



**Association of  
American Medical Colleges**  
655 K Street, NW, Suite 100, Washington, DC 20001-2399  
T 202 828 0400  
aamc.org

June 7, 2019

The Honorable Lamar Alexander  
Chairman  
Senate Health, Education, Labor and  
Pensions Committee  
455 Dirksen Senate Office Building  
Washington, DC 20510

The Honorable Patty Murray  
Ranking Member  
Senate Health, Education, Labor, and  
Pensions Committee  
154 Russell Senate Office Building  
Washington, DC 20510

Dear Chairman Alexander and Ranking Member Murray:

On behalf of the Association of American Medical Colleges (AAMC), I write to thank you for inviting feedback on the Lower Health Care Costs Act of 2019. The AAMC appreciates this bipartisan, thoughtful discussion draft, as well as the opportunity to provide the perspective of academic medicine.

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 154 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

Rising health care costs and patient understanding of their financial responsibility are important issues facing our health care system. The AAMC recognizes the inherent complexity of these issues, and stands ready to assist the Senate Health, Education, Labor, and Pensions Committee ("the Committee") as it seeks to improve health care for patients while also lowering costs.

The AAMC applauds the Committee for the years of work that have culminated in this thoughtful, comprehensive, and bipartisan discussion draft. The AAMC also appreciates the opportunity to provide feedback on this discussion draft legislation. We hope that these comments are helpful in your efforts, and that they can serve as a continuation of our dialogue with the Committee.

### **Ending Surprise Medical Bills**

The AAMC firmly believes that patients should be protected from surprise medical bills, and that they should be removed from billing disputes. We appreciate that Title I addresses this issue.

Teaching hospitals often are where individuals go when experiencing an emergency and these patients are at their most vulnerable while seeking and receiving emergency medical services. They should not incur the additional stress of being balance billed when they were unable to choose a provider that would have been in network. Additionally, the AAMC does not believe that patients should be billed for services that they could not have reasonably known would be out-of-network, particularly when they took appropriate steps to ensure that their care would be in-network.

As you know, the AAMC joined several hospital association stakeholders in proposing the attached set of guiding principles addressing surprise medical bills. We have used these principles to evaluate several surprise billing legislative proposals, including those in the Lower Health Care Costs Act of 2019.

The AAMC agrees with the Committee's approach that patient cost-sharing for emergency health care services should be based on the in-network amount, and that the cost-sharing should be counted toward the patient's in-network deductible. We are pleased that the proposal would prohibit balance billing and hold patients harmless by only requiring them to pay the in-network cost-sharing amount for out-of-network emergency care, care provided by ancillary providers, and out-of-network diagnostic services at in-network facilities.

Section 102 would require that, prior to the provision of any post-stabilization out-of-network service, the out-of-network hospital provide the patient with written information on estimated charges for ongoing treatment, including a list of in-network practitioners or hospitals that could provide the same service and estimated amount each would charge. We believe the patient's health plan is the primary and best source of this information, and they are best positioned to discuss confidential, plan-specific information with the patient including their cost-sharing. Detailing and communicating a patient's coverage should remain the primary responsibility of the insurer.

Imposing an additional notice requirement on teaching hospitals in particular would be overly burdensome in emergency situations, and also could be detrimental to patients. Major teaching hospitals are common sites for emergency treatment due to their "stand-by capacity" and 24/7 readiness – trauma centers, burn units, psychiatric services, and more. In many of these situations the emergency patient requires hospitalization and yet, under the discussion draft, the teaching hospital would be required to inform the patient that they are out-of-network. A hospital in this situation would be required to find another in-network institution to send the patient and be confident that the other institution would actually be willing and able to immediately accept the patient transfer.

For example, for a patient who breaks their hip there is a "window of time" that is known to be optimal for the patient to have a repair. The patient may be stabilized but the time and effort of making the transfer as well as the inconvenience and potential harm of transporting an injured patient may compromise their recovery. Another example is a patient who presents to the emergency department with pneumonia. They may receive antibiotics in the emergency room

and appear clinically stable, but for some individuals the care in the next few hours may determine their long-term recovery. These scenarios are true of many urgent situations. The AAMC is concerned about the type and amount of stress that would be levied on a patient who has just been stabilized and is now being told that they are out-of-network and must be moved.

### **Resolving Out-Of-Network Payment Disputes**

The AAMC appreciates that in Section 103 the Committee has sought feedback on several options to resolve out-of-network payment disputes. We believe that the Committee should select a resolution process that is both fair and preserves the right of providers and hospitals to negotiate with insurers. We also oppose any proposal to set statutory benchmark payments. To that end, we urge the Committee to reject Options 1 and 3.

We are concerned about Option 1 which has been referred to as “network matching.” We believe this proposal imposes on the right of physicians to contract with health plans of their choosing and stands to put hospitals in the middle of these complex negotiations.

Option 3 would set a benchmark payment in statute to resolve billing disputes. The AAMC opposes statutory rate setting and urges the committee to reject this proposal. Statutory rate setting will disincentivize insurers to negotiate with providers, and instead allow them to use statutory benchmarks to negotiate rates with providers. Not only does this undermine the fundamental practice of private negotiation, but it will lead to narrow networks – which oftentimes limit patient access to needed health care services and providers – as health plans will lose incentive to offer competitive rates and fair business practices to encourage providers to enter into contracts.

The AAMC is specifically concerned that statutory rate setting stands to potentially limit beneficiary access to academic medical centers due to the perceived higher costs of care at our facilities. Major teaching hospitals and medical schools are a critical component of the US health care system because their joint missions of patient care, medical research, and education benefit the health care of all. While only 5% of all hospitals, AAMC’s member major teaching hospitals account nationwide for 24% of Medicare inpatient days, 25% of all Medicaid inpatient days, 31% of all hospital charity care costs, 21% of all psychiatric beds, 61% of all pediatric intensive care beds, 71% of all Level 1 trauma centers, and 96% of all NCI registered cancer treatment centers. We believe it is important that as many patients as possible have access to teaching hospitals and the critical services they provide.

Therefore, the AAMC strongly urges the Committee to reject this option, as it would destabilize academic medicine and workforce training by allowing insurers to use benchmark payments as leverage to pay academic medical centers less, or to justify cutting them out of networks completely. The Committee should preserve the process of rate negotiation between providers and insurers.

Option 2 would allow billing disputes to be resolved through Independent Dispute Resolution (IDR). Given the success of state laws, particularly in New York, we believe that this may be the most expeditious and fair way to resolve billing disputes, particularly for physicians. The AAMC, however, also urges the Committee to ensure that any entity certified to complete IDR be informed enough to understand the complexities of the health care system. This entity must ensure that decisions made are fair to both parties, and that the entity has appropriate criteria to make decisions that are standardized and uniform.

### **Reducing the Prices of Prescription Drugs**

The AAMC appreciates the Committee's commitment to addressing high drug prices in its discussion draft to reduce health care costs. Ever-increasing prescription drug costs are one of the biggest problems in health care today, and we encourage the Committee to seize this opportunity to lower drug prices and improve patient access to critical medications. The proposals included in this draft are a positive first step to increase competition. Though we commend these efforts, we are concerned that they may not result in lower drug costs for patients. We encourage the Committee to address this issue directly and consider additional reforms that will put downward pressure on drug prices to help Americans afford their lifesaving medications.

To that end, the AAMC participates as a member of The Campaign for Sustainable Rx Pricing (CSRxP) which has submitted detailed comments and suggestions on these drug pricing provisions. We urge the Committee to seriously consider these recommendations, particularly the Fair Accountability and Innovation Research (FAIR) Act.

### **Improving Transparency in Health Care**

The AAMC appreciates the need for patients to have more price transparency regarding their financial responsibility. Indeed, several of our nation's teaching hospitals have already risen to this call and have worked to develop price transparency tools at their institutions, which allow patients to access their coverage and cost-sharing information as it applies to the services they are seeking at hospitals. However, the AAMC cautions the Committee that any provisions relating to patient price transparency should be explicitly tied to strict privacy considerations. In an era where health care information is a sought-after commodity, it is critical that any data collected for study or distribution be appropriately safe guarded.

The AAMC is pleased that the discussion draft recognizes the role of health plans in maintaining current and accurate information on provider networks under Section 304. However, this provision appears to shift the responsibility for improving the accuracy of provider directories from insurers to hospitals, despite the fact that health plans are the entity that are primarily responsible for maintaining these directories. The AAMC feels that holding providers responsible for the accuracy of this data is misplaced.

Section 305 would require providers to bill a patient for services within 30 days after the service, or the patient would not have to pay. Our AAMC-member teaching hospitals take great efforts to ensure timely bills, but this policy is unrealistic and loses sight of the responsibility of insurers to the timeliness of billing. Often, insurers have at least 30 days to process a claim. After the claim is processed, the provider would then be able to determine the patient's cost-sharing obligation, which would typically occur more than 30 days after the date of services.

Additionally, if there is a more complicated coverage issue that requires appeals or continuous communication with the insurer about the coverage, it becomes impossible for the provider to meet the 30-day requirement. The AAMC recommends that a good faith attempt to submit the bills in as timely a manner as possible should suffice as compliance with the policy.

The AAMC also is concerned with Section 309, which would require providers to furnish to patients expected cost-sharing for services at the time of scheduling a health care service or within 48 hours of enrollee requesting cost-sharing information. Further, it allows plans to avoid contracting with providers that do not agree to this provision, and requires insurers to provide "good faith estimate" of enrollee's cost-sharing obligation within 48 hours of request.

As we have previously stated, we believe that patients' health plans are the appropriate entities to furnish patient-specific cost-sharing information, not the provider. Providers will most likely not have access to plan-specific requirements nor up-to-date cost-sharing amounts specific to each patient, but insurers do, and are therefore in the best position to provide this information to their members. The AAMC is concerned that the language, as written, seems to require hospitals and providers to comply with a stricter standard for providing the patient with the estimate of cost-sharing as compared with the requirements for the health plan (hospitals must provide "expected" and insurers provide "good faith"). Therefore, the AAMC suggests that the provider estimate also be considered a "good faith" estimate based on the information the provider has available, with the understanding that that patients should check with their plans for a more accurate cost-sharing obligations. Additionally, requiring this information to be made available within 48 hours is overly burdensome.

Sections 301 and 302 include a number of requirements that would affect provider health plan contract requirements. We share the concerns of the American Hospital Association (AHA) about the impact this would have on health care delivery arrangements.

### **Improving Public Health**

The AAMC is pleased to see that the Committee has included Title IV, which proposes a number of critical public health programs. AAMC-member institutions are at the forefront of addressing social determinants of health in the health care system, and we share your goal of improving population health through targeted programming and investments.

The AAMC greatly appreciates the Committee's recognition of the need to build capacity and extend specialty health care services through technology under Section 404. As a leader in this

space, the AAMC launched Project CORE: Coordinating Optimal Referral Experiences in 2014 to help academic medical centers (AMCs) improve the referral experience for both clinicians and patients. Through Project CORE, the AAMC has partnered with 27 AMCs to successfully implement eConsults and enhanced referrals, tools built into the electronic medical record. Through this innovative model, CORE AMCs are improving efficiency and effectiveness at the interface between primary care and specialty care, thereby improving quality of care and access in a patient-centered way.

The AAMC strongly supports continued investment in, and development of, eConsult tools such as Project CORE.

We also support Section 405 which focuses on public health data system modernizations. The AAMC suggests including language about “data granularity” so that these systems are able to capture information at levels more useful than five- or nine-digit zip codes. This will help facilitate public health planning and intervention development. Additionally, it would also benefit better social and community risk adjustment for quality metrics on the health care side.

The AAMC is pleased to see that in Section 407 the Committee has provided an authorization of appropriations for a grant program that will establish training programs to reduce and prevent discrimination in the provision of health care services related to prenatal care, labor care, birthing, and postpartum care. While the ability of any single educational intervention on its own to overcome pervasive societal and systemic challenges is limited, we believe that support for this training would represent an important step in raising awareness among health professionals of conscious and unconscious discrimination in health care delivery, particularly if educators are permitted to use grant awards to support educational research on other potentially effective strategies as well.

The AAMC suggests that Section 408 would benefit by explicitly dedicating funds in the contract for “longitudinal evaluation” of these training efforts, as opposed to simply identifying the “best practices” in the absence of robust evaluation.

Finally, the AAMC applauds the Committee for highlighting health disparities related to maternal health under Section 410. We suggest adding similar language on health disparities in Sections 403, 404, 406, and 409. A key to addressing disparities is to ensure that they are considered and addressed at every step.

### **Improving the Exchange of Health Information**

The AAMC appreciates that Section 501 proposes that commercial payers be brought under similar interoperability rules that the Centers for Medicare and Medicaid Services proposed for Medicaid, Medicare Advantage, and plans sold on the exchanges. However, the AAMC continues to be concerned about the privacy and security of the information collected once it goes through the application programming interfaces. We propose that there be requirements established regarding the best practices for these apps.

Chairman Alexander and Ranking Member Murray

June 7, 2019

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We appreciate your thoughtful efforts to bring down the costs of health care in a bipartisan way. We recognize that this draft legislation is the culmination of years of hard work and congressional inquiry. We look forward to working with you and the full spectrum of stakeholders to continue strengthening our nation's health. If you have any additional questions, please contact Len Marquez at [lmarquez@aamc.org](mailto:lmarquez@aamc.org) or Ally Perleoni at [aperleoni@aamc.org](mailto:aperleoni@aamc.org).

Sincerely,



Karen Fisher, J.D.  
Chief Public Policy Officer



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,

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