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Statement for the Record
of the
Association of American Medical Colleges
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

The Association of American Medical Colleges (AAMC) appreciates the opportunity to provide testimony and the perspective of academic medicine for this hearing on protecting patients from surprise medical bills.

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

A surprise medical bill can occur when a patient receives out-of-network emergency care, or when they receive an unexpected bill for care that they thought was covered by their health plan. These surprise bills can deeply financially impact patients, and ultimately undermine academic medicine's core mission of providing outstanding patient care, by introducing an element of uncertainty into the provider-patient relationship.

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

The AAMC shares the Committee's approach that patient cost-sharing for emergency health care services should be based on the in-network amount. We are pleased that the proposal would prohibit balance billing and hold patients harmless by only requiring them to pay the in-network cost-sharing amount for out-of-network emergency care and for care in which the patient could not reasonably choose their provider. However, the AAMC has serious concerns with the Committee's proposal to base the provider's reimbursement on a statutory benchmark rate.

As you know, the AAMC joined several hospital association stakeholders in proposing the attached set of guiding principles addressing surprise medical bills. We have used these principles to evaluate several surprise billing legislative proposals, including that of the "No Surprises Act," which has been proposed by the Energy and Commerce Committee ("the Committee"). Additionally, the AAMC has joined with these hospital groups to urge the Committee to re-evaluate several of the proposals in this draft legislation, particularly in regard to benchmark rate-setting. That letter is also attached to this testimony.

The AAMC provides the following comments on the discussion draft:

Prohibiting balance bills and holding patients harmless

The AAMC is pleased that the discussion draft would take patients out of the middle of surprise medical bill situations; however, we are concerned that the draft legislation does not appear to actually prohibit balance billing, but rather, imposes a penalty on providers who issue a surprise bill. The AAMC urges the Committee to specifically include a prohibition on balance billing in order to provide patients with the most protection.

Increasing transparency though notice and consent

The discussion draft requires that, at the time of scheduling, patients receiving scheduled care be given written and oral notice about the provider's network status and any potential charges they could be liable for if treated by an out-of-network provider. Though we support transparency, we believe the patient's health plan is the primary and best source of this information, and they are best positioned to discuss confidential, plan-specific information with the patient, including their cost-sharing. Detailing and communicating a patient's coverage should remain the primary responsibility of the insurer.

With regard to emergency situations, imposing an additional notice requirement on hospitals, and teaching hospitals in particular, would be overly burdensome and also could be detrimental to patients. Major teaching hospitals are common sites for emergency treatment due to their "stand-by capacity" and 24/7 readiness – trauma centers, burn units, psychiatric services, and more. We believe that the notice requirements in the discussion draft could slow emergency care and run counter to the expediency required in emergency situations. Additionally, in an emergency situation, a patient's primary concern should not be with the network status of their providers, but rather, with receiving the treatment that they need.

Resolving billing disputes

The AAMC opposes statutory rate setting and urges the committee to reconsider this proposal. Statutory rate setting will disincentivize insurers to negotiate with providers, and instead allow them to leverage statutory benchmarks to gradually negotiate lower overall rates with providers. Not only does this undermine the fundamental practice of private negotiation, but it will lead to narrow networks – which oftentimes limit patient access to needed health care services and providers – as health plans will lose the incentive to offer competitive rates and fair business practices to encourage providers to enter into contracts.

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

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

The AAMC suggests that the Committee explore other options for resolving disputes between payers and providers. Given the successes of state laws, particularly in New York, the AAMC believes that the Committee should consider an Independent Dispute Resolution (IDR) process. We believe that this may be the most expeditious and fair way to resolve billing disputes, particularly for physicians. The AAMC, however, also urges the Committee to ensure that that any entity certified to complete IDR be informed enough to understand the complexities of the health care system. This entity must ensure that decisions made are fair to both parties, and that the entity has appropriate criteria to make decisions that are standardized and uniform.

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Thank you for considering our comments. We appreciate your thoughtful efforts to end surprise medical bills, and look forward to working with you and the full spectrum of stakeholders to continue strengthening our nation's health. If you have any additional questions, please contact Len Marquez at lmarquez@aamc.org or Ally Perleoni at aperleoni@aamc.org.

May 28, 2019

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

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

Dear Chairman Pallone and Ranking Member Walden:

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

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

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

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

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

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

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

Sincerely,

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

Attachment

February 20, 2019

Dear Congressional and Committee Leadership:

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

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

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

- **Define “surprise bills.”** Surprise bills may occur when a patient receives care from an out-of-network provider or when their health plan fails to pay for covered services. The three most typical scenarios are when: (1) a patient accesses emergency services outside of their insurance network, including from providers while they are away from home; (2) a patient receives care from an out-of-network physician providing services in an in-network hospital; or (3) a health plan denies coverage for emergency services saying they were unnecessary.

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

- **Ensure patient access to emergency care.** Patients should be assured of access to and coverage of emergency care. This requires that health plans adhere to the “prudent layperson standard” and not deny payment for emergency care that, in retrospect, the health plan determined was not an emergency.

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

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

- **Educate patients about their health care coverage.** We urge you to include an educational component to help patients understand the scope of their health care coverage and how to access their benefits. All stakeholders – health plans, employers, providers and others – should undertake efforts to improve patients' health care literacy and support them in navigating the health care system and their coverage.

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

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

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

Sincerely,

American Hospital Association
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