

**Testimony
of the
American Hospital Association
for the
Committee on Energy and Commerce
Subcommittee on Health
of the
U.S. House of Representatives
“No More Surprises: Protecting Patients from Surprise Medical Bills.”
June 12, 2019**

Madam Chairwoman, my name is Tom Nickels, I am the 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 today.

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.

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. Therefore, it is imperative for Congress to act on this issue to protect consumers from surprise medical bills in all states and in all forms of health coverage.



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.**

The AHA agrees with the Committee that the patient should both be protected financially, as well as removed from the negotiating process between the health plan and the provider. Specifically, patients' cost-sharing obligations should be limited to the in-network amount. Once the patient is protected, providers and insurers can work together – without engaging the patient – to determine appropriate reimbursement, consistent with standard negotiations. **The AHA asks that the Committee preserve the ability of providers and insurers to negotiate private contracts and not establish a fixed payment amount for out-of-network services.** Arbitrary reimbursement rates could disrupt local market forces in ways that could have significant negative unintended consequences. Chief among them is the disincentive this will create for health plans to maintain adequate networks and act as good business partners to their providers. Without sufficient network adequacy requirements that address specific critical specialties and subspecialties, insurers can simply default to a benchmark payment and decline to contract with many different types of physicians. This dissolution of networks could undermine patients' ability to access care for services not protected through this draft legislation, as well as undermine efforts to enhance care coordination and improve quality through different types of value-based arrangements. Should the Committee continue to pursue some role for the government in determining reimbursement, we encourage you to consider an independent dispute resolution process in place of a benchmark rate. Our response to the Committee's request for input on their draft legislative proposal is included (see Attachment 1), and we address these and other issues below.

ISSUES RELATED TO SURPRISE BILLING

Reference Pricing. The Committee's discussion draft establishes a minimum payment standard for out-of-network emergency care and care provided by out-of-network ancillary providers during otherwise in-network care. The payment standard would be set at the median contracted (in-network) rate for the service in the geographic area in which the service was delivered. States would have the ability to determine their own payment standards for plans they regulate. We urge the Committee to reject specifying a national reimbursement rate or approach 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 negative consequences, including, as referenced above, the creation of a

disincentive for insurers to maintain adequate provider networks. Increases 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 point to a government-sanctioned, 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 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.

The Committee's discussion draft provides \$50 million in grants for states to develop or maintain an all-payer claims database (APCD) that would presumably assist in determining a median contracted (in-network) rate. We appreciate the Committee's efforts to develop APCDs, as we recognize the value of collecting claims for a number of different purposes, such as quality improvement activities. However, we do not believe that the Committee should rely on APCDs for purposes of setting national policy, and instead encourage consideration of funding for studies on the best way to implement these data collection entities and support such efforts at the state level.

Dispute Resolution. While the AHA believes that hospitals and payers 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, such as arbitration.

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-style" 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. Baseball-style arbitration has some clear advantages in that it 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. The simple act of having an arbitration process incentivizes health plans and providers to resolve disputes in advance, including by coming to an agreement on in-network contract terms. In fact, in states with such

processes, a very small percentage of out-of-network claims ever make it to arbitration. 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.¹ 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.” That 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.² In fact, for reasons like this, the National Association of Insurance Commissioners (NAIC) adopted a dispute resolution process as part of their 2015 Model Act on network adequacy.

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 to incentivize parties to resolve disputes before moving to arbitration.
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 to not unduly influence future cases.
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. Specifically, services provided in hospitals by out-of-network ancillary providers would be incorporated into the fee that the hospital negotiates with the health plan. These providers would not be permitted to bill a patient separately. The hospital then would be responsible for compensating the provider.

¹ 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

² 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/6onkj1jaiy3f1618iy7i0qpzdoew2zu9>

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 and ancillary partners, and, alone, do nothing to protect patients from surprise bills. We strongly oppose such a model.

Setting reimbursement for bundles of services 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 and the final bills are reconciled against a target. In other words, even in many bundled payment models, health plans are not paying a single entity, such as the hospital, a single rate for the entire course of care.

Along with 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 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.

In-network Guarantees. One suggested solution to surprise medical billing is to have in-network hospitals guarantee to patients and health plans that every practitioner caring for the patient in the facility is considered in-network. Some health policy experts have described this approach as “network matching,” where the facility-based practitioner would be required to contract with every plan for which the facility has a contract. The AHA opposes this approach because it interferes with the fundamental relationship between hospitals and their physician partners and severely limits providers’ ability to negotiate contract terms with insurers. **In other words, this provision would essentially eliminate any ability of physicians to negotiate fair contract terms with health plans, including, but not limited to, their reimbursement level.**

We believe that 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. In addition, providers should be able to refrain from entering into contracts with health

plans based on other considerations, such as whether the health plan is a fair business partner.

The approach also raises certain antitrust concerns in that it would require that a hospital compel non-employed physicians practicing in its facility to participate in the same health plan networks. It is conceivable that some impacted physicians would threaten or bring suit against the hospital, charging that such compulsion violates federal or state antitrust laws that prohibit restraint of trade in certain circumstances.

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 for all services. First, there is an inherent uncertainty in health care that means that a course of treatment can easily change as a result of how a particular patient responds to a treatment protocol or how their unique disease or injury progresses. For many services, it simply is not realistic – and could be misleading – to give patients assurances of how their care will proceed and the associated cost. Any transparency requirement should take into account the “shoppability” of a given service or course of treatment. In addition, generating an out-of-pocket cost estimate requires that a provider communicate with a patient’s insurer 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 as part of a surprise billing solution.

Notice and Disclosure. The Committee’s discussion draft requires providers, at the time of scheduling, to give patients both oral and written notice about the provider’s network status and any potential charges they could be liable for if treated by an out-of-network provider. 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 difficult in some of these instances. 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 the Committee to focus on fully protecting patients by prohibiting surprise bills rather than relying on

notice as part of the solution. Should the Committee move forward with legislative language requiring notice and disclosure, we would ask that you include physicians and insurance plans in any requirements, as they too have a role to play in keeping patients informed of network status and anticipated costs.

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 the Committee to avoid any solution that could further erode the comprehensiveness of networks. For example, if Congress were to adopt 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.³ 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 the Congress to address air ambulance service issues while developing legislation solutions related to surprise medical billing. More specifically, we ask that the Congress extend similar consumer protections from out-of-

³ GAO-19-292 Air ambulance www.gao.gov/assets/700/697683.pdf

network billing to air ambulance services and include air ambulance services in network adequacy requirements.

CONCLUSION

We thank you for the opportunity to share the hospital and health system field's suggestions and concerns as they relate to surprise medical billing. We appreciate that this issue is a priority for the Committee on Energy and Commerce, as it is for our patients and members. We urge Congress to enact a legislative solution that protects patients from surprise billing without having unintended negative consequences on the health care system.

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 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 respond to your request for information related to the development of the No Surprises Act to protect patients from surprise medical bills. The AHA appreciates your leadership to shield patients from the financial burden of unexpected medical expenses.

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 and our members. To that end, we have adopted the attached set of guiding principles to use as we evaluate legislative proposals, such as the one put forward by the Energy and Commerce Committee. We support a federal-level solution to protect all patients, including individuals who receive health care coverage through Employee Retirement Income Security Act of 1974 (ERISA) plans and for those who live in states that have not yet enacted comprehensive legislation to address surprise medical bills.

The AHA shares the Committee’s objective of protecting patients from balance billing in certain circumstances by out-of-network providers and limiting patient cost-sharing to the in-network amount. These patient protections would apply to all emergency services or in cases where a patient cannot reasonably choose their provider. **However, we are concerned with the Committee’s draft legislation’s approach to determining reimbursement for out-of-network providers. The AHA believes that once the patient is protected from surprise bills, providers and insurers should then be permitted to negotiate payment rates for services provided. We strongly oppose approaches that would impose arbitrary rates on**



providers. It is the insurers' responsibility to maintain comprehensive provider networks, and a default payment rate would remove incentives for plans to contract with providers.

Our specific comments to the discussion draft are as follows.

PROHIBITING SURPRISE MEDICAL BILLS

We interpret the discussion draft to prohibit balance billing by out-of-network providers for all emergency services, as well as when the patient is treated in an in-network facility but cannot reasonably choose their provider, a position with which we agree. However, we are concerned with how the bill is drafted in that it amends the Public Health Service Act Section 2719A rather than replaces it or amends it to explicitly prohibit balance billing. We are concerned that without a specific prohibition, the draft legislation would still permit balance billing for emergency services, albeit subject to penalties discussed below. We encourage the Committee to consider adding a specific prohibition.

ENFORCEMENT OF SURPRISE MEDICAL BILLS THROUGH CIVIL MONETARY PENALTIES

The discussion draft uses civil monetary penalties to enforce its prohibition on surprise medical bills. The discussion draft seems to approach the prohibition on surprise medical bills not by directly prohibiting surprise bills but by imposing a penalty if a surprise bill is issued. It also is not clear how a violation would be triggered. Would the patient have to initiate a challenge, thus defeating the purpose of taking the patient out of the middle of provider plan payment disputes? **The AHA believes that once the patient is protected, resolution of the disputed claims should be left to the plans and providers. If a provider continues to balance bill the patient, then a penalty should be applied and civil monetary penalties would be preferable to other approaches, such as using Medicare Conditions of Participation.**

PROVIDER AND PRICE TRANSPARENCY

The discussion draft requires providers, at the time of scheduling, to give patients both oral and written notice about the provider's network status and any potential charges they could be liable for if treated by an out-of-network provider. **The AHA supports increased transparency with regard to both in-network provider status as well as potential costs patients will face. We also believe that providing the patient with network status information is important, but is not a solution to surprise medical bills.** The best way to protect patients is by simply banning balance billing in specific circumstances. Further, the nature of emergencies and the legal requirements regarding how and when coverage may be discussed can make providing notice in some of these instances difficult. Even when scheduling care, patients can be overwhelmed. We do not think relying on notice should be part of a solution to surprise bills.

ESTABLISH MINIMUM PAYMENT STANDARD

The discussion draft establishes a minimum payment standard for out-of-network emergency care and care provided by out-of-network ancillary providers during otherwise in-network care. The payment standard would be set at the median contracted (in-network) rate for the service in the geographic area the service was delivered. States would have the ability to determine their own payment standards for plans they regulate.

The AHA opposes setting a rate in statute, given the risk this creates for setting rates too low and compromising patient access to care. Rate setting would be nearly impossible to get right and ignores the many factors that providers and health plans consider when deciding whether or not to enter into a contract. Factors that may be relevant to one provider may not be relevant to another provider, which means that the median contracted in-network rate may not be the appropriate payment level. Considerations include a provider's size or mix of services, such as whether a provider is the only hospital or health system in a community offering advanced trauma services, and whether a provider and payer have negotiated to enter into a value-based contracting arrangement. Providers also consider whether an insurer is a good business partner when determining when to contract. For example, does the insurer have a history of delaying prior authorization decisions or denying claims inappropriately? We should maintain the incentives on insurers to not only pay fairly but also to engage in good business practices. Rate setting, creates a disincentive for insurers, as it removes the need for health plans to form comprehensive networks and to contract and negotiate with providers.

The discussion draft also suggests a reliance on all-payer claims databases to determine the median contracted rate. We have concerns about the viability and burden associated with all 50 states establishing all-payer claims databases in a reasonable timeframe. Our recommended approach, protecting patients and then leaving providers and insurers to determine reimbursement, can be implemented immediately.

As an alternative to rate setting, there may be a role for an alternative dispute resolution process, such as arbitration or mediation in any instance of disagreement between providers and payers. We encourage the Committee to consider a "baseball-style" arbitration model in which each party must submit a proposed final offer, with the arbiter to determine the appropriate payment level. The process still would allow providers and plans to negotiate and simply would be a backstop for any claims that result in a dispute. We expect, as is the experience of states with such models today, that an arbitration backstop would create an incentive for plans and providers to come to an agreement before such a process is triggered. If arbitration is needed, the baseball-style format allows for the most expedited process at a cost that is lower than traditional arbitration or litigation.

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:

- Provide for an efficient process, such as “baseball-style” arbitration.
- Place the responsibility to initiate the request for arbitration with the provider or health insurer, not the patient.
- Allow state government appointment of the arbitrator to ensure better understanding of local markets.
- Split the cost of arbitration between the two parties in dispute.
- Establish fixed timelines to ensure expeditious handling of the process.
- 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.
- Require that the arbitrators’ decisions are confidential.
- Apply arbitration to self-insured ERISA plans.

ALL-PAYER CLAIMS DATABASES

The discussion draft provides \$50 million in grants for states to develop or maintain an all-payer claims database that would assist in determining a median contracted (in-network) rate. The AHA supports price transparency innovations, such as all-payer claims databases. We recognize the value of collecting claims for a number of different purposes, such as quality improvement activities. We caution the Committee against considering all-payer claims databases as a comprehensive solution to price transparency. Specifically, adoption of these databases to-date is uneven, and it has been challenging to determine the correct data to collect, to secure all of the data from all payers in a state and then determine how to use the data. For example, only 18 states have set up these systems, and many have struggled with data completeness and accuracy.

There also are issues of privacy and security and questions regarding who receives access to the data and for what purposes. At this stage, we do not believe that the Committee should rely on all-payer claims databases for purposes of setting national policy. We instead encourage consideration of funding for studies on the best way to implement these data collection entities and support such efforts at the state level.

INCREASING TRANSPARENCY AND ENSURING NETWORK ADEQUACY FOR CONSUMERS

We agree with the Committee that consumers should better understand their health plans and which providers are in their network. The growth in high-deductible health plans and narrow insurance networks 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 the Committee to avoid any solution that could further erode the comprehensiveness of networks. As stated earlier, by using 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, thereby 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 trying to schedule care.

We also encourage the Committee to strengthen existing network adequacy rules to address some of the issues of health plan participation by hospital-based specialists who practice in hospitals. This oversight would require action by the states and Congress to implement specific requirements for ERISA plans. Network adequacy will not improve without substantial oversight by both state and federal regulators.

PROTECTING CONSUMERS FROM SURPRISE BILLS FROM AIR AMBULANCES

Our hospital and health system members have raised concerns about the increase in surprise billing from air ambulance services and the need for federal engagement on this issue. Given that the Federal Aviation Administration regulates air ambulances, state governments have limited ability to address these issues. The Government Accountability Office 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.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 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 within the jurisdiction of the Committee, we encourage Congress to address air ambulance service issues while developing legislative solutions related to surprise medical billing.

We look forward to continuing to work with the Committee on solutions to stop surprise medical bills.

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

The Honorable Frank Pallone
The Honorable Greg Walden
May 28, 2019
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Thank you for your consideration of our comments. Please contact me if you have questions or feel free to have a member of your team contact Megan Cundari, senior associate director, at mcundari@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President

Attachment

SURPRISE BILLING PRINCIPLES

America's hospitals and health systems are committed to protecting patients from "surprise bills" and support a federal legislative solution to do so. These types of 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 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 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 billing in the scenarios outlined above. In the event a patient chooses to go out-of-network for care, these principles should not apply.

- **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," 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 determined 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 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.