



December 21, 2018

The Honorable Maggie Hassan
330 Hart Senate Office Building
Washington, DC 20510

Dear Senator Hassan:

The National Coalition on Health Care applauds you for your leadership on S. 3592, the No More Surprise Bills Act of 2018. The problem of "surprise" medical bills is real and appears to be growing, with negative financial consequences for patients and the entire health care system.

Patients are Being Harmed Financially

The Patient Protection and Affordable Care Act (PPACA) included historic patient protections to limit patients' financial liabilities for uncovered medical expenses by setting maximum annual and lifetime out-of-pocket limits on essential health benefits. Unfortunately, when patients receive covered benefits from providers who are out-of-network, those providers may balance bill on these services without limit, leaving even the most informed patients potentially exposed to thousands of dollars in uncovered costs. Adding insult to injury, health plans often do not apply out-of-pocket costs incurred for out-of-network services towards annual deductibles and out-of-pocket limits.

The surprise bill problem is arising frequently with hospital emergency department services, where the "prudent layperson" standard was expanded in PPACA to patients covered by individual and group health plans. The prudent layperson standard protects patients who experience a medical emergency from being responsible for cost-sharing in an amount greater than the in-network amount for emergency services, regardless of whether the providers are in-network. However, providers are not prohibited from balance billing if the amount paid to the provider by the plan is less than its billed amount. Some providers are declining to join insurance networks and billing patients at undiscounted charges.

Over the last ten years, the healthcare industry has been undergoing consolidation in virtually every sector. Consolidation has strengthened the economic power of certain providers relative to health plans in particular geographic markets and within particular "service lines", such as emergency department physician services, anesthesia, and other hospital-based specialists.

1111 14TH STREET, NW, SUITE 900, WASHINGTON, DC 20005 | (202) 638-7151 | NCHC.ORG

Table with 5 columns: Role, Name, Title, Organization, and Contact Info. Includes Chairmen (Jack Lewin, John Rother), Board of Directors (Liana Bailey-Crimmins, Blair Childs, Don Crane, Chris Dawe, David Dobbins, Kevin Donnellan, The Honorable David Durenberger, Michael Maccoby, Shawn Martin, Adrienne B. Morrell, Margaret E. O'Kane), and other staff members (Melissa Schulman, Damon Silvers, Christine Simmon, Susan Turney).

For all of the reasons cited above, there is a clear need for federal legislation to protect patients, particularly the millions who are covered by employer-sponsored group plans. These employees and their families play by the rules, enroll in coverage, and pay their premiums yet nevertheless could face crushing, out-of-network “surprise” medical bills.

The National Coalition on Health Care released a comprehensive [report](#) in July 2018 that highlights the causes of a growing health care affordability crisis, and offers strategies to address them. We held summits in major cities around the U.S., and heard from health care purchasers, experts, and consumers as we analyzed cost trends, drivers, and strategies for slowing health care cost growth. Surprise medical bills are a symptom of lack of competition, and can be addressed by changing how health care services are paid for, and by giving patients and purchasers more tools to push back against unjustifiably high charges for services. The dispute mechanism outlined in S. 3592 is such a tool.

Twin Goals: Protect Patients, Prevent Premiums from Climbing Higher

S. 3592 is intended both to protect patients from unexpected and large medical bills, and to incentivize hospitals, hospital-based providers, and health plans to come together to reach more reasonable contractual arrangements. Only legislation that accomplishes both of these goals—protecting patients and increasing the proportion of hospital services delivered “in-network” — will prevent the total cost-of-care and everyone’s premiums from increasing.

The Solution: Pay for Hospital-based Services Under All-Inclusive Fees

The National Coalition on Health Care strongly supports overhauling the payment systems throughout our health care system to pay for value and outcomes instead of paying separately for each service, test, and procedure. For hospitals and hospital-based providers, that means paying one fee, or “bundled payment”, to cover all of the services delivered by the hospital and its employed nurses, technicians and aides, and those delivered by the physicians practicing in the hospital.

Medicare must lead the way on payment reform, as it did 30 years ago when it began paying hospitals for a bundle of inpatient services based on patients’ diagnoses, called “diagnostic related groups”, or DRGs. It is time for Medicare to create bigger bundles that include physician services together with hospital services. When Medicare leads on payment reform, commercial insurers often follow. There are many instances where commercial payers use Medicare’s payment structure to set their own reimbursements, which helps to simplify administrative costs and align incentives across providers and payers. Medicare beneficiaries rarely face balance billing situations, as most hospitals and hospital-based physicians agree to accept Medicare payment and comply with its restrictions on balance billing.

NCHC Comments on Specific Provisions of S. 3592

Making the transition from volume-based payment to value-based payment will take time. In the short-term, we support reforms such as S. 3592 to protect insured patients from crushing medical bills. Below are our comments and questions as you prepare to re-introduce this legislation in the 116th Congress.

Providers and services covered by S. 3592 (Sec. 2729)

The providers and services covered are limited to hospital-based providers and services. While many of the egregious cases arise in hospital-based situations, we are aware that other providers, such as air ambulances and free-standing emergency departments, seem to have business models built around remaining out of insurance networks. We recommend that you add air ambulance and free-standing emergency departments to the list of covered providers.

Notice and consent process

We support the notice and consent process, and acknowledge that it will need to be integrated into the appointment booking and “pre-op” processes. While providers may object that the notice and consent process will interfere with clinical care, we believe it can lead to important and neglected conversations between patients and care teams to inform the patient decision-making process. We recommend that the notice process include web-based written notices posted on the hospital and provider web portals to accompany verbal notices.

Providers who are not participating in health plan networks will likely be unable to estimate the patient’s share of out-of-network services, which could be 100% of gross charges. The most important estimate for the patient would therefore be the total amount of charges if the services are performed out-of-network. The patient could then go to his or her plan and ask what amount, if any, the plan would pay for the plan’s share of out-of-network services. Similarly, the patient could attempt to negotiate directly with the provider to reach a discounted fee.

Compliance

Incorporating the notice and consent process into Medicare conditions of participation may not be sufficient to encourage high rates of compliance. We believe it is equally important for the independent dispute mechanism entity established in your legislation to publish the names of providers who do not comply with the notice and consent process, and publish the names of hospitals with high rates of providers who do not participate in the same insurance networks as the hospital.

Payments Made by Patients in Surprise Billing Situations Included in Cost-sharing Limitations (Sec.3)

This section should clarify if payments made by patients for out-of-network services are also applied to any deductibles as well as cost-sharing limits.

Accountability of health plans

Fixing the growing problem of surprise medical bills is a shared responsibility among providers, hospitals, and health plans. It is unfair to ask patients to navigate the growing complexity of insurance coverage, the frequent movement in and out of networks by providers, and the lack of transparency and availability of reliable cost estimates in advance of receiving medical care. By requiring plans to honor the terms of their insurance contracts with patients by applying out-of-network costs to deductibles and annual out of pocket limits, health plans are likely to develop new tools and mechanisms to keep patients informed about which providers are in their provider network.

Dispute resolution mechanism and entities

We support the general structure and arbitration process as described in S. 3592, and believe it would incentivize more productive negotiations and more network participation by the covered providers. We believe the choice of a last best offer from the parties could contribute to more reasonable offers, but if the neutral party must use the average in-network rate in the same geography, such an average may not exist in many markets. We recommend

using Medicare rates for the closest set of services in that geography instead. These rates are publicly available and are set independently of insurance carriers and providers that may have a dominant market share in certain geographies.

In order to further encourage the parties to negotiate and reach settlements to participate in insurance networks, we recommend consideration of giving the dispute mechanism entity the authority to designate certain decisions as precedents that would apply more broadly beyond the specific claim brought before the entity. In other words, the decision would apply that rate or rates to all similar services delivered in out of network situations by the provider for a certain period of time, such as twelve months, or until the parties reached a contract. This would likely reduce the number of disputes brought before the entity, and encourage the parties to establish and maintain contracts.

Relation to state dispute resolution mechanisms

States have jurisdiction over the fully-insured market. Most commercially insured people, however, are covered in employer-sponsored self-insured arrangements. We support the effort to align the dispute mechanism process and entities between the self-insured and group markets established under S.3592 with any such mechanisms set up in states to govern the individual and group markets under their authority.

We applaud your leadership and the framework you have outlined in No More Surprise Medical Bills Act of 2018, which could be applied to other dispute mechanisms in health care where competition is lacking and private parties are unable to settle on rates or prices that are reasonable and have some relation to costs. We look forward to working together with you in the 116th Congress as you and your colleagues seek solutions to this issue and other vexing health care cost challenges.

Sincerely,

A handwritten signature in black ink that reads "John Rother". The signature is fluid and cursive, with the first name "John" and last name "Rother" clearly legible.

John Rother
President and CEO