December 14, 2020

The Honorable Patty Murray

U.S. Senate

154 Russell SOB

Washington, DC 20510

Dear Sen. Murray,

I am writing to thank you for your efforts to protect patients from surprise medical bills and to offer some comments on various sections of the No Surprises Act. We appreciate that this is a priority issue for you, as it is for the Washington State Hospital Association (WSHA).

***Support the independent dispute resolution process.*** We agree that providers should be prohibited from balance billing patients for out-of-network emergency care, certain ancillary services provided by out-of-network providers at in-network facilities, and for out-of-network care provided at in-network facilities without the patient’s informed consent. Patients should only be required to pay the in-network cost-sharing amount. They should not be put in the middle of provider – health plan reimbursement disputes.

Under your bill, providers and health plans would negotiate payment rates. If they fail to reach an agreement, they could avail themselves of an independent dispute resolution (IDR) process. Your IDR process is very similar to one developed in Washington State by hospitals, providers, and insurers. We very much appreciate and support this approach and are grateful that this proposal does not impose arbitrary reimbursement rates.

Washington State’s law requires plans to pay a commercially reasonable rate for out-of-network services. This language would strengthen the No Surprises Act and help make sure that public payer reimbursement rates – which are usually below the cost-of-care – don’t skew the payment rates downward.

Finally, we appreciate that the No Surprises Act takes into account states’ solutions to surprise medical bills. It defers to state law for state-regulated products and, as in the Washington State statute, allows self-funded plans to opt into state surprises billing protections.

***Significant concerns about other billing provisions.*** The second part of your bill deals with a variety of issues not related to surprise billing. We have several serious concerns about these.

First, the legislative language appears to hold facilities responsible for physician and professional claims, even when a physician or professional is not employed by the facility. However, the facility would not have access to essential information needed to fulfill this task. This would result in a significant change in the relationship between independent providers and hospitals, require a revamping of the billing systems, and add considerable cost burdens to the hospital. We urge you to clarify that independent providers are responsible for their own contracting and billing.

Second, while we support the goal of expediting the billing process, the timeline outlined in Section 117 is simply unworkable.

Facilities and providers would be required to share with patients a list of items and services provided during a visit within 15 days of discharge or the date of the visit. Providers would then have 30 days following discharge or date of service to submit bills to the patient’s health plan. Health plans would then have 30 days to adjudicate the bills. Upon receiving the adjudicated bill, the provider would have 30 days to bill the patient for their cost-sharing amount. Patients receiving bills after 90 days would not be obligated to pay the bill.

Providers don’t control how quickly health plans adjudicate bills and have no recourse if health plans fail to meet the timeline set out under this provision. We are concerned that this process will lead to a spike in unpaid claims and increases in uncompensated care. ***We strongly urge you to remove this section.***

Third, pricing transparency. Hospitals and health systems are committed to helping patients get the information they need to make informed health care decisions. We are concerned that several of the pricing transparency provisions won’t help us meet this goal.

For example, it appears that providers would have to provide “good faith estimates” for all scheduled care. Hospitals already work closely with patients to determine the cost of procedures and services. Requiring hospitals to establish a separate process to provide such estimates would add significant cost and administrative burdens to hospitals. We urge clarifying that any “good faith estimate” is only required when requested by the patient.

Related to this is the requirement that health plans use the “good faith estimate” to develop an “Advanced Explanation of Benefits.” When patients are preparing for scheduled services, they are looking mostly for their out-of-pocket costs. We are concerned that patients would not receive enough benefit from this process to justify its cost.

Again, thank you for your consideration of our comments on the No Surprises Act. We look forward to continuing to work with you as we seek solutions to prevent surprise medical bills.

Sincerely,

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Cassie Sauer Jacqueline Barton True

President and Chief Executive Officer Vice President, Rural Health Programs

Washington State Hospital Association Washington State Hospital Association