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

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

Dear Chairman Scott and Ranking Member Foxx:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) is writing to comment on provisions of the Ban Surprise Billing Act that will be marked up this week. We appreciate that the issue of surprise medical billing is a priority for your Committee, as it is for our field and our patients.

While the AHA supports efforts to shield patients from the financial burden of unexpected medical expenses, we are concerned with the Committee's legislative approach to determining reimbursement for out-of-network providers.

The AHA believes that once the patient is protected from surprise bills, providers and insurers should then be permitted to negotiate payment rates for services provided. We strongly oppose approaches that would impose arbitrary rates on providers, which could have significant consequences far beyond the scope of surprise medical bills. It is the insurers' responsibility to maintain comprehensive provider networks, and a default payment rate would remove incentives for health plans to contract with providers or to offer fair terms and results in a huge windfall to commercial insurance companies at the expense of the nation's community hospitals. We urge the Committee to not move legislation that would cause disruption to the patients and communities we serve.

Our specific comments on the provisions follow.

PREVENTING SURPRISE MEDICAL BILLS

The legislation prohibits balance billing by out-of-network providers for all emergency services, at hospital emergency departments, at freestanding emergency departments and for air ambulances, as well as when the patient is treated in an in-network facility but cannot reasonably choose their provider, a position with which we agree.

The copayment or coinsurance rates for the patients would be based on the health plan's median contracted rate and any deductibles or out-of-pocket maximums would apply as if the services were provided by a participating provider.

The Ban Surprise Billing Act establishes a minimum payment standard for out-of-network emergency care and care provided by out-of-network ancillary providers during otherwise in-network care. The payment standard would be set at the median of the negotiated rates for the service in the geographic area the service was delivered, with an inflationary increase that references the urban consumer price index (CPI-U). States would have the ability to determine their own payment standards for plans they regulate.

The AHA opposes setting a rate in statute, given the risk it creates for setting rates too low and compromising patient access to care, and we ask the Committee to strike the benchmark rate language. Rate setting would be nearly impossible to get right and ignores the many factors that providers and health plans consider when deciding whether or not to enter into a contract. Factors that may be relevant to one provider may not be relevant to another provider, which means that the median contracted in-network rate may not be the appropriate payment level. Considerations include a provider's size or mix of services, such as whether a provider is the only hospital or health system in a community offering advanced trauma services, and whether a provider and payer have negotiated to enter into a value-based contracting arrangement. Providers also consider whether an insurer is a good business partner when determining when to contract. For example, does the insurer have a history of delaying prior authorization decisions or denying claims inappropriately? Incentives should be maintained on insurers to not only pay fairly but also to engage in good business practices. Rate setting creates a disincentive for insurers, as it removes the need for health plans to form comprehensive networks and to contract and negotiate with providers.

Rate setting also would extend beyond surprise medical billing scenarios by incentivizing insurers to depress in-network rates. **The Congressional Budget Office's (CBO) score of legislation on surprise medical billing passed in June by the Senate Health, Education, Labor and Pensions Committee (S. 1895), which tied the benchmark payment to the median in-network rate, states that more than 80% of the estimated budgetary effects (savings) – or about $19 billion – arise from changes to *in-network* payment rates.** As CBO notes, creating a method for reimbursing out-of-network rates that sets a benchmark rate would result in payments to

providers, both inside and outside of networks, moving toward the median rates. **According to CBO, "The cost of surprise bills is a small portion of all health care spending, but policies to address surprise bills can have important consequences for the health care system because they affect negotiations between insurers and providers.**" CBO found a similar impact in their analysis of the House Energy and Commerce legislation (H.R. 2328) passed in July. "The vast majority of health care is delivered inside patients' networks, and more than 80 percent of the estimated budgetary effects of title IV would arise from changes to in-network payment rates. CBO and JCT estimate that by creating a method for reimbursing out-of-network care at median in-network rates, payments to providers—inside and outside of networks—would converge around those median rates." **In an effort to solve the discrete problem of surprise medical billing, Congress must avoid harming the hospitals that provide the in-network care and the patients they serve.**

CBO also noted, "…over time, payment rates for affected providers would increase somewhat more slowly because changes in the median in-network rate would be tied to the rate of growth in the consumer price index for all urban consumers (CPI-U) and the pace of CPI-U growth lags behind that of payment rates for affected providers." The inflationary adjustment of CPI-U is generally below medical inflation, and is therefore not the most accurate inflationary index to be considered for this purpose.

INDEPENDENT DISPUTE RESOLUTION PROCESS

The Ban Surprise Billing Act allows providers and facilities to use an independent dispute resolution (IDR) process for claims with median contracted reimbursement rates of more than $750 for providers and facilities and more than $25,000 for air ambulances.

The IDR process is "baseball-style" and binding. Batching of certain claims would be permitted. The IDR entity would be instructed to take into account a limited set of factors, including the median contracted rate for comparable services. Billed charges would not be permitted for consideration. The fees for the IDR process would be paid by the losing party. The Secretaries of the Departments of Health and Human Services (HHS) and Labor would make public general information about the IDR process and decisions.

We believe that the instructions to the IDR entity outlined in the legislation are limited and skewed toward insurers. The factors should be expanded to include others, such as: demonstration of good faith efforts (or lack of good faith efforts) made by the out of network provider or plan; prior negotiated rates, if applicable; and other relevant economic aspects of provider reimbursement for the same specialty within the same geographic area.

PROVIDER DIRECTORIES

The Ban Surprise Billing Act specifies a number of requirements on health insurance plans to produce provider directories, keep them up-to-date and provide this information to their subscribers both online and in printed formats. We agree with that consumers should better understand their health plans and which providers are in their network. However, it is unclear as to whether these provisions will improve provider directories or simply add significant burden to the system. There is a lack of consistency regarding requirements placed on the group health plans in this legislation: provider directory updates are required every 90 days, versus current law regarding Medicare Advantage and qualified health plans, which is far better for consumers, and requires these updates to be made every 30 days.

Certain requirements also are placed on providers to transmit provider directory information to each health plan. We are concerned that these requirements are duplicative of current operating procedures. And if the health plan and provider have a contract, the health plan is already aware of this. We question the need to establish a separate process for the provider to alert the health plan that they are coming in or going out of network.

The legislation should be clear about how these rules do or do not apply to health plans that do not have networks, i.e., no-network plans that use reference-based pricing. We also encourage the Committee to consider requiring minimum network standards for all health plans.

PREVENTING CERTAIN CASES OF BALANCE BILLING/NOTICE REQUIREMENTS

The Ban Surprise Billing Act requires hospitals to give patients both oral and written notice of any items or services they may receive from out-of-network providers, as well as the estimated cost of services and cost-sharing obligations and whether there are any in-network providers at the facility who may be able to furnish the services.

The AHA supports increased transparency with regard to both in-network provider status, as well as potential costs patients will face. However, the primary responsibility for ensuring provider directories – the source of this information – are accurate lies with health plans. A preferred approach would be that the legislation direct health plans to identify in-network providers and allow the out-of-network provider to help coordinate patient communication with the health plan. Hospitals are already working on securing information for patients but insurers and other providers should be required to work with facilities to ensure a timely result.

The legislation also puts undue burden on the hospital by requiring that facilities retain for two years their own signed notices, as well as those of any non-participating providers who are delivering services at the facility. It is unclear that such a provision is

required in order to protect patients. Rather, providers who are unable to show that such notice was provided should simply be unable to balance bill. If maintenance of records is required, each provider should be responsible for their own paperwork.

Penalties

The Ban Surprise Billing Act allows the imposition of civil monetary penalties of up to $10,000 per violation to enforce its prohibition on surprise medical bills. In the exception section, there is a provision for a waiving of penalties if a provider unknowingly violated any section of the bill. However, providers are required to reimburse, with interest, both patients and the plan in cases of erroneous balance billing. However, there are no accommodations made for situations in which the balance billing is the result of inaccurate information from the health plan, such as those related to covered services and benefits and/or errors in the provider directory. In these instances, health plans – not the provider – should be responsible for reimbursing patients.

Thank you for your consideration of our comments on the Ban Surprise Billing Act. We look forward to continuing to work with the Education and Labor Committee regarding solutions to stop surprise medical bills.

Sincerely,

/s/

Richard J. Pollack
President and Chief Executive Officer

cc: Members of the House Education and Labor Committee