Kentucky Hospital Association

Kentucky Hospitals' Requests Regarding U.S. House Surprise Billing Legislation

H.R. 2328 was passed out of the House Energy and Commerce Committee with a substitute bill that includes **delaying the Medicaid DSH Cuts for two years and the No Surprises Act (H.R. 3630) to address surprise billing.** While the No Surprises Act established out-of-network provider payment at the health plan's median in-network contracted rate, **H.R. 2328 was amended to add an independent dispute resolution process, using baseball-style arbitration.**

KHA and Kentucky Hospital Concerns:

H.R. 2328 takes a small step in the right direction by including a dispute resolution process; however, KHA has the following concerns and requests for changes:

- **Eliminate the benchmark rate and establish an "interim" appealable payment –** Use of a health plan's "median" rate as a benchmark for out-of-network provider payment will harm providers and patients. It creates a significant risk that plans could set arbitrarily low rates, and remove the need for insurers to negotiate with providers or form comprehensive networks. This approach would create a windfall for health plans while transferring millions of dollars in losses to community hospitals. Financially struggling rural hospitals – which treat a disproportionate share of Medicaid and underinsured patients – are at greatest risk as they often must pay more to secure physician specialties, yet this will not be accounted for in a one-size-fits all approach.

  KHA recommends amending the bill to establish an "interim" appealable payment to an out-of-network provider at the plan's average payment for the same services delivered in-network, where such payment would not be considered "final" unless the provider chose NOT to appeal the interim payment through the independent dispute resolution mechanism.

- **Expand Independent Dispute Resolution (IDR) Considerations –** H.R. 2328 restricts the information the IDR entity will consider in selecting the best rate to only the median contracted rate of the health plan whose payment is being disputed. **KHA recommends the bill be amended to include consideration of payments made to the provider or facility for the same services by other health plans in which the provider or facility is non-participating.** This would give the IDR entity the ability to recognize if the health plan in question is reimbursing well below the market rate to ensure fair compensation for providers.

- **Remove the Appealable Dollar Threshold and Clarify Appeal Bundling –** H.R. 2328 appears to exclude the ability of a provider to use the IDR process if the plan's median payment for an individual item or service is not more than $1,250.

KHA recommends removing the dollar threshold which would govern when a payment could be appealed. Otherwise, providers will be constrained in the ability to appeal and will be forced to potentially accept reduced payment for many individual services.

Key features of H.R. 2328:

- **Effective Date -** January 1, 2021
- **Applicability -** hospitals, independent freestanding emergency departments, ambulatory surgery centers, lab and radiology facilities.
- **Patient Protection -** Patients are held to their in-network cost sharing for services delivered by non-participating emergency providers and non-emergency providers at an in-network facility.
- **Out-of-Network Payments -** Health plans must pay the median contracted rate:
  - For 2021, the median is the insurer's 2019 negotiated rates (inflated by the 2019-2020 CPI-U) for all plans within the same line of business. CPI-U is an inaccurate metric for medical inflation and will not keep up with the cost of providing care.
- **Independent Dispute Resolution (IDR) -** A nonparticipating provider/facility or a health plan may request an IDR of an out-of-network payment, but only under very limited circumstances.
  - The IDR has 30 days to determine which final of-

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fer of payment, as submitted by the provider and the health plan, is most reasonable.

- **Bundling in a Single Appeal -** Appeals permitted if related to treatment of the same condition and services were furnished within a 30 day span.
- **Penalties -** The civil monetary penalty is $10,000 per violation, but it is waived if a provider or facility was unaware that they should not be sending a balance bill and correct the mistake within 30 days. It is very likely that providers will mistakenly trigger this provision and face the penalty.
- **Notices -** Each health facility, provider and health plan must publicize information on this law and how patients can contact regulatory authorities.
- **When Balance Billing is Permitted -** A nonparticipating provider may balance bill for non-emergency services at a participating facility if an oral notice is given and the patient signs a consent not less than 72 hours prior to receiving the service, acknowledging the provider is nonparticipating with a cost estimate.
- **Provider Directories -** Health plans must update them at least every 90 days and remove providers if information cannot be verified.
- **Network Adequacy -** Secretary of Labor to issue report on the affect of the law, including the impact on adequacy of provider networks in group health plans.

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