

Statement
of the
American Hospital Association
for the
Committee on Education and Labor
Subcommittee on Health, Employment, Labor and Pensions
of the
U.S. House of Representatives
"Examining Surprise Billing: Protecting Patients from Financial Pain"
April 2, 2019

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) appreciates the opportunity to submit for the record our comments on surprise medical billing.

We believe the last thing a patient should worry about while receiving health care services is an unanticipated medical bill that impacts their out-of-pocket costs and undermines the trust and confidence that patients have in their caregivers. Hospitals and health systems are deeply concerned about the impact of such bills and are committed to finding a solution that first and foremost protects patients.

The AHA Board of Trustees believes addressing surprise medical bills to protect patients is a top priority for our members. Following are the AHA board-approved principles.

GUIDING PRINCIPLES

America's hospitals and health systems are committed to protecting patients from surprise bills and support a federal legislative solution to do so.



Surprise billing typically occurs when a patient receives an unexpected bill for care they thought was covered by their health plan, or when they receive a bill for out-of-network emergency services. Some forms of coverage, including Medicare and Medicaid, have strong patient protections against surprise billing. However, other types of coverage, most notably self-funded, employer-sponsored plans regulated through the Employee Retirement Income Security Act of 1974 (ERISA), do not contain the same protections. While many state governments have attempted to address this issue, only a few have passed comprehensive protections, and states have limited regulatory oversight of ERISA plans.

The three most typical scenarios for when a patient receives an unexpected bill occur when: (1) a patient accesses emergency services outside of their insurance network, including from providers while they are away from home; (2) a patient has acted in good faith to obtain care within their network but unintentionally 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. In all of these situations, we believe it is critical to protect patients from surprise bills.

We have developed the following principles to help inform the debate regarding surprise medical billing in the scenarios outlined above. In the event a patient chooses to go out-of-network for non-emergency care, these principles should not apply. In February of this year, the AHA and five other national hospital associations sent a joint letter to Congress outlining our position using these principles as a guide (see attachment 1).

PROTECT THE PATIENT. Any public policy solution should protect patients and remove them from payment negotiations between insurers and providers.

Patients, regardless of the type of health care coverage they have, should be protected from gaps in insurance coverage that result in surprise bills. Patients should have certainty regarding their cost-sharing obligations, which should be based on an in-network amount. Patients should not be “balance billed” in the situations described above, meaning they should not receive a bill from the provider beyond their cost-sharing obligations. Patients should not have to bear the burden of serving as an intermediary between health plans and providers, rather health plans should be responsible for paying providers directly.

ENSURE PATIENTS HAVE ACCESS TO EMERGENCY CARE. Any public policy solution should ensure that patients have 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 claimed was not an emergency. Recent actions by some health plans to deny coverage of emergency services puts patients’ physical, mental and financial health at risk.

PRESERVE THE ROLE OF PRIVATE NEGOTIATION. Any public policy solution should ensure providers are able to continue to negotiate appropriate payment rates with health plans.

The government should not establish a fixed payment amount for out-of-network services. Health plans and providers take into account a number of factors when negotiating rates. Any rate or methodology sufficiently simple for national use would not be able to capture these factors. In addition, a fixed payment rate could undermine patients' ability to access in-network clinicians by giving health plans less of an incentive to enlist physicians and facilities to join their networks because they can rely on a default out-of-network payment rate. Providers and health plans should be able to develop networks that meet consumers' needs, and not be compelled to enter into contracts that could thwart the development of more affordable coverage options that support coordinated care.

EDUCATE PATIENTS. Any public policy solution should 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 their health coverage and the health care system.

ENSURE ADEQUATE PROVIDER NETWORKS AND GREATER HEALTH PLAN TRANSPARENCY. Any public policy solution should include greater oversight of health plan provider networks and the role health plans play in helping patients access in-network care.

Patients should have access to easily understandable provider network information to ensure they can make informed health care decisions, including accurate listings for hospital-based physicians in health plan directories and websites. Patients also should have adequate access to in-network providers, including hospital-based specialists at in-network facilities, rather than simply a minimum number of physicians and hospitals. Federal and state regulators should ensure both the adequacy of health plan provider networks and the accuracy of provider directories. Health plans should be responsible for an efficient and timely credentialing process to minimize the amount of time a physician is "out-of-network."

SUPPORT STATE LAWS THAT WORK. Any public policy solution should take into account the interaction between federal and state laws.

Many states have undertaken efforts to protect patients from surprise billing, but federal action is necessary to protect patients in self-insured employer-sponsored plans regulated under the Employee Retirement Income Security Act, which cover the majority of privately insured individuals. Any federal solution should provide a default to state laws that meet the federal minimum for consumer protections.

ADDRESSING OTHER ISSUES

Notice and Disclosure. Many stakeholders see a role for hospitals in notifying patients of the potential for out-of-network care in non-emergency settings, and most hospitals have some form of notice-and-disclosure protocols in place. Some existing notice requirements at the state level include that hospitals:

- notify patients that they may be provided care from physicians not in the patient's network;
- post the health plans they participate in, as well as their contracted physician groups;
- inform patients before scheduling non-emergency services as to network status of care providers; and
- provide patients with the medical codes and estimated fees for any potential out-of-network care.

While we believe that providing the patient such network status information is important, it is not in and of itself a solution to surprise medical bills. The nature of emergencies, and the legal requirements regarding how and when coverage may be discussed, make providing notice in some of these instances difficult. Notice may not be particularly effective in other scenarios as well. Additional paperwork can often be confusing for patients, especially in instances where they may not have another timely alternative for care.

Network Adequacy and Patient Education. Today, hospitals work with patients and their insurers to help them navigate the health care system, including scheduling follow-up care with in-network providers. These efforts have grown commensurate with the growth in high-deductible health plans and narrow insurance networks. Patients enrolled in these newer health plan products often lack an understanding of their out-of-pocket obligations before their plan coverage starts, or that their plan's narrow network limits their access to hospitals and providers. Ensuring adequate networks and patient education regarding the health insurance products they purchase is critical to addressing surprise medical bills.

Bundling of Emergency Department Services. Some stakeholders are promoting the use of "bundling" of hospital and physician services as a way to reduce the incidence of surprise medical billing. While full details on the approach are not yet available, the model, as currently explained, would have insurers negotiate and contract with hospitals for a single rate for emergency care. Hospitals, presumably, would then be responsible for negotiating and contracting with physicians for their services. This concept may seem simple and straightforward in theory; in reality, however, this approach would be administratively complex, fundamentally change the relationship between hospitals and their physician partners, and, alone, do nothing to protect patients from surprise bills. We strongly oppose such a model.

The unique nature of emergency care – namely the uncertainty and potential for high variation – makes it a poor candidate for bundled payments. Several variations of bundled payments for episodes of care have been implemented over the past decade with mixed success. Developing such an arrangement involves a complex array of clinicians, statisticians, lawyers and others to define the services and duration of the bundle, to appropriately price it, and to ensure that any financial relationships between the various providers adhere to state and federal law, including the Stark law and Anti-kickback Statute. To date, the greatest success in bundling has been for services for which the clinical care is well defined and little variation is expected, such as for certain planned joint replacements. For the vast majority of these bundles, physicians and hospitals continue to negotiate their own rates with insurers. Any individual visit to an emergency department can involve countless possible services – from initial diagnosis and confirmatory tests to trauma and complicated surgical procedures involving multiple physicians and other providers, depending on an array of factors. Simply put: Bundled payments are not appropriate for emergency care.

Bundled payments alone also do nothing to stop patients from receiving surprise bills and may put patient access to care at risk. In fact, the proponents of this model note that it must be coupled with a state or federal law that specifically bans balance billing. This ban is the solution to surprise bills, and one that we support. Bundling, therefore, appears to meet some other objective, including allowing insurers to transfer to hospitals their responsibility for establishing comprehensive physician networks and managing the associated financial risk. Hospitals are not set up to manage this type of risk, and patient access to care in their communities could be threatened if they are unsuccessful.

Reference Pricing. We urge committee members to reject legislative proposals specifying a national reimbursement rate for out-of-network services. Health plans and hospitals have a longstanding history of resolving out-of-network emergency service claims, and this process should not be disrupted. We are particularly concerned that any attempt at setting a reimbursement standard in law will have significant consequences, including the creation of a disincentive for insurers to maintain adequate provider networks. Growth in the use of no-network, reference-based pricing models in the commercial market suggests this is already a growing strategy, and one that would accelerate if the insurer could simply default to a government-established, out-of-network rate or methodology.

The process of rate negotiation is a core function of managing a health plan. The process takes into account a number of factors that could not be accounted for in a government rate or methodology. For example, health plans and providers often consider their entire lines of business, volume, quality, partnerships on special programs or initiatives, and other factors when setting rates. Any rate or methodology sufficiently simple for national use would not be able to capture the many factors that health plans and providers consider in individual markets, and health plans should not be absolved of the core function of establishing provider networks, including negotiating rates with providers.

Air Ambulances. Some of our hospital and health system members have raised concerns about the increase in surprise billing for air ambulance services and the need for federal engagement on this issue. The Federal Aviation Administration (FAA) regulates air ambulances, and federal law pre-empts states from regulating rates, routes and services of air carriers, which has limited state governments' ability to address air ambulance balance billing issues.

The Government Accountability Office recently released a report on air ambulance surprise bills that found that, between 2010 and 2014, the median prices charged by air ambulance providers for helicopter transports approximately doubled, and the number of air ambulance helicopters grew by more than 10 percent.¹ In addition, the agency found that, in 2017, about two-thirds of air ambulance transports for privately insured patients were out of network, insurers typically paid only a portion of the out-of-network services, and almost all of the consumer complaints involved balance bills of over \$10,000. As required by the FAA Reauthorization Act of 2018, the Secretary of Transportation has formed an advisory committee on air ambulance patient billing. The advisory committee is directed to recommend ways to protect consumers from surprise air ambulance bills. While this issue is not in the jurisdiction of the committee, we would ask you to consider air ambulance service issues while developing legislation solutions related to surprise medical billing.

CONCLUSION

We thank you for the opportunity to share the hospital and health system field's principles and concerns as they relate to surprise billing. We appreciate that this issue is a priority for Congress, as it is for our field and our patients. We have outlined a solution to the issue of surprise billing, and urge Congress to enact legislation.

¹ GAO-19-292 Air ambulance www.gao.gov/assets/700/697683.pdf



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