



Issue: “Surprise” Billing (Out-of-Network billing)

Background: Trying to understand the cost of healthcare continues to become a problem for consumers. Healthcare consumers are asking hospitals to provide more transparent costs for services and procedures. While public focus on this issue is not new, trends in the healthcare marketplace are heightening its importance. Most healthcare consumers have an option to choose the physicians, hospitals, and healthcare systems that align with their choice of healthcare providers and insurance benefits. In emergent/urgent situations however, that choice may become limited or non-existent. In these emergency situations, some of these services may be furnished by providers that do not align with a patient’s insurance plan, resulting in larger, unexpected amounts due. The three most typical scenarios are when: (a) a patient accesses emergency services outside of their insurance network while they are away from home; (b) a patient receives care from an out-of-network physician providing services at an in-network hospital; or (c) a health plan denies coverage for emergency services stating that the services were unnecessary.

AAHAM is committed to doing everything possible to better serve patients and to treat them equitably, with dignity, compassion, and respect, from the bedside to the billing office. AAHAM strongly supports protections for patients from unexpected out-of-network health care costs when the patient does not have time to make a choice for their healthcare. Particularly, for costs incurred during an emergency or medical situation in which additional services are provided by out-of-network clinicians without the patient’s prior knowledge. AAHAM supports negotiations that result in fair payment from an insurer to the provider while protecting patients from a lack of a contract, however, we cannot do this without the help of the insurance carriers. Therefore, we need to have insurance carriers at the table for this conversation. Insurers should be required to participate in providing better education to their members about out-of-network or non-covered charges according to their benefit plan. Insurance companies require mandatory credentialing of all providers working in every hospital and clinic across the country. Insurance companies, through their healthcare claims history and internal data analytics systems, also know which physicians have historically been involved in the care provided at each healthcare organization. Health plans should be required to pro-actively educate their members with this information so that consumers can make educated decisions for scheduled, planned services.

We were pleased to see Congress include baseball style arbitration language in the December 2020 Consolidated Appropriations Act. This language does take the patient out of the equation and forces both the providers and payers to negotiate in good faith. However, we still have concerns with the final text of the No Surprises Act. There are provisions in this Act which hospitals are not able to meet and would like to work with you on changes that address the concerns raised by Congress, but also create a system that is achievable for hospitals.



Recommendations: AAHAM and its members seek to work with Congress, and the Administration, to address problems in the No Surprises Act, which are unrealistic timetables for hospitals to meet. They include:

Section 103:

1. ***The time deadlines in the dispute resolution process for out of network rates are impractical and weigh heavily against providers.*** If the parties cannot agree on the process, and if the state does not have an established process, the Act provides for an Independent Dispute Resolution Process (“IDR”) to determine out of network rates. The applicable time periods are not realistic. 30 days to negotiate a resolution; 4 days to give notice triggering the IDR; 3 days to select an arbitrator; 3 days for the HHS Secretary to select an arbitrator; 10 days to submit the proposed offer for reimbursement; and a 90 day "cooling off period" that prevents the party submitting the dispute to the IDR from submitting another case related to the same item or service involving the same party for 90 days. These time periods will be impossible to meet without adding significant staff and taking resources away from patient care. The dispute resolution process needs to be made workable with reasonable and practical time periods for each step in the process. The time period to initiate formal IDR should be flexible based on progress made in the informal negotiations. Once an impasse is determined by either side, initiation of the IDR process should be allowed within a reasonable time, not to exceed 365 days. The time for arbitrator selection should be no less than 60 days and no more than 90, or the selection is made by HHS. HHS should have at least 30 days to make the selection for this to be workable. The 90 day “cooling off” period should be eliminated entirely.

Section 104:

- ***Providers can only send bills to patients for their in-network deductible amount if the patient is out of network.*** This would be complex for providers to identify the patient’s in-network deductible and to bill patients for this amount. Insurance companies are not providing this information to healthcare providers in a standard format today. The manual operational processes required for hospitals, as well as insurance companies, to comply with this would increase healthcare costs.
- ***Prohibits “certain out of network providers” from balance billing patients unless an estimate of charges was provided 72 hours from when the services are received.*** Hospitals are already required to provide cost estimates to patients that request an estimate via the Pricing Transparency regulation. Forcing hospitals to provide this to all patients, and not just those patients that request this information, will increase healthcare cost by forcing hospitals to hire additional staff to comply. There are currently no standardized price estimation tools on the market that will automatically generate and deliver an accurate price estimate to every single patient. Adding staff members, which will drive up the cost of healthcare, will be what hospitals are forced to do in order to comply with this requirement.



Section 112:

- ***Providers must identify 3 days in advance of service and not later than 1-day post scheduling the service what type of coverage the patient is enrolled in and provide a good faith estimate to the patient.*** Hospitals are already required to provide cost estimates to patients that request an estimate via the Pricing Transparency regulation. Forcing hospitals to provide this to all patients, and not just those patients that request this information, will increase healthcare cost by forcing hospitals to hire additional staff to comply. There are currently no standardized price estimation tools on the market that will automatically generate and deliver an accurate price estimate to every single patient. Adding staff members, which will drive up the cost of healthcare, will be what hospitals are forced to do in order to comply with this requirement.

Section 117:

- ***Requires providers to give patients a list of services received upon discharge or end of a visit and not later than 15 calendar days after date of visit.*** Medicare conditions of participation provider documentation regulations allow 30 days post discharge for final diagnosis and completion of the medical record for the visit. A final bill cannot be sent to the insurance company prior to the completion of the medical record. This allows for accurately documenting, charging, coding and billing on behalf of the patient. Providers will not be able to provide these upon discharge, and very few within 15 days of date of visit due to waiting for the completion of the record. We would like to see this language modified to require hospitals to provide this information only to patients that request it, and only after 30 days post discharge. Requiring hospitals to provide this to every patient will increase healthcare costs through additional staffing and supplies to produce these. We would like to see this time requirement moved to 30 days post discharge, knowing that there may be unique cases that fall outside of this, but that the norm should be 30 days from when the provider signs and certifies the documentation.
- ***Provider must bill the health plan no later than 30 calendar days after discharge.*** AAHAM supports timely filing laws that are already in existence and asks that hospitals should continue to comply with the timely filing requirements in their state and/or within their contract with the insurance company. Medicare timely filing is currently 12 months from the date of discharge. Medicaid and commercial insurance timely filing range anywhere from 90 days to 12 months after discharge depending on state law and/or the insurance contract. Reducing timely filing requirements to 30 calendar days after discharge will conflict with Medicare conditions of participation provider documentation regulations which allow 30 days post discharge for final diagnosis and completion of the medical record for the visit. A final bill cannot be sent to the insurance company prior to that. We ask that current timely filing laws and/or contracted timely filing requirements are utilized moving forward.
- ***If a patient receives a bill more than 90 calendar days after receiving care, the patient is not obligated to pay.*** This issue is not as simple as it may sound and is not good healthcare policy. Today we do everything we can within our direct control to send bills out in a timely manner, but the shared responsibility between providers and payors when it comes to this timetable, must be factored in. We would urge Congress to work with providers on a compromise that addresses concerns. The language on this should read that the hospitals will send a patient due bill to the patient no more than 30 days after the final payment or final denial is received and posted from the insurance company.