Kentucky Hospital Association

# Kentucky Hospitals' Requests Regarding U.S. Senate Surprise Billing Legislation

**The Lower Health Care Costs Act of 2019 (S. 1895), introduced by Sens. Lamar Alexander and Patty Murray, passed out of the Senate HELP Committee on June 26, 2019. S. 1895 would have a negative impact on Kentucky's hospitals.**

## *KHA and Kentucky Hospital Concerns:*

- ### 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 removes 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.**

- ### Include an independent dispute resolution process, like ones that have passed and been successful in several states

  A government-set rate will never be adequate for all providers and, when set unreasonably low, will simply shift the burden to hospitals in the form of subsidies to maintain access to necessary physician services for their communities. KHA supports giving the out-of-network provider and insurer 30 days to negotiate payment and, if unsuccessful, payment would be resolved through a "baseball style" binding arbitration process where each side would present its best price to be selected by a neutral arbitrator. KHA's members believe this would result in payment which better reflects a competitively set price for the geographic market in which the services are rendered. Because both parties would share arbitration costs, there is a built-in incentive to resolve disputes through negotiation and minimize the number of claims that would be appealed through the arbitration process. **KHA opposes setting an arbitrary dollar amount on a claim that could be appealed through the arbitration process** – out-of-network providers should have the opportunity to appeal any payment they believe is unreasonable.

  Texas recently enacted bipartisan legislation to address surprise bills by requiring health plans to pay out-of-network providers at the usual and customary or an agreed on rate, subject to mediation for out-of-network facilities, and negotiation followed by binding arbitration for out-of-network providers. An arbitration process in New York has decisions split evenly between providers and insurers.

- ### Remove Health Plan Patient Steerage

  **S. 1895** would prevent an in-network hospital from negotiating clauses in contracts to prevent a health plan from steering enrollees away from the hospital. When hospitals negotiate payment rates with plans, they do so based on an expected volume of patients. **If a health plan is permitted to steer patients away from in-network hospitals, the lost volume will result in financial loss and, if substantial, could result in services closing and the community losing access to care.**

- ### Remove Prohibition on Health System Network Contracting

  **S. 1985** would remove the ability of hospital systems to negotiate on behalf of their entire system by prohibiting clauses in contracts to require a health plan to include all of a system's facilities as in-network. This would unreasonably shift negotiating leverage to health plans, which already have a competitive advantage over providers given the small number of commercial insurers in Kentucky and their large market share. **If insurers are given the ability to pick and choose the facilities within a system to be included in their network, the result will be narrower networks, reduced choice and access to in-network care for Kentucky's patients and consequently more out-of-network care.**

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- ### Remove Unreasonable Itemized Billing Timeframes

  **S. 1895** would require patients to receive a list of services upon discharge and receive their bill within 30 days or else the bill would not have to be paid. Kentucky's hospitals provide itemized statements upon request following discharge, but cannot reasonably produce this information at the time of discharge. Billing delays can occur due to multiple factors including inaccurate insurance information given by the patient and IT system issues. **Eliminating responsibility for payment of a late bill would only further harm hospitals by removing revenue needed to pay staff and maintain access to services.**

- ### Remove Unreasonable Timeframes to Produce Cost Sharing Estimates

  S.1895 would require providers to give patients good faith estimates of their expected out-of-pocket costs for specific health care services within 48 hours of a request. Kentucky hospitals are helping their patients obtain this information, but **a 48-hour mandated turnaround time is inappropriate, especially for small and rural facilities with limited staff.**

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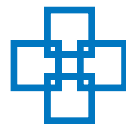

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