

**Testimony  
of the  
American Hospital Association  
for the  
Committee on Ways and Means  
Subcommittee on Health  
of the  
U.S. House of Representatives  
“Hearing on Protecting Patients from Surprise Medical Bills”  
May 21, 2019**

I am Tom Nickels, executive vice president of the American Hospital Association (AHA). On behalf of our nearly 5,000 member hospitals and health systems, along with our clinician partners, I appreciate the opportunity to testify.

Hospitals and health systems are deeply concerned about the effect of unanticipated medical bills on our patients, which could impact their out-of-pocket costs and undermine their trust and confidence in their caregivers. Protecting patients from surprise medical bills is a top priority for the AHA Board of Trustees and all of our members. To that end, we have adopted a set of guiding principles to use as we evaluate legislative proposals.

### **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 some 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; (2) a patient has acted in good faith to obtain care within their network but unintentionally receives care from an out-of-network clinician providing services in an in-network hospital; or (3) a health plan denies coverage for emergency services saying they were unnecessary, including in-network emergency services. **In all of these situations, we believe it is critical to protect patients from surprise bills.**

We have developed the following principles 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 do not apply. In February, 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 from their health plan 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 ERISA, which covers the majority of privately insured individuals. Any federal solution should include flexibility for state laws that meet the federal minimum for consumer protections.

## **OTHER ISSUES RELATED TO SURPRISE BILLING**

**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, as referenced above, 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 already is 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. In addition, providers consider other elements besides reimbursement when negotiating contracts, such as a health plan's history with respect to prior authorization and payment delays and denials, as well as other administrative burdens imposed by a particular plan. Setting a rate or methodology sufficiently simple for national use, even if geographically adjusted, would not be able to capture the many factors that specific health plans and specific providers consider. In addition, it would remove incentives for health plans to maintain comprehensive networks and follow fair business practices as a way of encouraging providers to enter into contracts. Health plans should not be absolved of the core function of establishing provider networks, including negotiating rates with providers.

**Arbitration.** While the AHA believes that hospitals and payers generally should be left to negotiate reimbursement for out-of-network claims without government interference, there may be a role for an alternative dispute resolution process for physician claims. A number of states have passed laws to establish a dispute resolution process to mediate out-of-network claims primarily between physicians and health insurers. Prominent among these processes is baseball arbitration. In this binding arbitration model, each party must submit a proposed best and final offer to the arbitrator and the other party with the opportunity to submit a written explanation. The arbitrator must choose one of the two final offers, without modification, from those submitted. The “baseball-style” arbitration has some clear advantages in that it limits an arbitrator's discretion and also frequently provides an incentive to the disputing parties to offer reasonable proposals to the arbitrator. It also typically expedites resolution of the dispute and significantly reduces costs as compared to traditional arbitration or litigation. Several states have established “baseball-style” arbitration to resolve out of network balancing billing claims. New York is one such state that frequently is referenced as having a successful process. One study noted that the New York law reduced out-of-network billing by 34 percent.<sup>1</sup> A more recent study noted that, “as of October 2018, IDR [New York's independent dispute resolution entity] decisions have been roughly evenly split between providers and payers, with 618 disputes decided in favor of the health plan and 561 decided in favor of the provider... Additionally, insurers and physicians appear to be making ‘a real concerted effort’ to work out their payment disputes before filing with IDR.” The study also noted that while it may be too soon to know if the arbitration process leads to higher out-of-network prices, there had not yet been an inflationary impact on insurers' annual premium rates.<sup>2</sup>

Other approaches to alternative dispute resolution processes can be found in the National Association of Insurance Commissioners' (NAIC) 2015 Model Act on provider

---

<sup>1</sup> Surprise! Out-of-Network Billing for Emergency Care in the United States; Zack Cooper, Fiona Scott Morton, and Nathan Shekita; NBER Working Paper No. 23623 July 2017, Revised January 2018

<sup>2</sup> New York's 2014 Law to Protect Consumers from Surprise Out-of-Network Bills Mostly Working as Intended: Results of a Case Study; Corlette, S. and Hoppe, O.; Georgetown University Health Policy Institute – Center on Health Insurance Reforms; May 2019  
<https://georgetown.app.box.com/s/6onkj1jaiy3f1618iy7i0gpzdoew2zu9>

network adequacy standards. In that model act, NAIC addressed consumer protections for patients regarding surprise medical bills. The model legislation would require health plans to establish payment programs for out-of-network physicians and require plans to adopt a structured mediation process to resolve any remaining payment disputes with out-of-network providers.<sup>3</sup> The NAIC approach would help limit a patient's financial exposure to in-network cost-sharing and require balance bills of \$500 or more above in-network cost sharing to be forwarded to the health insurer for resolution via the mediation process. It is important to note that state level solutions, such as New York or NAIC, do not resolve surprise bills experiences by patients covered by ERISA plans.

For arbitration to work within the context of a federal solution to surprise medical billing, it would need to be designed effectively and accommodate existing state programs.

The key design elements should:

1. Provide for an efficient process, such as “baseball-style” arbitration.
2. Place the responsibility to initiate the request for arbitration with the provider or health insurer, not the patient.
3. Allow state government appointment of the arbitrator to ensure better understanding of local markets.
4. Split the cost of arbitration between the two parties in dispute.
5. Establish fixed timelines to ensure expeditious handling of the process.
6. Follow established procedures for documentation and claims recommended by the American Arbitration Association to include processes to reduce costs, such as allowing batching of similar claims.
7. Require that the arbitrators' decisions are confidential.
8. Apply arbitration to self-insured ERISA plans.

**Bundling of Services.** Some stakeholders are promoting the use of “bundling” of hospital and clinician services as a way to reduce the incidence of surprise medical bills. While full details are not yet available, we are aware of two possible approaches. The first relates specifically to emergency care and would have insurers negotiate and contract with hospitals for a single rate for all of the services provided during an emergency. Hospitals then would be responsible for negotiating and contracting with clinicians for their services. The second approach relates to services provided in hospitals by out-of-network ancillary providers during scheduled care. Similarly, these ancillary providers would not be able to bill a patient separately. Rather, the hospital would be required to negotiate with the insurer and submit a “single bill.” The hospital then would be responsible for compensating the provider.

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

---

<sup>3</sup>National Associations of Insurance Commissioners, Network Adequacy Update, July 2016. accessed at: [www.naic.org/cjpr\\_topics/topic\\_network\\_adequacy.htm](http://www.naic.org/cjpr_topics/topic_network_adequacy.htm)

from surprise bills. We strongly oppose such a model and have communicated our concerns to Congress (see attachment 2).

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, clinicians 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.

Similarly, a patient's need for ancillary services during a given procedure can be highly variable. In addition, it would be highly likely that some of the ancillary providers practicing at a hospital would be in-network while others would not. This approach suggests that hospitals and health plans would need to negotiate multiple rates for the same service with different combinations of out-of-network ancillary providers. This process would add significant administrative burden and cost to the system and could result in delays in patient billing.

Despite all of this added complexity and cost, the act of “bundling” all bills into a single bill alone does nothing to stop patients from receiving surprise bills. In fact, the proponents of bundling bills note that in order to stop out-of-network providers from billing outside of the single bill, policymakers also must specifically ban balance billing. In other words: the ban is the solution to surprise bills, and one that we support. Bundling is not the solution and, therefore, appears to meet some other objective – 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.

**Providing an Estimate of a Patient's Out-of-Pocket Costs for Services.** Some legislative proposals would require hospitals and other providers to give patients an estimate of their out-of-pocket cost obligations at the time of scheduling care. While many hospitals and health systems are working toward being able to provide this information prior to care, there are a number of reasons why they may not be able to provide an estimate at the time of scheduling. Generating an out-of-pocket cost estimate requires that a provider communicate with a patient's insurance provider to obtain the individual's cost sharing responsibilities, including where he or she is with

respect to reaching annual deductible or out-of-pocket maximums defined by the insurance product. While these processes increasingly are helped by automated technologies, they still require significant engagement among hospital, health system and health plan staff to ensure accuracy. We encourage Congress to allow providers and health plans to continue their development of consumer-focused price transparency tools without inserting a potentially unworkable component to a surprise billing solution.

**Notice and Disclosure.** Some proposed solutions have incorporated a role for patient notification of the potential for out-of-network care in non-emergency settings. While we believe that providing the patient with information on network status is important, it is not in and of itself a solution to surprise medical bills. Indeed, today, most hospitals have some form of notice-and-disclosure protocols in place, and a number of states have specific notice requirements. However, these have demonstrated limitations. 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 non-emergency scenarios as well. Additional paperwork often can be confusing for patients, especially in instances where they may not have another timely alternative for care. We therefore encourage Congress to focus on fully protecting patients by prohibiting surprise bills rather than relying on notice as part of the solution.

**Network Adequacy and Patient Education.** Hospitals and health systems work with patients 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, which demand greater patient awareness of the limitations of their coverage. Patients enrolled in these types of health plan products often lack an understanding of their out-of-pocket obligations before their coverage starts, or that their plan's narrow network limits their access to hospitals and providers.

Ensuring adequate networks and patient education about the health insurance products they purchase is critical to addressing surprise medical bills. We encourage Congress to avoid any solution that could further erode the comprehensiveness of networks. For example, if Congress adopts a rate-setting methodology that enables insurers to pay providers below what they would pay as a result of negotiations with providers, insurers will be incentivized to default to building networks that meet the bare minimum standards for network adequacy, relying on the out-of-network rate for as many claims as possible. This means that patients will have access to even fewer in-network providers when they are looking to schedule care.

**Air Ambulance.** 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 preempts states from regulating rates, routes and services of air carriers. This 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 doubled, and the number of air ambulance helicopters grew by more than 10 percent.<sup>4</sup> 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 greater than \$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 encourage Congress to address 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 the Committee on Ways and Means, as it is for our field and our patients. We urge Congress to enact a legislative solution.

---

<sup>4</sup> GAO-19-292 Air ambulance [www.gao.gov/assets/700/697683.pdf](http://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



April 2, 2019

The Honorable Richard Neal  
 Chairman  
 Committee on Ways and Means  
 United States House of Representatives  
 1102 Longworth House Office Building  
 Washington, DC 20515

The Honorable Kevin Brady  
 Ranking Member  
 Committee on Ways and Means  
 United States House of Representatives  
 1139 Longworth House Office Building  
 Washington, DC 20515

Dear Chairman Neal and Ranking Member Brady:

America's physicians, hospitals and health systems are fully committed to protecting patients from surprise medical bills. No patient should have the added stress and financial burden of receiving a bill for out-of-network emergency care that they could not avoid or out-of-network care that they reasonably could have expected to be in-network. Our organizations support a federal legislative solution to protect patients in these scenarios that limits patients' cost-sharing obligations to the in-network amount, and prohibits balance billing when the opportunity for health plans and providers to arrive at a fair payment rate is ensured.

The simplicity of the solution outlined above is in stark contrast to the complexity of another, untested idea that has been raised as part of the important dialogue about solving this issue: hospital bundled billing. 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, does nothing to protect patients from surprise bills. We strongly oppose such a model.

Bundled billing is not appropriate for many types of medical services. For example, the unique nature of emergency care – namely uncertainty and the 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 the Anti-Kickback Statute. To-date, bundling has been tested by the Center for Medicare & Medicaid Innovation and some commercial payers in limited circumstances and, in general, early results indicate it could work for services for which the clinical care pathway is well defined and little variation is expected, such as for certain planned joint replacements. Even so, 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 complicated trauma and surgical procedures involving multiple physicians and other providers, depending on an array of factors. Simply put: bundled payments are not appropriate for emergency care and have not been sufficiently tested for widespread adoption for other types of care.

Surprise bills are a direct result of a lack of negotiated contract between the patient's insurer and the hospital and/or physicians that provided their care. We support solutions that focus on arriving at a fair

payment from an insurer to a provider while protecting patients from the consequences that can arise when an insurer lacks adequate contracted providers. In contrast, bundling facility and physician payments in these situations simply allows insurers to transfer to hospitals their responsibility for establishing comprehensive physician networks and managing the associated financial risk.

We should remain focused on taking patients out of the middle of standard negotiations between insurers and providers and protecting them from “surprise bills” when they have not had the opportunity to choose who provides their care, while rejecting unproven proposals that would up-end the foundation of relationships that hold the health care system together.

Sincerely,

American Hospital Association  
American Medical Association  
Federation of American Hospitals