



June 25, 2019

The Honorable Lamar Alexander  
Chairman, Committee on  
Health, Education, Labor & Pensions  
United States Senate  
Washington, DC 20510

The Honorable Patty Murray  
Ranking Member, Committee on  
Health, Education, Labor & Pensions  
United States Senate  
Washington, DC 20510

Dear Chairman Alexander and Ranking Member Murray:

On behalf of our member hospitals and health systems, we are fully committed to helping the Committee address the issue of health care affordability. We agree with the Committee's goal, outlined in the Lower Health Care Costs Act (S.1895), to give America's families needed protection from the problem of "surprise medical bills" that result from unexpected gaps in coverage or medical emergencies. However, we have serious concerns about the legislative provision that sets a benchmark rate in statute for the out-of-network payments, as well as provisions that seek to change privately negotiated contracting arrangements between hospitals and insurance companies.

First, we would like to focus on the establishment of a benchmark rate to resolve out-of-network payment disputes between providers and insurers. Specifically, S.1895 calls for a median in-network rate to be paid in these instances. We oppose the setting of a payment rate in statute. 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.

While we believe that hospitals and insurance companies should negotiate reimbursement for out-of-network claims without government involvement, there may be a role for a dispute resolution process for physician claims. A number of states have enacted these processes, ranging from mediation to variations of arbitration. Such a

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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. 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.

Second, we would like to express our concerns about the contracting provisions that are part of the transparency section of the Lower Health Care Costs Act. We believe these restrictions could lead to even more narrow networks with fewer provider choices for patients, while adversely affecting access to care at rural and community hospitals serving vulnerable communities. We urge the Committee to remove these provisions from S.1895. We believe the provision that would prevent providers from declining unfair tiering and/or steering restrictions imposed by insurers would undermine the basis for value-based care and ask the Committee to consider the impact on patients if insurance companies can undermine value-based care arrangements by directing which hospitals and health systems a patient may use for their care. In addition, the provision that would strike clauses in contracts that require health plans to contract with all hospitals in a system would be unfair, particularly to rural and urban hospitals, by allowing insurance companies to select the hospitals in the system with which they contract. In addition to the economic efficiencies of having an insurance company contract with an entire system, such as allowing a system not to duplicate services at every site of care, we are concerned that patients in vulnerable communities, including inner cities and rural areas, could see their access to care limited if this selection process occurs.

We appreciate your consideration of these suggestions and look forward to continuing to work with you on federal legislative solutions to address health care affordability.

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