Federation of American Hospitals®

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President and CEO

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The Honorable Frank Pallone, Jr.
Chairman
House Committee on Energy & Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Greg Walden
Ranking Member
House Committee on Energy & Commerce
2322 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pallone and Ranking Member Walden:

Thank you for the opportunity to comment on the "No Surprises Act" discussion draft. On behalf of our member hospitals and health systems, we appreciate the urgent need to protect patients from "surprise bills" and are committed to working with you to find a federal legislative solution.

The Federation of American Hospitals (FAH) is the national representative of over 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay acute, inpatient rehabilitation, long-term acute care, psychiatric and cancer hospitals in urban and rural America, and provide a wide range of acute, post-acute, and ambulatory services.

General Comments

We support a federal legislative solution and believe it should protect the patient financially, ensure patient access to emergency care, remove the patient from health plan/provider payment negotiations, preserve the role of private negotiation, ensure access to comprehensive provider networks, and support state laws that work.

To that end, policy solutions must have patients at their center, and we support the draft's intent to prohibit balance billing and hold the patient to in-network cost-sharing in circumstances where the patient has no reasonable control over the network status of the providers administering care. Additionally, we appreciate that the draft makes further provisions to remove the patient from the health plan/provider payment negotiation by requiring the plan to make the payment directly to the provider. These provisions will provide the protections required to solve this problem for patients.

Unfortunately, as constructed, the discussion draft's provider/health plan payment provisions will upend private payment negotiations between providers and health plans with ramifications far beyond the narrower issue the legislation seeks to cure. By setting a payment ceiling, through a plan driven, non-transparent process, the discussion draft disincentivizes plans to create comprehensive networks – contrary to the preferred outcome, and harmful to patients. The payment ceiling would allow plans to engage in inappropriate "gaming" by refusing to network or removing from networks providers with negotiated rates above the ceiling set by the draft. For example, if a provider has a negotiated rate above the payment ceiling, the plan can save money by refusing to contract with that provider and paying the lower, out-of-network rate. Instead of incenting plans to negotiate network agreements with providers in good faith, the payment ceiling will be used as inappropriate leverage and have outsized influence not only on the small part of the market the legislation intends to address but on in-network payment and contracting across the country. We also anticipate that costs will be shifted onto hospitals as we seek to ensure appropriate staffing of our facilities and meet our obligations to provide emergency medical care as required by the Emergency Medical Treatment & Labor Act (EMTALA).

We strongly oppose any legislation that includes such a set payment given the considerable harm it would impose on our hospitals and patients.

While we believe preserving provider/plan negotiation is the most appropriate process for solving payment disputes, we do believe there are other market-based solutions available to help determine provider/health plan payment in these instances. A number of states have implemented the use of mediation and/or arbitration to settle these payment disputes with great success.[1] We believe that such a dispute resolution process that allows a neutral third party to mediate or determine fair payment is far superior to setting a statutory payment rate and will avoid the negative consequences for patients that setting a rate will likely incur.

Should the Committee move toward an arbitration process, such as those in Florida or New York, at a minimum, such process should include:

- Time limited private payment negotiation (e.g., mediation) between the provider and health plan prior to arbitration;
- Provider-initiated, voluntary arbitration with the losing party incurring the cost of the arbiter; and
- No limitation on what information the arbiter can consider in making the determination.

As demonstrated in the states where it has been implemented, such a system is an efficient means to settle disputes, will not result in increased health care costs, and will likely see diminished use as providers and plans understand the likely outcome of the dispute resolution process and settle disputes on their own.

[1] The recently-passed legislation in Texas is a good example of a hybrid approach – utilizing mediation for hospitals and arbitration for physicians. Florida utilizes provider-initiated, voluntary arbitration for hospitals and physicians, while New York utilizes arbitration for physicians.

Section-by-Section Comments

Section 2 (a)(1) – Median Contracted Rate & Rulemaking

As previously described, we oppose the use of a set payment ceiling in determining provider/plan payment. Beyond our general opposition, we believe the discussion draft sets up a non-transparent, plan-driven payment determination methodology. As drafted, the legislation leaves it to the Secretary to determine the methodology by which the **plan** will calculate the payment rate and the information that must be made available to the provider. Such a system will be ripe for abuse by the plans with no authority for the Secretary to penalize plans for improper payment under the methodology, in striking contrast to the draft's harsh penalties on providers for (even inadvertently) sending balance bills to patients.

Section 2 (a)(1) – Recognized Amount (State Law Precedence)

The FAH appreciates the recognition that many states have acted to protect patients enrolled in state-regulated insurance products from surprise bills and believes that any federal legislative action should not preempt state laws that address payment from state-regulated insurance plans to providers. As currently drafted, it is clear that the federal payment ceiling set forth in the "No Surprises Act" would apply to the out-of-network plan/provider payments in states that have not enacted such legislation. It is unclear, however, which payment amount – federal or state – would apply to federally-regulated plans in states that have enacted legislation impacting state-regulated plans. We suggest clarifying the language to avoid plan/provider confusion.

As noted above, the FAH opposes the use of a set payment ceiling in determining provider/plan payment and would oppose the federal standard being applied in states that have enacted their own legislation to address out-of-network plan/provider payments.

Section 2 (c) – Civil Money Penalties

We are concerned with the imposition of a civil money penalty (CMP) in the case of a provider billing a patient when such a bill was prohibited under the legislation. It is likely that as providers update billing systems to accommodate the legislative changes, there may be an occurrence where a bill is sent in error to a patient. At a minimum, we would suggest a grace period be included in the legislation to allow providers time to implement the system changes required to comply with the legislation and, post that implementation period, prior to penalties being assessed, be provided with the opportunity to correct any bills that are inadvertently sent to patients.

Section 2 (d) – State All Payer Claims Databases

Experience with All Payer Claims Databases (APCD) has been variable depending on participation in the APCD, comprehensiveness of the data included, available uses and security of the data. Given the discussion draft does not link the use of data from the APCD to the policy in the underlying legislation and that the parameters required for funding under the grant program are minimal, we are concerned that funds authorized by the legislation will be used by states to create APCDs of mixed quality.

At a minimum, we would suggest the legislation not only require applying states to detail the measures they will take to ensure uniform data collection and data security but also provide more explicit parameters for those factors and the use of the data. Given current Supreme Court precedent that prevents states from requiring certain plans to provide data to APCDs (*Gobeille v. Liberty Mutual Insurance*), we are skeptical that any state developed APCD will be of sufficient quality to support its use.

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Thank you for the opportunity to comment on the discussion draft and for your consideration of our comments. We look forward to our continued engagement on this issue and finding a solution that protects patients.

Sincerely,