe for sending timely bills on the date the health plan adjudicates a claim**

**and sends remittance information to the provider, rather than on the date of discharge.** In order for a patient bill to be accurate and reflect the true out-of-pocket cost, the health plan needs to process the claim. Requiring providers to send bills prior to the completion of this process would mean that some patients would inevitably receive statements with inaccurate balances, causing further confusion and directly contradicting the purpose of this legislation.

We also recommend updating “upon discharge” in (a)(1) to “after discharge” and adding “as requested” to this requirement. Often, a full list of services received is not available at discharge because departments wait until after a patient is discharged to submit final charges. Requiring patients to wait until all charges are submitted could delay discharge and unnecessarily increase their length of stay. In addition, this information may not be of interest to every patient. Itemized bills can be provided upon specific request but should not be mandated for every patient.

Finally, the AHA recommends clarifying that a good faith attempt is in compliance with this policy. We are concerned that, without clarification, an attempt to comply with this policy could still render our members out of compliance if there is no proof of receipt or if a bill is returned due to a wrong address. One member has reported that between 4 percent and 6 percent of insured patient bills are returned due to a bad address.

#### **TITLE IV: IMPROVING PUBLIC HEALTH**

**The AHA supports Title IV of the draft legislation as it proposes to make important investments in public health priorities like maternal health, vaccinations and public health data systems.**

Improving and eliminating disparities in maternal health outcomes is a top priority for America’s hospitals and health systems. This legislation would advance progress on this critical issue by funding programs that develop and disseminate best practices to improve maternal outcomes; educate health care professionals on implicit bias in order to reduce and prevent discrimination; establish or support existing state perinatal quality collaboratives; and establish programs to deliver integrated health care services to pregnant and postpartum women.

We commend the Committee on Section 407 of the bill, which would authorize Title VII training grants to address discrimination and implicit bias. We encourage the Committee to specify training in the areas of cultural and linguistic competence to reduce health disparities. We also urge the Committee to require the Secretary to work with professional medical societies to develop recommendations for continuing medical education programs, as many currently practicing medical professionals may have not received appropriate training in implicit bias or cultural competency.

In addition, the AHA is pleased that the legislation would bolster efforts to address vaccine-preventable illnesses by authorizing a national educational campaign to increase the awareness of and combat misinformation about vaccinations. We also applaud the provisions that would fund the much needed modernization of public health data systems used by the Centers for Disease Control and Prevention and state and local health departments.

## **TITLE V: IMPROVING THE EXCHANGE OF HEALTH INFORMATION**

### **REQUIREMENT TO PROVIDE HEALTH CLAIMS, NETWORK AND COST INFORMATION – SEC. 501**

The draft bill requires commercial health plans in the group and individual markets to make certain information easily available, including historic claims, encounter and payment data, network information, and individualized out-of-pocket estimates for common procedures and all prescription drugs. As noted in our comments on Title III, this information is critically important for patients as they make decisions about their health and health care. However, it has not always been easily accessible, or even reliably accurate. **We applaud the Committee’s attention to transparency – particularly in regard to a patient’s out-of-pocket costs – and its recognition that health plans are key players in this effort.**

In particular, we appreciate that the draft bill would require health plans to give in-network facilities and practitioners access to this data. This will be beneficial for a number of reasons, including ensuring that our members are better able to respond to inquiries about a patient’s cost of care. Hospitals and health systems are acutely aware of the challenges patients may experience when looking up the cost of their care, as patients often turn to hospitals, not health plans, for this information. While the uncertain nature of health care is one fundamental challenge, another is that patients and their providers do not always have easy access to information on how the health plan will assess cost-sharing for a particular service. While some mechanisms exist to make such information available to hospitals and health systems, they frequently do not work. This new legislation would help to ensure that patients – and the hospitals and health systems that serve them – can easily gain access to this important data.

While we are supportive of this policy overall, we are concerned about the privacy and security of a patient’s health information when entered into a third-party application – a key tenant of this proposal. While patients should have access to their health information, including the right to use the information as they see fit, it is unclear whether patients are aware of the ramifications of their actions when sharing their data with third-party vendors who are not governed by HIPAA. Once shared, their data can be shared with other actors, sold or used to generate advertisements. It also may be at risk of being further exposed as third-party vendors are not required to encrypt patients’ data, leaving the data vulnerable to hacking. We encourage the Committee to extend HIPAA protections to third-party apps that access patient data via these APIs, ultimately promoting the safety and security of this data, regardless of where it resides.



#### **RECOGNITION OF SECURITY PRACTICES – SEC. 502**

**The AHA is pleased the draft legislation would incentivize strong cybersecurity practices by encouraging HHS to consider entities' adoption of recognized cybersecurity practices when conducting audits or administering fines related to the HIPAA Security Rule.** Hospitals and health systems understand that it is our responsibility to protect patient information and, more importantly, their safety against cyber threats.

Despite complying with HIPAA rules and implementing best practices, hospitals and health care providers will continue to be the targets of sophisticated cyberattacks, and some attacks will inevitably succeed. Whether exploiting previously unknown vulnerabilities or taking advantage of an organization with limited resources, attackers will continue to be successful. The AHA believes that victims of attacks should be given support and resources, and enforcement efforts should rightly focus on investigating and prosecuting the attackers. Merely because an organization was the victim of a cyberattack does not mean that the organization itself was in any way at fault or unprepared. Similarly, a breach does not necessarily equate to a HIPAA Security Rule compliance failure. The AHA has encouraged the HHS Office of Civil Rights to consider ways to develop a safe harbor for HIPAA-covered entities that have shown they are in compliance with best practices in cybersecurity, such as those promulgated by HHS, in cooperation with the private sector, under section 405(d) of the Cybersecurity Information Sharing Act of 2015.

#### **GAO STUDY ON PRIVACY AND SECURITY – SEC. 503**

**We appreciate the Committee's focus on the importance of ensuring the privacy and security of patient health information.** Our members strongly support patients having easy access to their health information so that they can be partners in their care. **However, we do not believe that patients should have to sacrifice data protections and data privacy in order to receive easy access to their health information.** We are deeply concerned that third-party applications and tools not governed by HIPAA are increasingly accessing patient data and using it in ways of which patients likely are unaware. Patients' data is their own, and no organization, whether regulated by HIPAA or not, should be allowed to capitalize and monetize their data without the patient fully understanding what is occurring and agreeing to it. The AHA has urged the Office of the National Coordinator to consider the ramifications of its proposals and consider ways that we can help patients get easy access to their data without sacrificing their control or the protections HIPAA offers.

## **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.