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TO: House Committee on Energy and Commerce

FROM: Kenneth E. Raske, President

SUBJECT: GNYHA Comments on *No Surprises Act* Discussion Draft

Thank you for the opportunity to comment on draft bill language of the *No Surprises Act*, which is designed to protect health care consumers from surprise billing practices. Greater New York Hospital Association (GNYHA) commends Committee Chairman Pallone and Ranking Member Walden for their leadership in drafting legislation to address a problem that is negatively impacting so many consumers across the country.

GNYHA represents more than 160 hospitals and health care systems in New York, New Jersey, Connecticut and Rhode Island, and was closely involved in the negotiation of New York's highly successful surprise bill law, which has become a model for how to address the problem of surprise medical bills nationally. We believe that our experience in developing and, importantly, implementing New York's law could prove beneficial to Congress as it considers Federal options to resolving the problem of surprise medical bill. Below are some general principles that we believe should guide Federal legislation, as well as specific comments on the Committee's discussion draft.

General Principles

- Patients should be held harmless for surprise bills that arise in emergency situations when they receive services from out-of-network providers and when, through no fault of their own, they receive services from out-of-networks providers at in-network hospitals. This means their out-of-pocket cost should be no greater than if they received the services in-network, and should not be balance billed.
- Patients should not be placed in the middle of negotiations between insurers and providers over payment in surprise bill situations.
- Determining the appropriate payment for out-of-network services should be left to negotiation between providers and insurers. Government should not dictate a default out-of-network payment amount, as this would have significant unintended consequences in terms of provider/insurer contract negotiations and result in diminished provider networks that would limit consumer choice and access.
- Reducing the number of surprise medical bills should be an important component of any legislation. This will require:

- increased oversight of plans in terms of network adequacy and accuracy of provider directories, including holding insurers accountable for errors so patients are held harmless when they inadvertently receive out-of-network services due to inaccurate information provided by the insurer
- disclosure requirements for insurers and providers about network participation status in advance of scheduled services

- State laws that address surprise bills should not be preempted by any Federal law as long as they hold the consumer harmless for additional out-of-pocket expenses. In such states, Federal law should only apply to self-insured, employer-sponsored plans governed by ERISA.

Comments specific to draft *No Surprises Act*

We are pleased that the draft bill incorporates a number of the important principles outlined above, particularly the need to hold consumers harmless and insulate them from payment disputes between insurers and providers. The proposed legislation also very importantly recognizes the need to support state laws that work. There are, however, several areas that we believe require clarification and/or modification:

- The definition of "recognized amount" appears to refer to required payments to non-participating "providers" as opposed to "facilities." This therefore leads us to believe that the bill is not suggesting payment of a new "market-based" rate for non-participating hospitals but rather largely for non-participating physicians. Does this mean that existing Department of Health and Human Services regulations requiring a *minimum* payment to non-participating hospitals of the greater of three (GOT) (in-network rate, out-of-network rate, or Medicare rate) for emergency services would remain in place, but balance billing would now be prohibited? It is confusing because the new language at 300gg-19(a) subsection b(1)(c)iii specifies payment to the "provider or facility" the amount by which the "recognized amount" exceeds the cost sharing. This would seem to indicate the definition of the "recognized amount" includes facilities. Please clarify the intent here. We recommend maintaining the GOT minimums as the initial interim payment to be made to non-participating hospitals for emergency services.
- The "recognized amount" definition defers to state law in a state "that has in effect a State law that provides for a method for determining the amount that is required to be covered by a health plan ...." for services received from non-participating providers. We recommend the following modification to this section:

  "that has in effect a State law that:

  I. prohibits health plans from imposing cost-sharing amounts on participants, beneficiaries or enrollees for services from a non-participating provider or facility that is greater than the cost-sharing amount that would apply had services been furnished by a participating provider or health facility; and

  II. requires health plans and providers to negotiate a reasonable reimbursement amount without involving the participant, beneficiary or enrollee or provides for a method or process for determining the appropriate reasonable reimbursement amount that is required to be covered by a health plan or health insurance issuer offering group or individual health insurance coverage regulated by such State in the case of a participant, beneficiary, or enrollee covered under such plan or coverage and receiving such item or service from a nonparticipating provider or facility ...."

We believe this would more clearly ensure that the consumer is held harmless while at the same time accommodating state laws with varying approaches for determining out-of-network reimbursement, including arbitration processes.

- The "recognized amount" in states with such laws as defined above is defined in terms of the in-network contracted rate. We strongly recommend this be modified, as allowing health plans to pay the same out-of-network as in-network creates disincentives for them to contract and gives them unfair leverage in contract negotiations. Hospitals always want to be in-network because if they are not, they will not have access to an insurer's enrollees for scheduled services.

  A median in-network rate is not a "market rate"—it is a discounted rate that reflects the value that insurers bring to a contractual relationship by making a population available to those providers. In the absence of a contracted arrangement, the insurer's enrollees are not available to providers except in unusual circumstances such as emergencies. The insurer is therefore not delivering the same value to the provider and should not receive the same discounted rate. Some providers do not participate with certain insurers because their payment rates are unreasonably low. Allowing insurers to pay the same to participating and non-participating providers encourages insurers to low-ball provider rates and diminishes the value of a contract. Those contracts are important for consumers as well as providers, as they include consumer protections and ensure access.

  Rather than establishing a default in-network median rate for surprise bill situations, we strongly recommend creating a national baseball-style arbitration process that requires the arbiter to consider usual and customary charges as well as contracted payment rates in settling surprise bill payment disputes. This process has proven very effective in New York. The median contracted rate or GOT could be used as an initial interim payment that could be challenged by either party through a dispute resolution process.

- Substantive disclosure requirements for insurers and providers about network participation and expected cost are very important to reducing the number of surprise bills and providing consumers with information they need to make health care decisions. We recommend that the Committee include additional disclosure requirements in this legislation. The requirements in New York's law have proven both effective and workable. The attached chart on New York's surprise bill law summarizes these disclosure provisions.
- The discussion draft establishes civil monetary penalties on providers if they inappropriately hold patients liable for costs above their cost-sharing liability. We believe this requires clarification. Providers should not be penalized if they inadvertently send a bill to a patient that the patient is not responsible for. This can happen on occasion for a variety of reasons, such as when plans do not response to claim submissions, issue incorrect explanation of benefits, erroneously deny payments for eligibility or coverage reasons, or if they issue payment directly to patients instead of providers. Providers should not be penalized if they promptly correct inappropriately issued bills. Penalties are only appropriate if the provider inappropriately pursues a patient for a payment they are not liable for.
- We also recommend that the draft bill incorporate penalties on insurers when they provide inaccurate information to enrollees about their networks or coverage.

Thank you again for the opportunity to comment on this important draft legislation. Please contact Jon Cooper (jcooper@gnyha.org) or Kathleen Shure (kshure@gnyha.org) if you have questions or would like to further discuss GNYHA's comments.

Out-of-Network (OON) Coverage Provisions in Final SFY 2014-15 New York State Budget

APRIL 1, 2014

OON PROVISION	FINAL BUDGET AGREEMENT
General OON Insurer Requirements	Insurers must provide enrollees and prospective enrollees in subscriber contracts or other written material: 1. The methodology for determining OON reimbursement. 2. The amount the insurer will reimburse under this methodology set forth as a percentage of "usual and customary" cost (not Medicare). 3. Examples of anticipated out-of-pocket costs for frequently billed OON services. 4. Information in writing and on Web site that permits enrollee to calculate anticipated out-of-pocket costs for OON services. Upon request, insurers must disclose to enrollee: • Whether a provider scheduled to provide a service is in-network. • The dollar amount the insurer will pay for a specific OON service.
	Usual and Customary (UCR) is defined as the 80th percentile of Fair Health. If an insurer offers products with OON coverage, it must make available at least one product that reimburses for OON at 80% UCR. If no OON coverage is available in a rating region, the Insurance Superintendent may require an insurer to make available an option that reimburses for OON at 80% UCR. Superintendent may waive the requirement to make available a product at 80% UCR if it represents a hardship for the insurer. Does not apply to emergency services provided in hospitals.
OON Emergency Service Reimbursement (Patient Hold Harmless)	All insurers must ensure that enrollees receiving OON emergency services incur no greater out-of-pocket costs for emergency services than if they received services in-network. *Extends hold harmless rules currently applicable to HMO products to all NY licensed insurance products including Preferred Provider Organizations (PPO) and EPOs – no balance billing patients. Providers may bill charges to plan, and plan may seek to negotiate a payment amount, but in absence of agreement on a negotiated amount, insurers must ensure patient is held harmless from any additional payment obligation.

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OON PROVISION	FINAL BUDGET AGREEMENT
Hospital Disclosure Provisions (on Hospital Web site)	Hospitals shall post: • To the extent required by Federal guidelines, a list of standard charges for items and services, including DRGs; • A listing of plans with which it participates; • A statement that physician services are not included in hospital charges, that physicians who provide services in the hospital may or may not participate in the same plans as the hospital, and that patients should contact their physicians to determine the plans in which they participate; • The name, mailing address, and phone number of physicians employed by the hospital along with the insurance plans they participate in; • The name, mailing address, and phone number of the hospital-based physician groups with which the hospital has contracted, including anesthesiologists, radiologists, and pathologists, and instructions on how to contact these groups to determine their plan participation.
Hospital Disclosure Provisions (in Registration or Admission Materials Provided in Advance of Non-Emergency Hospital Services)	Hospitals shall: • Advise patients or prospective patients to check with the physician arranging their hospital services to obtain information on any other physician expected to provide services and whether the services of physicians who are employed or contracted by the hospital, including anesthesiology, pathology, and/or radiology are anticipated to be required. • Provide patients or prospective patients with information on how to determine the health plans participated in by the physicians who are employed or contracted by the hospital and who are reasonably anticipated to provide services to the patient.
Physician Disclosure Provisions	Physicians shall disclose to patients and prospective patients, in writing or through a Web site and verbally at the time an appointment is scheduled, the health care plans they participate in and the hospitals with which they are affiliated. If a physician does not participate in the patient's or prospective patient's health care plan, the physician must: • Inform the patient prior to the provision of non-emergency services that the amount or estimated amount they will be billed is available upon request, and; • Upon request, disclose in writing the amount or estimated amount they will be billed for services anticipated to be provided. For care to be provided in a physician's office or coordinated or referred by the physician, a physician must provide a patient or prospective patient with the name, practice name, mailing address, and phone number of any provider scheduled to perform anesthesiology, laboratory, pathology, radiology, or assistance surgeon services prior to the provision of services. At the time a non-emergency hospital service is scheduled, a physician shall provide the patient and the hospital with the name, practice name, mailing address, and phone number of any other physician scheduled at the time of pre-admission testing, registration, or admission to provide services and information on how to determine the plans the physician participates in.

OON PROVISION	FINAL BUDGET AGREEMENT
Other Health Care Professional Disclosure Requirements	Health care professionals (includes group practices, diagnostic and treatment centers, and health centers) must disclose to patients and prospective patients in writing or through a Web site, and verbally at the time an appointment is scheduled, the health care plans they participate in and the hospitals with which they are affiliated. If a health care professional does not participate in the patient's or prospective patient's health care plan, they must: • Inform the patient prior to the provision of non-emergency services that the amount or estimated amount they will be billed is available upon request, and; • Upon request, disclose in writing the amount or estimated amount they will bill for services anticipated to be provided.
Dispute Resolution Process for Emergency and Surprise Bills	Requires Superintendent to establish process for resolving disputes between health plans and physicians over physician bills for emergency services and for non-emergency "surprise bills." Surprise bills are bills for: • services rendered by a non-participating physician at a participating hospital • services from a non-participating provider upon referral from a participating provider without written consent acknowledging non-participation status • for an uninsured patient, services rendered by a non-participating physician where the patient has not received the disclosures now required by law Dispute process is not applicable to certain evaluation and management Current Procedural Terminology (CPT) codes for hospital/ED-based services where the physician's fee is below 120% UCR or below a dollar threshold established by the Superintendent. Depending on circumstances, plan, physician, or patient can submit dispute to an independent dispute resolution entity (IDRE) certified and selected by the Superintendent. For emergency services, patient is held harmless for any additional payment obligation other than applicable copayments, coinsurance, and/or deductibles, but the insurer or the physician may submit bills for review by the IDRE. Uninsured patients may also submit bills for emergency services to the IDRE. In surprise bill situations, if the patient has assigned benefits to the non-participating physician, the patient is also held harmless. In these situations, insurer or physician may appeal to dispute resolution entity. If benefits are not assigned, patient is not held harmless but may submit the dispute for review to the independent review entity. The IDRE will determine a reasonable fee for the services provided, and in doing so must consider a variety of factors but in the end shall select either: • the plan payment amount, or • the non-participating physician's fee. The IDRE may direct the plan and the physician to attempt to resolve their dispute through good faith negotiation if it determines a resolution is likely or if it determines that both the plan's payment and the physician's fee are unreasonable extremes.

OON PROVISION	FINAL BUDGET AGREEMENT
Expanded Consumer Protections	Certain consumer protections applicable to managed care products are extended to all insurance products with networks, such as Exclusive Provider Organizations (EPOs). Expanded protections include: • Enrollees must be permitted to go OON if plan does not have a geographically accessible and qualified provider in-network. • Due process procedures around authorizations are established for OON requests including external appeal rights when an insurer denies a request for an OON referral on the grounds that a qualified in-network provider is available to provide the service. • Patients with life-threatening or degenerative and disabling conditions must be permitted to have care coordinated by a specialist and must be given access to specialty care centers. • Existing utilization review and external appeal rights are now applicable to all policies that incorporate provider networks. Provider directories must now include physicians' hospital affiliations and the languages they speak. Directories must be posted on insurer Web sites and updated within 15 days if a provider is added or terminated or if a physician changes hospital affiliations. Insurers must provide enrollees with information on how to submit a claim for health care services. Insurers that utilize a network of providers must ensure that the network is adequate. State will review networks to ensure they meet adequacy standards.