February 11, 2020

The Honorable Dan Kildee
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Kildee:

On behalf of the Michigan Health & Hospital Association (MHA) members, including more than 130 hospitals, health systems and other health care organizations, I am writing in support of the Consumer Protections Against Surprise Medical Bills Act of 2020. The MHA appreciates the efforts of the House Committee on Ways and Means to develop the most effective approach to surprise medical billing introduced to date.

As the MHA has stated to members of the Michigan Congressional Delegation, the most important legislative action is to prohibit balance billing in nearly all situations and to limit patients' obligation to their in-network cost-sharing responsibilities. We strongly support these provisions in the legislation.

However, once the patient is protected, hospitals and health systems must be permitted to work with health plans to determine appropriate reimbursement, as is outlined in the bill. We strongly oppose approaches that would impose arbitrary rates on providers, which could have significant consequences far beyond the scope of surprise medical bills. These arbitrary rate-setting mechanisms will impact the health care marketplace to the advantage of health insurers, beyond what is intended in legislation considered in other House and Senate committees.

The MHA commends you and the Committee for not using this legislation to include references that are extraneous to the surprise medical billing issue, such as those related to privately negotiated contracts, which have been incorporated into other bills and would lead to narrower provider networks with fewer choice for patients.

As you move forward with the legislative process, the MHA would appreciate your consideration of the following comments.

PREVENTING SURPRISE MEDICAL BILLS

The legislation prohibits providers from balance billing patients for emergency services or medical care the patient reasonably could have expected to be in-network, and does not allow patients to be charged more than the in-network cost-sharing amount. We agree with protecting patients from surprise medical bills and for developing a workable approach for determining the patient's cost-sharing amount so they are removed from any discussions between the health plan and the provider regarding reimbursement. The Committee also has gone further than any other legislative efforts to remove patients from the reimbursement process by requiring that health plans accept when patients have assigned their benefits to the provider. This provision would require that plans reimburse providers directly, rather than sending reimbursement to the patient (who in turn must then compensate the provider).

OUT-OF-NETWORK PAYMENTS

Out-of-network reimbursement would be determined either through a provider's acceptance of a health plans' initial payment, through a period of "open negotiation" or, ultimately, through a mediated dispute resolution process. The Consumer Protections Against Surprise Medical Bills Act allows providers and health plans to continue current practice, which is to directly negotiate fair and appropriate reimbursement. Recognizing that some negotiations may not resolve in a timely manner, the Committee established a mediated dispute resolution process. While we expect this option will rarely be used, we appreciate that the Committee has designed it in such a manner to allow for continued negotiation and

enable providers and health plans to bring any information they deem relevant to the independent mediation entity.

We appreciate that the Committee has developed a thoughtful approach to calculating the median contracted rate, which could be used to determine patient cost-sharing, as a data point during negotiations and as a consideration factor for mediators. It is important that the calculation of the median contracted rate considers the facility type, as recognized in the legislation. We interpret this to mean that certain types of providers, e.g., critical access hospitals or academic medical centers, will be compared against like providers and not against other types of facilities that may have very different cost structures.

We encourage the Committee to explicitly direct the mediator to a previously negotiated contracted rate between the health plan and provider, which will better reflect the unique circumstances of a particular payer/provider relationship. We ask that the mediator be directed to disregard public payer reimbursement rates, which are well known to be below the cost of providing care. And we request that the mediator be explicitly pointed to other considerations, such as emergency department-only agreements, single case agreements and rental networks.

We also support requiring that the non-prevailing entity pay the cost of mediation as a deterrent to overreliance on mediation. In addition, we support the concept of a “frequent flyer” penalty to further encourage health plans and providers to come to agreement on reimbursement during the open negotiation period and not abuse the mediated dispute resolution process, and would encourage the Committee to consider making this change to the legislation.

CONSUMER PROTECTIONS

Hospitals and health systems are committed to helping patients access the financial information they need to make decisions about their care. It appears that the text could be read that providers/health plans provide “good faith estimates” for all scheduled care, not just upon request. We ask the Committee to clarify that the estimate is only required when requested by the patient. We recommend the estimate include only the patient’s out-of-pocket costs (which would reflect where they are in their annual deductible and out-of-pocket cost limits) so the patient is able to easily find the information most important to them and to ease the administrative burden on providers and health plans.

PENALTIES

The Consumer Protections Against Surprise Medical Bills Act outlines how civil monetary penalties (CMPs) can be assessed on hospitals for violations of the Act.

Hospitals would be subject to a penalty for each instance in which either the facility or a contract provider working in the facility sent a balance bill to an out-of-network patient following an emergency without providing appropriate notice. We ask the Committee to clarify that their intent is to impose CMPs on the provider who bills a patient in violation of the statute so a hospital is not subject to a penalty for action taken by an independent clinician. **We also note the absence in the legislation of specific penalties on health plans for their violations and ask the Committee to explain how they intend to hold plans accountable for their actions.**

Thank you for your consideration of these comments on the Consumer Protections Against Surprise Medical Bills Act. I look forward to continuing to work with you regarding solutions to prevent surprise medical bills.

Sincerely,

Laura Appel
Senior Vice President