Minnesota Hospital Association

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June 5, 2019

Chairman Lamar Alexander
Ranking Member Patty Murray
Senate Health, Education, Labor, and Pensions Committee
430 Dirksen Senate Office Building
Washington, DC 20510

VIA EMAIL: LowerHealthCareCosts@help.senate.gov

Re: Bipartisan Discussion Draft Legislation to Reduce Health Care Costs

Dear Senators Alexander and Murray:

On behalf of the Minnesota Hospital Association (MHA) and the 142 hospitals and health system members across our state, thank you for the opportunity to comment on the bipartisan discussion draft to reduce health care costs.

I write today to comment primarily on Title I of the discussion draft and, in particular, the three proposed options related to surprise bills. Other provider organizations, including our colleagues at the American Hospital Association, will also submit comments that will cover other portions of the discussion draft. MHA aligns itself with the views of AHA and encourages your attention to their comments.

Minnesota's health care providers, health plans, and the state government have successfully partnered to reduce surprise bills for Minnesota residents, and I write today to offer Minnesota's perspective on this very important question. Minnesota law provides protections for patients from surprise bills. In 2017, MHA supported a new state law that:

- limited a patient's financial responsibility to the amount they would have paid if they had received in-network services,
- ensures patients have access to emergency care, and
- requires a health plan and nonparticipating provider to negotiate payment. If a payment agreement cannot be reached by the health plan and the provider, either party may elect to refer the matter to binding arbitration.

The new law has worked well in Minnesota and would be an excellent model for federal legislation. Concerns about surprise bills have dropped dramatically in Minnesota and those issues that do arise are often associated with self-insured plans that are, pursuant to federal law, exempt from the Minnesota requirement.

Based on Minnesota's success at reducing surprise bills, I provide the following observations related to the discussion draft's proposal to reduce surprise bills.

The Minnesota Hospital Association Strongly Supports the Following Provisions

Based on Minnesota's experience, the following proposals from the discussion draft are likely to lead to a reduction in surprise bills without significant disruption to the overall health care market:

1. Independent Dispute Resolution is, by far, the best proposed option for reducing surprise bills without significant disruption to the overall health care market. The Committee should support the use of independent dispute resolution (IDR) substantially similar to the proposal outlined in Subtitle B-Option 2 of the discussion draft. Minnesota has adopted a similar proposal and it has been quite successful. That said, as discussed more fully below, the use of IDR should not be limited to only those bills that are more than $750. Use of a default payment rate for any services will have a negative impact on the health care market and will likely lead to market disruptions affecting patient access to care.

2. Including language maintaining state-based surprise billing protections is critical. MHA strongly supports the language included throughout the alternative proposals protecting state-based methods of preventing surprise billing. Failure to include such language in a final draft would undermine the success already achieved in many states and would lead to substantial disruptions in markets, like Minnesota, that have already reduced surprise bills.

The Minnesota Hospital Association Has Concerns on the Following Provisions

1. The "In-Network Guarantee" language will reduce patient access to health care. It is important to note that the issue of surprise bills arises almost exclusively as a result of the narrow networks and restrictive payment policies implemented by health plans. In Minnesota, as in most other states, a provider may not participate in a health plan's network without the health plan's consent. Health plans are free to include or exclude any providers they see fit and, in the experience of Minnesota health care providers, do so without explanation and without the opportunity for the provider to challenge the exclusion.

   Furthermore, even if the health plan is willing to add a provider to a network, not all providers are willing or able to accept what the health plan defines as its in-network rates. It is common for health plans in Minnesota to propose in-network reimbursement rates that are well below the provider's costs of providing services.

As a result, the proposed "In-Network Guarantee" contained in Section 103 of the discussion draft will have a negative impact on access to care. If a health plan and a provider are unable to reach an agreement to add the provider to the health plan's provider network, the In-Network Guarantee will force a hospital to either:

- exclude from its medical staff any providers who are not also part of the network of *every* health plan that the hospital contracts with, or
- refuse to contract with any health plan that excludes a hospital provider in its network.

Either method of compliance will limit the hospital's ability to provide access to care. The hospital will either accept less forms of insurance, leading to increased out of pocket costs for patients, or will have less providers on staff to provide care. Neither option is good for patients.

Notably, the health plan authority to exclude providers cannot be overcome by the discussion draft's proposed language purporting to establish a "Provider Choice." As discussed above, health plans retain the authority to define which providers are in-network and an individual provider's practice in a contracted hospital does not modify that right.

Even more disturbing, the "Failure to Comply" section of the discussion draft actually creates a significant financial incentive for a health plan to exclude providers. This provision affirmatively prohibits a health plan for paying hospitals and providers for services that are *actually provided* to a health plan participant when the provider is not a part of the health plan's network. As a result, the Failure to Comply provision will allow health plans to reduce costs and still have services provided to its health plan participants simply by refusing to contract with a provider.

2. <u>The Federal Government's establishment of a "Default Payment Rate" will disrupt market negotiations between providers and health plans and will lead to reduced access to care for patients</u>. Provider rates in the commercial market are the result of a variety of factors. The discussion draft's proposals to establish a default rate should be rejected by the Committee. Such a default rate is unlikely to fully account for all market factors and will lead to market disruptions, shortages, and misalignment of scarce health care resources.

   In addition, a default rate is likely to reduce the ability of providers and health plans to reach agreement on alternative payment rate. One party or the other – depending on whether the default rate is too high or too low for the specific market – is likely to reject any attempt to modify the rate and will lead to refusals to negotiate. A fixed payment rate also harms patient access to in-network providers because health plans will have no incentive to provide incentives to providers to join a network.

Thank you for the opportunity of offer these comments. If you have questions, feel free to contact me.

Sincerely,

Ben Peltier
Vice President, Legal and Federal Affairs

c: Senator Tina Smith
Senator Amy Klobuchar