



**CALIFORNIA
HOSPITAL
ASSOCIATION**

*Providing Leadership in
Health Policy and Advocacy*

May 28, 2019

Chairman Frank Pallone
Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

Ranking Member Greg Walden
Energy and Commerce Committee
2322 Rayburn House Office Building
Washington, DC 20515

SUBJECT: Pallone and Walden Draft "No Surprises Act" Legislation

Dear Chairman Pallone and Ranking Member Walden:

California's more than 400 hospitals and health systems share the Energy and Commerce Committee's goal of protecting patients from unexpected medical bills. At a time when patients should be focused on getting well, they should not be burdened with worries about bills or whether their provider is "in-network" or "out-of-network." We appreciate you calling attention to this issue with the introduction of the "No Surprises Act" and we look forward to working with you to craft a balanced and effective solution.

Below please find several guiding principles as we work together to protect patients:

Retain Provisions that Shield Patients from Balance Billing

Hospitals are the places people turn to in times of greatest need — the birth of their children, treatment for devastating diseases, and critical care after an accident. It is during these times that patients should be focused on what matters most, not on how much they will be billed for their care.

California has made significant headway in preventing unexpected bills, both for surprise billing (occurring when patients receive services from an out-of-network provider despite receiving these services in a contracted hospital) and balance billing (occurring when a health insurance company partially pays a provider for services and the provider bills the patient for the remainder).

Per the 2009 California Supreme Court case *Prospect Medical Group v. Northridge Emergency Medical Group*, balance billing is banned for all services if patients are in-network; this ban also extends to all emergency services, regardless of a patient's network status. With respect to surprise billing, a 2016 state law prohibits bills from an out-of-network provider for non-emergency services; instead, patients are only responsible for the in-network cost sharing amount. However, there are gaps in these protections, related mostly to federal ERISA plans and some state-regulated PPO products. **These protections have proven effective and should be preserved.**

The provision permitting states to determine their own payment standards for plans they regulate should be maintained.

While California has made impressive strides to protect patients with state-regulated health care coverage, patients covered by federally regulated ERISA plans — such as self-insured plans provided by employers and union trust funds — do not benefit from these state-level protections. These federally regulated plans operate with minimal regulatory oversight, are not required to include essential health benefits, have no network adequacy requirements, no financial solvency requirements, and do not afford patients the opportunity to appeal coverage decisions to regulators. Further, ERISA does not grant providers important rights, such as protections ensuring timely payment or prohibitions on rescinding authorizations. **It is incumbent on the federal government to further protect patients by enacting protections in these areas.**

Remove Payment Methodology

The payment methodology proposed in the No Surprises Act is not necessary and potentially harmful. Setting contract rates that are below the cost of care creates an incentive for health insurance companies to avoid contracting with hospitals at all, especially for emergency care that hospitals are **legally obligated to provide with or without a contract**. The impact this would have on network adequacy — a measure of a health insurance company's ability to provide enrollees with timely access to a sufficient number of in-network providers, including primary care and specialty physicians — would be detrimental for patients and communities.

Setting specific rates for the reimbursement of services is the wrong answer to a complex problem. The introduction of rate setting could lead to an immediate, arbitrary reduction in hospital resources and, over the longer term, create an even bigger problem. By giving insurance companies an unfair advantage in negotiating with hospitals, insurers will have no incentive to negotiate, creating a systemic underfunding problem — all with no action to address the core drivers of health care costs.

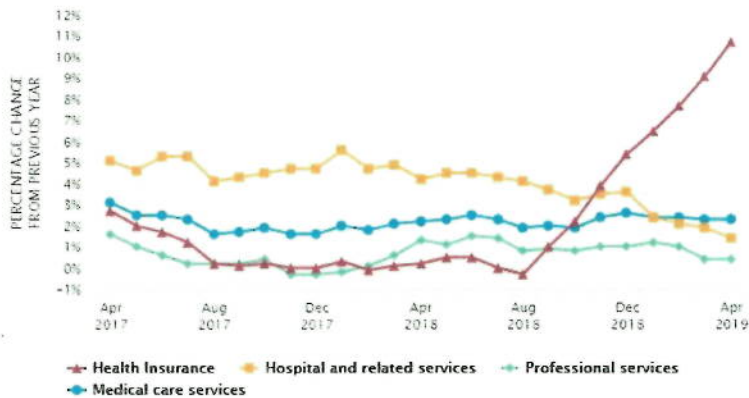
In addition, setting inadequate payment rates to hospitals does not guarantee health insurance companies will reduce costs for patients. As Figure 1 (below) indicates, the rate of growth for spending on health insurance has been increasing sharply relative to growth in hospital spending, which has been trending down. Nationally, hospital spending grew at less than 2% over the previous year (as of April 2019), while spending on health insurance premiums increased by more than 10%. **The rate-setting provision should be deleted and the bill should be limited to protecting patients from balance billing.**

Figure 1

Health insurance inflation rising faster

Unadjusted percentage change from previous year

The chart below is interactive: [click](#) or [touch](#) to see more.



Notes:

The medical care services index comprises the professional services, hospital and related services, and health insurance categories of the CPI. Medical care services is one component of the medical care index.

Source: U.S. Bureau of Labor Statistics monthly consumer price index reports

Exempt Certain States from Unworkable Patient Notification Processes

California's law banning the "corporate practice of medicine," which prevents hospitals from directly employing physicians, makes the proposed patient notification process not viable for California hospitals. In fact, California's law goes so far as to prevent hospitals from even requiring that contracted physicians accept the same insurance as the hospital. As you might expect, this creates massive confusion for patients, as their hospital and their doctor might accept entirely different types of insurance. **States that prohibit the corporate practice of medicine should be exempt from patient notification requirements.**

Remove Proposed Civil Monetary Penalties

Civil monetary penalties do little to provide additional patient protection and divert resources that should go to patient care. **The proposal to make balance billing violations subject to civil monetary penalties should be deleted from the bill.**

Incorporate Provisions to Address Air Ambulance Providers

The legislation, as currently drafted, does nothing to prevent surprise out-of-network bills from ground or air ambulances, despite the fact that these services are frequently delivered out-of-network. Federal law prevents states from addressing balance billing for air ambulances in particular. **Any federal legislation addressing surprise billing should incorporate ambulance services within the emergency service protections.**

In addition to protecting patients from unexpected bills, hospitals have a duty to safeguard the critical resources needed to meet the needs of their communities, from disaster preparedness to stringent seismic standards compliance to round-the-clock emergency care. And this comes at a time when California's hospitals are already doing their part to keep costs down. The cost of

hospital care in California is more than 5% below the national average, and has averaged a scant 3% growth over the past three years.

As we work together to protect patients, it's critical that we do so in a way that does not have long-lasting negative effects on California's hospitals, the people they care for, and the communities we share. If you have questions or would like to discuss further, please call Anne O'Rourke, CHA senior vice president, federal relations, at 202-488-4494.

Sincerely,



Carmela Coyle
President & CEO