May 28, 2019

The Honorable Frank Pallone
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Greg Walden
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Pallone and Ranking Member Walden:

On behalf of our member hospitals, health systems and other health care organizations, we are fully committed to protecting patients from "surprise medical bills" that result from unexpected gaps in coverage or medical emergencies. We agree with the Committee's goal, outlined in its summary of the "No Surprises Act," that America's families need relief from this problem and we welcome the opportunity to share our comments regarding the Committee's discussion draft.

Our organizations have previously outlined to Congress the scenarios in which patients should be protected when they receive a surprise medical bill, as well as the principles that should be used to evaluate legislative proposals. The letter is attached for your reference. For these comments, we would like to focus on one component of the "No Surprises Act:" the establishment of a benchmark payment to resolve out-of-network payment disputes between providers and insurers. Specifically, the discussion draft calls for a median in-network rate to be paid in these instances. We oppose the setting of payment rate in statute and would ask that you instead consider an independent dispute resolution process.

We are concerned that the rate-setting provision of the legislation is a plan-determined, non-transparent process that will upend private payment negotiation. A default rate will become the payment ceiling and remove incentives for insurers to develop comprehensive networks, as there are already increasing numbers of narrow network products offered that exclude certain types of providers. If an insurer can pay the same rate to all out-of-network providers, why would they make the effort to develop robust in-network insurance products for their subscribers? Moreover, setting a payment rate is difficult to do properly in statute, even when a geographic adjustment is provided, given the many factors that are currently used to determine payment. For example, rates usually take into account a provider's volume, services offered and quality improvement efforts.

The Committee should instead consider the establishment of a dispute resolution process, such as arbitration or mediation, as a way to resolve payment issues. Such a process could serve as a backstop after a period of direct negotiation between payers and providers and could, as evidenced by the experience in New York State, both reduce the incidence of out-of-network billing and incentivize network participation.

There are several ways that a dispute resolution process could be structured. We recommend the Committee require the provider or health insurer to initiate the request, rather than the patient, and ensure that the arbiter or mediator is independent and has an understanding of health care and the local market.

A number of states have enacted these dispute resolution processes, ranging from mediation to variations of arbitration. Some have put in place a binding arbitration "baseball style" process that requires both parties to submit a best offer in writing, with the arbiter responsible for choosing from between the two options, without modification. The cost of the arbiter could either be borne by the losing party or could be shared between the negotiating parties. Any dispute resolution process can be implemented quickly and efficiently and allows for similar claims to be batched. Another suggestion would be to follow the National Association of Insurance Commissioners' 2015 Model Act on provider network adequacy standards, which outlined a structured mediation process for disputes between insurers and out-of-network providers for bills of $500 or more. To be useful to all consumers, any dispute resolution process must be applied to those states that have not already enacted surprise medical billing legislation, as well as for self-funded plans regulated by the Employee Retirement Income Security Act of 1974 (ERISA).

We appreciate your consideration of these suggestions and look forward to continuing to work with you on a federal legislative solution to the issue of surprise medical billing.

Sincerely,

American Hospital Association
America's Essential Hospitals
Association of American Medical Colleges
Catholic Health Association of the United States
Children's Hospital Association
Federation of American Hospitals

Attachment

February 20, 2019

Dear Congressional and Committee Leadership:

On behalf of our member hospitals, health systems and other health care organizations, we are fully committed to protecting patients from “surprise bills” that result from unexpected gaps in coverage or medical emergencies. We appreciate your leadership on this issue and look forward to continuing to work with you on a federal legislative solution.

Surprise bills can cause patients stress and financial burden at a time of particular vulnerability: when they are in need of medical care. Patients are at risk of incurring such bills during emergencies, as well as when they schedule care at an in-network facility without knowing the network status of all of the providers who may be involved in their care. **We must work together to protect patients from surprise bills.**

As you debate a legislative solution, we believe it is critical to:

- **Define “surprise bills.”** Surprise 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 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.

- **Protect the patient financially.** Patients should have certainty regarding their cost-sharing obligations, which should be based on an in-network amount. Providers should not balance bill, meaning they should not send a patient a bill beyond their cost-sharing obligations.

- **Ensure patient access to emergency care.** Patients should be assured of 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.

- **Preserve the role of private negotiation.** Health plans and providers should retain the ability to negotiate appropriate payment rates. The government should not establish a fixed payment amount or reimbursement methodology for out-of-network services, which could create unintended consequences for patients by disrupting incentives for health plans to create comprehensive networks.

- **Remove the patient from health plan/provider negotiations.** Patients should not be placed in the middle of negotiations between insurers and providers. Health plans must work directly with providers on reimbursement, and the patient should not be responsible for transmitting any payment between the plan and the provider.

- **Educate patients about their health care coverage.** We urge you to 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 the health care system and their coverage.

- **Ensure patients have access to comprehensive provider networks and accurate network information.** Patients should have access to a comprehensive network of providers, including in-network physicians and specialists at in-network facilities. Health plans should provide easily-understandable information about their provider network, including accurate listings for hospital-based physicians, so that patients can make informed health care decisions. Federal and state regulators should ensure both the adequacy of health plan provider networks and the accuracy of provider directories.

- **Support state laws that work.** Any public policy should take into account the interaction between federal and state laws. Many states have undertaken efforts to protect patients from surprise billing. Any federal solution should provide a default to state laws that meet the federal minimum for consumer protections.

We look forward to opportunities to discuss these solutions and work together to achieve them.

Sincerely,

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