

June 14, 2019

The Honorable Bill Cassidy, M.D.  
United States Senate  
520 Hart Senate Office Building  
Washington, DC 20510

The Honorable Michael Bennet  
United States Senate  
261 Russell Senate Office Building  
Washington, DC 20510

The Honorable Todd Young  
United States Senate  
400 Russell Senate Office Building  
Washington, DC 20510

The Honorable Maggie Hassan  
United States Senate  
330 Hart Senate Office Building  
Washington, DC 20510

The Honorable Lisa Murkowski  
United States Senate  
522 Hart Senate Office Building  
Washington, DC 20510

The Honorable Tom Carper  
United States Senate  
513 Hart Senate Office Building  
Washington, DC 20510

Dear Senators Cassidy, Bennet, Young, Hassan, Murkowski and Carper:

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. The AHA appreciates that the Senate Bipartisan Working Group has a longstanding interest in shielding patients from the financial burdens of unexpected medical expenses and has actively engaged with stakeholders to craft its legislation. Below we provide specific feedback on the Stopping the Outrageous Practice (STOP) of Surprise Bills Act of 2019 (S. 1531).

We agree with the Working Group that it is essential to prohibit balance billing in certain scenarios and to limit the patient's obligation to one's 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. We believe there could be an important role for an independent dispute resolution (IDR) process, such as the one included in the legislation with some modifications, for physician claims only, much how some states have approached surprise billing protections, including New York.



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Our comments on specific sections of the legislation follow.

**SECTION 3: PROHIBITION ON SURPRISE BILLING AND ESTABLISHMENT OF AN IDR PROCESS**

The legislation would extend balance billing protections to patients in several scenarios, including during emergencies and when a patient could not reasonably know that a provider at an in-network facility was out-of-network. We largely agree with these scenarios. However, while we appreciate that patients may need additional time post-stabilization, we believe that the clinical care team is best positioned to determine when it is safe to transport a patient to a facility that reconnects them to their routine care team of in-network providers.

The legislation states that providers would automatically be paid the median in-network rate for out-of-network services and have 30 days to initiate an IDR if they would like to adjust the payment amount. The secretaries of the Departments of Health and Human Services (HHS) and Labor (DOL) would certify entities to perform the dispute resolution process. All requirements would apply to health plans regulated through the Employee Retirement Income Security Act of 1974 (ERISA).

**As stated previously, the AHA believes that hospitals and health systems should be permitted to negotiate reimbursement terms with health plans, but acknowledges that physician claims may benefit from having an IDR process as a backstop. While much of the structure of the IDR process as outlined in the legislation is positive, we object to setting a payment rate, including an automatic payment, in statute, as it undermines a provider's opportunity to negotiate fair reimbursement.** An automatic payment rate could disadvantage providers from finding suitable relief in the IDR process. In many cases, the difference between the automatic payment rate and what a provider believes is fair reimbursement may be financially significant to the provider and yet less than the cost of going to arbitration. As a result, the automatic payment will become a de facto benchmark payment rate as few claims will be brought to arbitration. While the ability to batch claims may make it worthwhile to pursue fairer reimbursement through the IDR process, it could take providers some period of time to accumulate a sufficient number of substantially similar claims to make arbitration an attractive option.

In addition, defining any rate in statute could create an illusion of adequacy among arbiters. In other words, a government-directed rate could bias the arbiter toward that rate or whatever is closest to it. In reality, however, setting rates is far more complicated and the risk of setting the payment too low, as well as ignoring the many factors that providers and health plans consider when deciding whether or not to enter into a contract, could compromise patient access to care. 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

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hospital or health system in a community offering advanced trauma services, and whether a provider and payer have negotiated to enter into a value-based contracting arrangement. Providers also consider whether an insurer is a good business partner when determining when to contract. For example, does the insurer have a history of delaying prior authorization decisions or denying claims inappropriately? We should maintain the incentives for 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.

We recommend that the Working Group strike the section that specifies an automatic payment at the median in-network rate and instead move directly to 30 days of negotiation with the option for an IDR if an acceptable payment rate is not reached in that time. We support the IDR process outlined in S. 1531, including the option to batch claims with similar codes in order to expedite settlements. We believe that strict timelines associated with negotiation and the IDR process can address some provider concerns related to cash flow and the need for timely payment.

In addition, we strongly recommend that the Working Group ensure that all health plans have an adequate network of providers. This would require three important components: 1) applying specific network adequacy requirements to health plans regulated under ERISA; 2) requiring that all network adequacy requirements include specific clinical specialists and subspecialists; and 3) requiring that a minimum percentage of the in-network physicians practice at the in-network facilities. While there are many examples of network adequacy standards that apply to facilities that could be considered, we encourage the Working Group to consult with the clinical specialties to determine the appropriate quantitative standards needed to ensure adequate access.

#### **SECTION 4: NOTIFICATION OF NEW INSURANCE PRODUCTS**

The legislation requires insurers to notify the providers for which its contracts for in-network services of any new insurance products for which the provider may be eligible within seven days of offering the new product. The number and variety of new insurance plan offerings can be daunting for providers. Much of the burden currently falls on the providers to determine their in-network status for these new insurance products. This provision could be helpful to providers trying to assess their network status as they navigate these new market offerings.

#### **SECTION 5: TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES**

The draft legislation would require a health plan to clearly list in-network and out-of-network deductible amounts on an enrollee's insurance card. The AHA supports improving patient's access to and understanding of their expected out-of-pocket costs, and appreciates that this policy would take a step in this direction. We encourage you to also pursue efforts to improve providers' access to real-time information regarding

where a patient currently falls in their annual deductible, which would help providers' ability to answer patient pricing inquiries. We discuss this in the following section.

#### **SECTION 6: ENSURING PATIENT ACCESS TO COST-SHARING INFORMATION**

The draft legislation 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 are pleased to see so many of our members undertaking these endeavors on their own accord. However, imposing restrictions on provider-health plan contracts as a penalty for non-compliance is not the best approach, especially in light of the significant efforts toward improvement in this area by the hospital 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 our letters [here](#) and [here](#)). However, there are a number of challenges to providing accurate and reliable out-of-pocket cost estimates, not the 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 lab 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

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information, we hear from our members that health plans often do not comply fully with these requests. **We, therefore, encourage the drafters to broaden section 6(a)(2) and section 6(b) to require that health plans provide cost-sharing information to providers in a way that enables them to respond to patient inquires in a timely manner, such as through websites that providers can use to assess cost-sharing information based on a specific patient's coverage. In addition, insurers should be incentivized to work with providers on price estimator tools.**

#### **SECTION 7: MEDICAL LOSS RATIO**

In this section, health plans would be permitted to count the cost of the IDR process as medical costs for purposes of plans' medical loss ratio (MLR) calculations. MLR ratio calculations measure how much the premium dollar is going to actual medical care and serves as an important tool to hold health plans accountable. **We strongly oppose allowing health plans to divert dollars that are meant for direct patient care to pay administrative costs.** In addition to taking resources away from patients, this also would remove a financial incentive for health plans to avoid the IDR process by either contracting with providers or negotiating with them to resolve out-of-network claims. Specifically, if a health plan could build the cost of the IDR process into the MLR, they would have no incentive to resolve disputes early as they would face no financial consequences for taking every claim through the IDR process.

#### **SECTION 8: TRANSPARENCY REQUIREMENTS ON HOSPITALS**

The legislation would require that hospitals disclose financial relationships and profit-sharing agreements with physicians groups and make this information available in print and online. **The AHA is opposed to this provision, as it seeks to publicize, and therefore potentially undermine, private contracting arrangements.**

This section also requires hospitals to include all ancillary services within the hospital bill sent to patients, such as services provided by phlebotomists, laboratory technicians and echo-cardiogram technicians. We are unclear of the scope of this provision and whether it includes other common ancillary service providers, such as anesthesiologists. Absent clarity, our comments reflect a broad reading of the text. We also read the text as prohibiting these ancillary providers from billing a patient separately. Instead, the hospital would be required to negotiate with the insurer and submit a "single bill" and then the hospital then would be responsible for compensating the provider. **We oppose this approach and have previously communicated our concerns to Congress (see attachment).**

One concern about this provision is that it raises other legal vulnerabilities through its requirement that hospitals 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

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versa. For example, ostensible agency could apply to a non-participating ancillary service provider practicing in a hospital but employed by an outside management firm. In this case, the patient may believe that the non-participating practitioner is an employee of the hospital but, in fact, he or she is an “ostensible agent” who is employed by the outside company. This requirement that the hospital bill on behalf of non-participating ancillary practitioners could create confusion in a malpractice action when a patient sues the hospital for the actions of the non-participating ancillary practitioner. Legal safe harbors would need to be included to protect hospitals against unintended antitrust and malpractice claims if the Working Group chooses to move forward with this proposal.

The legislation further calls for a study by the HHS Secretary on the feasibility of hospitals and hospital-based provider groups providing patients a unified bill for all services offered within an episode of care. We recommend that the Working Group conduct this study before enacting provisions, such as in the previously described section, that require hospitals to bill patients for ancillary services.

#### **SECTION 9: TRANSPARENCY REQUIREMENTS FOR GROUP HEALTH PLANS**

The discussion draft would require health plans to report to HHS and DOL on: payment and denials for in-network and out-of-network claims; cost-sharing information and out-of-pocket costs for their enrollees; claims for out-of-network emergency services; and the number of claims for out-of-network care delivered in in-network hospitals. **The AHA supports these health plan transparency provisions, particularly with regard to reporting on payment denials for in-network and out-of-network claims.** We have heard from many member hospitals that health plans are using payment denials after care has been rendered to manage their financial exposure, and this provision would help provide more information on what is happening.

#### **SECTION 10: APPLICABILITY TO STATES WITH SURPRISE BILLING LAWS**

This section applies the provisions of S. 1531 to all self-funded plans, the Federal Employee Health Benefits Program plans and fully-insured plans in states that have not yet enacted their own surprise billing legislation. States would be allowed to set their own provider compensation levels and/or IDR methods for insurance plans regulated by the states as long as they protect patients from surprise medical billing as outlined in section three. **We support the Working Group taking action to protect patients in self-insured employer-sponsored plans regulated under ERISA, which covers the majority of privately insured individuals, as well as including flexibility for state laws that meet the federal minimum for consumer protections to remain in place. However, we have concerns about the provision that allows states to enact laws regarding rate-setting and in-network guarantees.**

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**SECTION 11: BALANCE BILLING STUDY**

The Secretaries of HHS and DOL are required to study the effects of the law once implemented. The study would review: the financial impact on patient responsibility for health care spending and overall health care spending; the incidence and prevalence of the delivery of out-of-network health care service; the adequacy of provider networks offered by health plans/issuers; the impact of connecting reimbursement to different claims databases; the number of bills that go to the IDR process; and the administrative cost of the IDR process and estimated impact on insurance premiums and deductibles. This information would be available to the public in a searchable database. In general, the AHA is supportive of the direction of this study. We believe, however, that the results of the IDR process should remain confidential to ensure the integrity of the process. Therefore, we would urge that any study respect and protect the confidentiality of such proceedings.

Thank you for your consideration of our comments. Please contact me if you have questions or feel free to have a member of your team contact Megan Cundari, senior associate director, at [mcundari@aha.org](mailto:mcundari@aha.org).

Sincerely,

/s/

Thomas P. Nickels  
Executive Vice President