American Hospital Association™
Advancing Health in America

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December 13, 2020

The Honorable Richard E. Neal
Chairman
Ways & Means Committee
U.S. House of Representatives

The Honorable Kevin Brady
Ranking Member
Ways & Means Committee
U.S. House of Representatives

The Honorable Frank Pallone, Jr.
Chairman
Energy & Commerce Committee
U.S. House of Representatives

The Honorable Greg Walden
Ranking Member
Energy & Commerce Committee
U.S. House of Representatives

The Honorable Robert C. "Bobby" Scott
Chairman
Education & Labor Committee
U.S. House of Representatives

The Honorable Virginia Foxx
Ranking Member
Education & Labor Committee
U.S. House of Representatives

The Honorable Lamar Alexander
Chairman
Health, Education, Labor & Pensions Committee
U.S. Senate

The Honorable Patty Murray
Ranking Member
Health, Education, Labor & Pensions Committee
U.S. Senate

Dear Chairman Neal, Chairman Pallone, Chairman Scott, Chairman Alexander, Ranking Member Brady, Ranking Member Walden, Ranking Member Foxx 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) thanks you for your efforts to protect patients from surprise medical bills. We appreciate that this issue is a priority for you, as it is for our field and our patients.

We agree with you that it is essential to prohibit balance billing in certain scenarios and

to limit patients' obligation to their in-network cost-sharing responsibilities. We strongly support provisions to protect the patient from surprise medical bills. Once the patient is protected, hospitals and health systems should be permitted to work with health plans to determine appropriate reimbursement, as is provided for in your bill. As you know, we strongly oppose approaches that would impose arbitrary rates on providers, which could have significant consequences far beyond the scope of surprise medical bills and impact access to hospital care, particularly in rural communities. **However, we urge you to consider several modifications to the dispute resolution process to reduce burden on all parties and ensure fair consideration of offers.**

We also would like to commend you for not including in the legislation certain provisions extraneous to the surprise medical billing issue, such as those related to privately negotiated contracts, which would lead to narrower provider networks with fewer choices for patients. **However, we have significant concerns with several of the provisions that would attempt to implement unworkable billing processes and transparency provisions that are duplicative and costly without clear added benefit for patients.**

Finally, we ask that any savings associated with this legislative initiative be directed to those providers that are on the front lines of treating COVID-19 patients, such as hospitals, physicians and nurses.

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

PREVENTING SURPRISE MEDICAL BILLS

The legislation prohibits providers from balance billing patients for emergency services or medical care the patient reasonably could have expected to be in-network, and does not allow patients to be charged more than the in-network cost-sharing amount. We applaud you for protecting patients from surprise medical bills and for developing a workable approach for determining the patient's cost-sharing amount so they can be "taken out of the middle" of any discussions between the health plan and the provider regarding reimbursement. We also appreciate that health plans are required to pay the provider directly for the out-of-network services, rather than sending reimbursement to the patient, and that an independent process would be available in the case of any disputes over reimbursement.

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

We have several questions and comments on the proposal:

- **Independent Dispute Resolution (IDR) Process.** Recognizing that some negotiations may not resolve in a timely manner, the legislation establishes an IDR process to adjudicate any disputes. While we expect this option would rarely be used, we appreciate that the legislation has designed it in such a manner to allow for continued negotiation and enable providers and health plans to bring any information they deem relevant to the independent mediation entity. We also appreciate that the IDR entity is instructed to consider a number of factors that may impact the cost of delivering care, including the training and expertise of the provider or facility; the acuity of the patient; the teaching status, case mix and scope of the services offered by the facility; demonstrations of good faith (or lack of good faith) made by providers or plans to enter into network agreements; and recently contracted payment rates between providers and plans. **However, we are concerned that the IDR process may be skewed if the arbiter is able to consider public payer reimbursement rates, which are well known to be below the cost of providing care. We urge that the legislation include an explicit prohibition on considering Medicare, Medicaid and other public payer rates, especially as these programs are not implicated by the surprise medical billing provisions.**

  We also recommend that the approach go further to reduce burden on all parties in two ways. The first is to allow for a longer time period for the batching of similar claims. Once the patient is held harmless, plans and providers should have the opportunity to consolidate as many similar claims at once to reduce burden on all parties. **We encourage allowing up to a year for batching of claims.**

  The second is to incentivize insurers to make fair initial payments so as to reduce the need for further negotiation and, potentially, use of the IDR process. **Specifically, we ask that the initial payment made by the insurer for out-of-network services be considered their offer for IDR, so as to incentivize them to pay a fair initial reimbursement.**

- **Enforcement of Surprise Medical Billing Violations.** We are unclear as to the oversight of this provision and, in particular, the role of states in overseeing providers. It appears optional for states to conduct oversight of provider compliance, and the federal government would act as an enforcement backstop in the event a state did not take up this responsibility. It also is unclear if states are limited to the civil monetary penalty limits outlined in the draft legislation. This approach could potentially result in uneven enforcement of the bill's protections.

  We also have questions regarding how the government intends to audit health plan compliance. For example, audits are limited to 25 plans of all types unless there is a complaint; this seems to be small number of maximum audits. In addition, the requirement for auditing is found in the sections related to the Public Health Service Act and Internal Revenue Code, but not in the section that

implicates the Employee Retirement Income Security Act of 1974 (ERISA). Instead, the departments of Health and Human Services (HHS) and Treasury are directed to consult with the Secretary of Labor on rulemaking. We are concerned about whether this arrangement is sufficient to ensure ERISA plans would be audited in the same manner as other health plans.

In addition, the legislation does not appear to establish penalties on plans that fail to reimburse providers for out-of-network care or that provide false or inaccurate information on their median contracted rate. **We ask you to include in the bill penalties for plans that fail to adhere to these provisions.**

- **Notice and Consent for Certain Out-of-Network Services.** We appreciate that there is an opportunity for out-of-network providers to work with patients who may be interested in receiving their services. However, the process as presented in the bill is confusing. It appears to put the onus on the out-of-network provider to give the notice and obtain consent, but then suggests that, in the case of out-of-network providers in facilities, it is the facility's responsibility to maintain the consent forms. Therefore, it is unclear as to the role of the facility versus the individual clinician in providing notice and consent. It also is unclear how the out-of-network provider will know what the in-network provider options would be for a patient, as well as whether the patient's health plan applies prior authorization or other care management requirements on items or services. **We encourage you to clarify that the out-of-network provider – whether the professional or facility – is responsible for managing their own notice and consent process and forms.**

TIMELY BILLING PROVISIONS

Hospitals and health systems share the goal of sending patients their bills in a timely manner. However, we have significant concerns about the specifications contained in the No Surprises Act. The legislation sets forth a 90-calendar-day timeframe for billing, after which patient billing could not occur or a refund, with penalties, would be imposed on the provider. We have the following concerns and recommendations regarding this approach:

- **Consolidation of Professional and Facility Claims.** The legislative text appears to hold facilities responsible for physician/professional claims, even when a physician/professional is not employed by the facility. However, the facility would not be privy to essential information such as the proprietary billing rates between that provider and the insurance plan, or the status of the provider in relation to the plan (e.g., whether they are credentialed by the plan). In addition, in order to operationalize this, the facility would need to build the infrastructure to solicit bills from providers and issue payments. **This would result in an unprecedented change in the relationship between independent hospitals and physicians and would require significant technology and legal resources, as well as a revamping of the billing**

workflow, to operationalize. This would add considerable burden and cost to the health care system and has the potential to result in a number of downstream consequences, including reducing patient access to certain specialties within a hospital or health system. And yet, this provision is not essential to resolving the issue of surprise medical bills. We strongly urge you to clarify that independent providers, including those working in facilities, are responsible for their own contracting with and billing of health plans.

- **Timeline for Bills.** We are concerned providers cannot control how quickly the plan responds to bills, and the plans appear to have a mechanism to stop their clock by claiming there is a dispute between them and the provider. It also is unclear in the legislative text as to whether the penalties occur if any 30-day window within the 90-day timeline is breached or only if the entire 90-day window is breached. Delayed responses from plans could subject providers to penalties and prevent them from billing patients if they cannot provide patients their cost-sharing information within the required 90-day window. **While we support the goal of expediting the billing process, we do not believe this provision accounts for the challenges providers face in receiving adjudicated claims back from insurers, and we urge you to remove these provisions.**

PRICE TRANSPARENCY PROVISIONS

Hospitals and health systems are committed to helping patients access the information they need to make decisions about their care. The draft legislation includes several provisions to advance patient access to health care cost information. We are concerned that several of these provisions are duplicative of each other and do not account for the significant expansion in the adoption of out-of-pocket cost estimator tools adopted by health plans and providers.

We encourage you to consider the following comments:

- **"Good Faith Estimates."** It appears that providers would be required to create "good faith estimates" for all scheduled care, not just upon patient request. Requiring hospitals to establish a separate, mandatory process to provide such estimates for all scheduled services regardless of whether the patient requested it or has access to an existing cost estimator tool would add significant burden and cost to the health care system without clear additional benefit to patients. **We ask the Committee to clarify that the estimate is only required when requested by the patient.**

- **"Advanced Explanation of Benefits (EOB)".** The legislation also would require that health plans use the provider's "good faith estimate" to create an Advanced EOB, which also would need to include a number of different data points. Based on our members' experience responding to patient requests for

cost estimates, we are concerned that the myriad numbers presented would confuse, not help, patients. We also believe this provision may be duplicative of Section 114 of the bill, which requires health plans to offer a price comparison tool for their members. As previously noted, adoption of such tools among both health plans and providers has grown significantly over the past year, including as a result of technological advances and the development of new resources.

Hospitals and health systems support the adoption of these cost-estimators. However, implementing such tools has required significant human and financial resources. **We therefore recommend reconsidering whether the good faith estimates and Advanced EOB add sufficient benefit for patients to offset the additional and duplicative burden and cost to the health care system. If you do move forward with this provision, we recommend the Advanced EOB only reflect the patient's out-of-pocket costs, as well as where they are in their annual deductible and out-of-pocket cost limits.** This will enable patients to more easily find the information most important to them.

Finally, we support your efforts to help patients understand their coverage by including critical information directly on their health plan benefit card. For example, we strongly support including the deductible amount, as well as out-of-pocket cost limits.

AMBULANCES

We are pleased that The No Surprises Act includes language to protect consumers from out-of-network bills associated with air ambulance services, as those entities should be subject to the same limitations on balance billing as other providers. The language also requires the establishment of an advisory committee to review the disclosure of ground ambulance charges and protect consumers from balance billing. **We do not think the legislation has sufficiently addressed this issue and would ask that you extend to ground ambulance services similar consumer protections from out-of-network billing as that required for air ambulances.**

Thank you for your consideration of our comments on the No Surprises Act. We look forward to continuing to work with you regarding solutions to prevent surprise medical bills.

Sincerely,

/s/

Richard J. Pollack
President and Chief Executive Officer