STATEMENT

of the

American Medical Association

to the

U.S. House of Representatives

Committee on Ways & Means

Re: Reduced Care for Patients: Fallout From Flawed Implementation of Surprise Medical Billing Protections

September 19, 2023

Division of Legislative Counsel

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The American Medical Association (AMA) appreciates the opportunity to submit the following Statement for the Record to the U.S. House of Representatives Committee on Ways & Means as part of the hearing entitled "Reduced Care for Patients: Fallout From Flawed Implementation of Surprise Medical Billing Protections." The AMA has long supported the goal of protecting patients from unanticipated medical bills. As such, we applaud the leadership of this committee in addressing surprise medical billing through a balanced approach to reconciling differences between physician charges and plan payments, while at the same time protecting patients by removing them completely from the dispute. The No Suprises Act (NSA) Congress enacted in 2020 has the potential to protect patients in surprise billing situations while maintaining market forces that ensure physicians, especially those in independent practices, can meaningfully participate in contract negotiations with health plans. The way in which the Administration has been implementing the NSA has not realized that potential and, if not corrected, will stymie achievement of this important policy goal to the detriment of patients and physicians.

Very broadly, the AMA is disappointed that the Administration has chosen to capitalize on a targeted policy response to surprise medical billing and use it as an opportunity to myopically address health care costs by artificially deflating payment rates for physicians who are providing the direct medical care to patients. By taking the balanced Independent Dispute Resolution (IDR) process specified in the statute and attempting to strip it down to a process that is largely inaccessible and unaffordable to independent or smaller practices and to where the outcome is nearly always predetermined and prejudicial to physicians, the Administration has disregarded the result of Congressional negotiations and placed yet another thumb on the scale in favor of health insurers in already highly concentrated health insurance markets.[1] In fact, members of the Ways and Means Committee, including the then Chairman and Ranking Member, wrote numerous times to outline the extensive bipartisan Congressional negotiations and implore the Departments of Health and Human Services (HHS), Treasury, and Labor to avoid any ambiguity or misinterpretations of the statute and, in turn, to implement the NSA to the letter of the law[2].

Unfortunately, under the Administration's approach to implementation, the immensely dominant insurance companies in already concentrated markets continue to gain more market power and physician practices are being forced to make difficult choices in response—consolidate, join health care systems, sell to insurance companies, turn to private equity, or close their doors. The result is not increased value for patient premiums but decreased patient choice and access.

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[1] American Medical Association. Competition in Health Insurance: A Comprehensive Study of U.S. Markets. 2022 Update. Available at: https://www.ama-assn.org/system/files/competition-health-insurance-usmarkets.pdf.

[2] See, e.g., www.aans.org/-/media/Files/AANS/Advocacy/PDFS/surprise-billing-regs-Neal-Brady-letter.ashx; www.aha.org/system/files/media/file/2022/11/key-house-committee-express-serious-concerns-regarding-latest-efforts-to-implement-the-bipartisan-no-surprises-act-letter-11-21-22.pdf; https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2FSuozzi-Wenstrup-SMB-Implementation-Letter-w-signa-6.17.21.pdf; and https://wenstrup.house.gov/uploadedfiles/2021.11.05_no_surprises_act_letter.pdf.

The AMA and dozens of organizations representing health care providers have taken every opportunity to express our concerns to the Administration and suggest changes to rules and guidance that would protect patients and the market balances Congress sought. Small improvements have been made aligning with our recommendations and we continue to express our concerns to the Centers for Medicare & Medicaid Services (CMS). However, the Administration continues to deviate from the statutory language and exceed its administrative authority in its implementation of the dispute resolution process, specifically. We have thus engaged in and supported[3] lawsuits that challenge the implementing regulations. For the AMA, litigation efforts are an option of last resort. But unfortunately, that is where we find ourselves and are validated by the U.S. District Court decisions that continue to recognize the Administration's overstepping of its authority.[4]

To be clear, the AMA supports the concept of the IDR process in the NSA and believes this process has the potential to fairly resolve payment disputes between physicians and health plans. Our current concerns are not with the process as outlined in the statute, but with its implementation. We believe the Administration has made several *correctable* missteps in the implementation process and urge Congress to support quick action by the Administration to address these issues and ensure that the NSA functions as intended. Below we identify and discuss the current and most pressing implementation issues that must be addressed quickly to ensure that physicians are able to meaningfully negotiate with health plans and keep their practices up and running in order to provide needed care to patients.

Overreliance on the QPA in the IDR process

Perhaps no implementation flaw has had greater repercussions on patients, physicians and the health insurance market than the Administration's overreliance on the qualifying payment amount (QPA) in determining a fair out-of-network payment. As this Committee knows, the statute was *not* drafted in a way that suggests the median contracted rate paid to other physicians should systematically be valued over other factors by IDR entities (IDREs) when determining the appropriate out-of-network rates, but rather in a way that recognizes there are many relevant factors that the IDREs should consider when determining a fair payment amount.

Unfortunately, the Administration has twice directed IDREs to consider the QPA the dominant factor in determining an out-of-network rate and to essentially disregard statutorily allowable information supporting a party's offer, including those enumerated in the law which Congress determined were relevant to determining a fair payment.[5] The AMA was pleased to finally see guidance in March 2023 that better reflected the balance Congress sought by permitting IDREs the independence to consider all allowable evidence presented by a party. Subsequently, we were disheartened to learn that the Administration appealed the US District Court ruling that ultimately led to that improved March guidance, and the AMA recently filed an amicus brief with the American Hospital Association (AHA) in support of the appellees.[6]

Some stakeholders have suggested physicians' opposition to the QPA playing a central role in IDR decisions is akin to exploiting market failures and inflating costs. This is a false narrative offered by those that seek to drive policy changes to undercut the ability of all physician practices—large and small, urban, and rural—to negotiate fair network contracts. The push to essentially force arbiters to consider only a

[3] See AMA-AHA amicus brief in TMA II; AMA amicus brief in TMA III

[4] See *Texas Medical Association, et al. v. United States Department of Health and Human Services*, Case No. 6:21-cv-425; *Texas Medical Association, et al. v. United States Department of Health and Human Service*s et al., Case No. 6:22-cv-372; *Texas Medical Association, et al. v. United States Department of Health and Human Services*, Case No. 6:23-cv-59-JDK; *Texas Medical Association, et al. v. United States Department of Health and Human Services*, Case No. 6:22-cv-450-JDK.

[5] 42 USC § 300gg-111(c)(5)(c)

[6] AMA-AHA amicus brief (5th Circuit).

single, insurer-calculated amount when determining payment to an out-of-network physician does not correct an imbalance in the system, it exploits it. Physicians are the backbone of the health care system and ensuring the financial health and sustainability of physician practices, specifically independent physician practices, should be a goal of all stakeholders who care about patient choice and access to medical care.

Market impact of overreliance on the QPA

Overreliance on the QPA during the payment resolution process will continue to have negative implications in the health insurance market and, therefore, patient access to care. With implementation of the NSA, the demands of patients and employers for in-network care for certain services has been lessened, which in turn has reduced the incentive for health plans to engage in meaningful contract negotiations with physicians. While we strongly support removing patients from the middle of payment disputes, we also appreciate that Congress recognized an additional check on health plans was necessary to reinforce this market force—a meaningful and balanced IDR process to allow providers the opportunity to make their case for a fair out-of-network payment.

Congress understood that this process could help influence a health plan to come to the contract negotiating table in the first place, offer a reasonable initial payment when a surprise bill happens, and settle most disputes in the open negotiations process. But when the IDR decision is essentially predetermined to be at or below the QPA, this important check on negotiating incentives established by Congress is significantly diminished.

We agree with analyses that insurers will likely pay many contracted physicians much less in the coming years as they negotiate contracts (and renegotiate current contracts) under the QPA's ceiling. We have already seen these scenarios playing out in states like North Carolina, where the largest commercial market insurer in the state sought contract amendments that slash long-standing fee schedules directly as a result of the Administration's first regulation establishing the IDR process in 2021. We have seen similar efforts by health plans across the country, as well as broader network reductions by health plans who are no longer concerned about patient access to in-network hospital-based care.[7] Whether such payment and network reductions will translate to reductions in health insurance premiums for patients is not yet known, though past experience suggests it is very unlikely. But they are certain to put an additional, if not fatal, financial strain on many independent physician practices and rural health care providers already struggling to make ends meet in their small businesses and in many areas where patient access is already under serious stress. The AMA continues to urge the Administration to codify in regulation that IDREs are not required to consider any allowable information over another when making a payment determination.

QPA calculation concerns

Problems associated with overweighting the QPA in the IDR process have been compounded by a QPA calculation methodology that permitted plans to offer QPAs below the median in-network rates, which the QPA is intended and required to represent. For example, the methodology laid out by the Administration in their July 2021 interim final rule (IFR) and subsequent guidance allowed plans to include rates for services that may never be provided and were never negotiated (e.g., ghost contract rates); permitted rates from other specialties to be included in QPA calculations; failed to include bonuses, penalties, and other risk-sharing adjustments that impact final rates; and allowed self-insured payers the discretion to choose whether they want to use rates solely from their individual product for QPA determination or incorporate

[7] See e.g. "Coming to a contract negotiation near you: the No Surprises Act," Modern Healthcare, 8/3/2022, available at https://www.modernhealthcare.com/insurance/no-surprises-act-influencing-insurers-rate-setting-plans.

all of the health plan's products' rates in the area. These allowances permitted plans and payers to manipulate the QPA in order to misrepresent the true median in-network rate to IDREs to their benefit.

The most recent NSA decision out of the US District Court for the Eastern District of Texas vacated many of these unlawful liberties taken by the Administration to deflate the QPA.[8] We are hopeful that the Administration will not appeal this decision but instead issue a new regulation and guidance that adhere to the District Court's decision and ensures that health plans are restricted in their ability to manipulate the QPA.

Additionally, we continue to press for more transparency requirements on health plans to demonstrate or explain how the QPA is calculated. The QPA remains an important component of the dispute resolution process, but when only one party understands how it was derived and the data used to generate it, the integrity of the process is compromised. The Administration should require health plans to provide physicians and IDREs with the data and methodology used to calculate the QPA.

Backlog in IDR process

Despite statutory timelines governing payment resolution in the NSA, there continues to be significant delays in the IDR process, separate and apart from pauses due to court decisions. According to the Departments' Initial Report on the Federal Independent Dispute Resolution (IDR) Process, April 15 – September 30, 2022,[9] there were over 90,000 claims submitted to IDREs between April 15 and September 30, 2022, but only 23,107 had been resolved by the end of the report period, and only 3,576, or 15 percent, resulted in an IDRE making a payment determination. A follow-up report[10] looking at the fourth quarter of 2022, found that while a greater percentage of closed disputes resulted in a payment determination (40 percent), still only 31,714 of the 110,034 initiated disputes had been closed. The AMA is very concerned about the financial impact, and the subsequent threat to practice sustainability, of the IDR backlog on the physicians waiting for resolution of their claims.

According to the reports, a cause of IDR claim delays has been the complexity of determining whether a claim is eligible for the federal process. Specific eligibility determination issues highlighted in the initial report include determining whether the federal IDR process or a state process applies, whether claims were batched correctly according to regulatory guidelines, and whether pre-IDR requirements, such as completion of the open negotiations period, have been satisfied.

Suggestions that the backlog is due to physicians and other health care providers submitting frivolous claims overlook the complexity associated with determining eligibility at the physician practice level, the regulatory requirements, or lack thereof, that fail to promote efficiencies, and the incentives for plans to challenge eligibility at every turn and disengage from the process all together. From the physician's perspective, significant financial resources go into pursuing the NSA's dispute resolution process, and allowing claims to pend for long periods of time in this process not only leaves physicians practices in difficult financial situations but threatens the legitimacy of the entire process that Congress carefully created to balance contracting incentives.

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[8] *Texas Medical Association, et al. v. United States Department of Health and Human Services*, Case No. 6:22-cv-450-JDK

[9] U.S. Department of Health and Human Services, U.S. Department of the Treasury, U.S. Department of Labor, "Initial Report on the Independent Dispute Resolution (IDR) Process April 15-September 30, 2022," (December 2022), available at https://www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf.

[10] U.S. Department of Health and Human Services, U.S. Department of the Treasury, U.S. Department of Labor, "Federal Independent Dispute Resolution Process – October 1 – December 31, 2022," (April 27, 2023), available at https://www.cms.gov/files/document/partial-report-idr-process-octoberdecember-2022.pdf.

Helping physicians determine the appropriate dispute resolution process

The AMA continues to hear from physicians who are struggling to determine whether an out-of-network claim is eligible for the federal process, or whether the specified state law applies in those states with existing surprise billing laws. While there are many nuances to determining the correct process beyond whether the health plan is state or federally regulated, including whether the federal law fills gaps in a specified state law, there are immediate policies that could aid physicians early in the process to reduce resource waste and consequential delays.

For example, the AMA believes that requiring plans to use Remittance Advice Remark Codes (RARCs), when providing the initial payment or notice of denial, would significantly reduce confusion. Specific RARCs were created with passage of the NSA and are available to identify if the NSA is applying to a claim or a specified state law, what process was used to determine an initial payment, how cost-sharing for an eligible claim under the NSA or a specified state law was calculated, and more. Ensuring the use of RARCs for all claims will provide physicians and IDREs with critical information about whether a particular claim is eligible for the federal IDR process and how to process claims if they are eligible.

Improving efficiencies through expanding batching of claims and bundling of services

Strict regulatory rules on batching of claims to take to the IDR process have resulted in inefficiencies and confusion, perpetuating the IDR claims backlog. Under the statute, batching is permitted whenever "items and services are related to the treatment of a similar condition," but the Administration's rules permitted batching only in much narrower circumstances—if the "items and services are the same or similar items and services," which are defined as an item or service that is "billed under the same service code, or a comparable code under a different procedural code system." This narrowing of the definition meant that far fewer claims could be batched together for IDR.

Again, a recent District Court decision vacated the Administration's inefficient batching rules,[11] and the AMA is hopeful that the Administration will now issue new rules and guidance compliant with the decision that expand the ability of physicians to batch claims for IDR purposes to reduce the backlog.

Similarly, the Administration should consider allowing greater flexibility in the bundling of services for a single claim. Although an October 2021 IFR described a bundled claim as one for which the health plans pays a single payment for multiple items or services furnished during an episode of care, August 2022 guidance clarified that a single payment for multiple items or services must be made at the service code level for the entire bundle in order to be considered a bundled arrangement and, therefore, be treated as a single determination under the IDR process. We think that greater efficiency, and reduced IDR backlog, could be achieved through a broader definition of bundled claims that includes services furnished during a single episode of care.

Addressing a lack of engagement in the open negotiations process

Congress required the 30-day open negotiations process as an important component of the dispute resolution process under the NSA and consistent and good faith use of this process should lead to fewer IDR claims. Unfortunately, we understand that health plans are frequently dismissing outreach from physicians to participate in the open negotiations process and refusing to respond with offers for payment. We also understand that payers may be using questions of eligibility regarding completion of the open negotiations period as a tactic to delay or deter the dispute resolution process from proceeding.

[11] *Texas Medical Association et al. v. United States Department of Health and Human Services et al.*, Case No. 6:23-cv-00059.

To address any disingenuous questions of eligibility, the AMA has encouraged the Administration to collect information from IDREs about parties that regularly question claim eligibility with a frequency and manner that suggests bad faith and urged the Administration to immediately address the actions of these parties through corrective action and penalties when necessary**.**

Additionally, to address a lack of engagement in the open negotiations process, we believe there are potential benefits to formalization of the open negotiations period and requiring the process to be conducted through the federal IDR portal. Such benefits include increased clarity on initiation and completion of the open negotiations period, which would reduce related eligibility issues. This transition could also reduce confusion about to whom or where initiating parties should send the open negotiation initiation form. Additionally, moving the open negotiations process to the portal provides an opportunity to make a preliminary eligibility determination regarding federal or state authority on a claim prior to IDR initiation.

As such, the AMA has asked the Administration to further explore the feasibility of this transition, with the caveat that there will be no additional administrative fee for use of the federal portal for the open negotiations period (i.e., the administration fee must not apply until the claim advances to the IDR phase). Good faith negotiations during this stage of the dispute resolution process must be encouraged and assessing a fee at this time would do just the opposite.

Financial barriers to accessing the IDR process

It is clear that Congress did not intend to create a dispute resolution process that purposely excluded those physicians who remain in independent practice, who serve rural or underserved populations, or who are facing financial instability, especially because these are the types of practices who may have little to no negotiating power with large health plans in the first place. However, policies established during the implementation process have essentially ensured that the process is only accessible for physicians in large enough or sophisticated enough practices, systems or financial arrangements to accept the financial risk that comes with pursing an IDR claim.

For example, in January, the Administration announced that the nonrefundable administrative fee, used to cover their costs associated with the IDR process, would increase 600 percent, from $50 to $350, in 2023. Notably, this decision was released in updated guidance on December 23, 2022, one week prior to taking effect, and reversing guidance released just two months prior stating that administrative fees would remain the same. This gave physician practices no time to anticipate or financially plan for this fee increase. Furthermore, the same guidance also simultaneously increased the IDRE fees by up to 40 percent for individual claims and up to 82 percent for batched claims.

Once again, a district court ruling invalidated this administrative fee increase due to the lack of notice and comment provided to stakeholders.[12] While the fee is now currently at $50, the AMA remains concerned about future increases that may be done through proper notice and comment.

In the immediate term, significant increases to the administrative fee create a threshold cost to participating in the IDR process, a policy which we note was considered but rejected by Congress during drafting of the NSA. For example, with a $350 administrative fee, if a physician is paid at or below $350 for a claim, which is the case for many claims currently being advanced to IDR, the process becomes cost prohibitive for that physician. While this is a barrier for all physicians, it is particularly harmful for smaller, less resourced practices, and for those practices that serve large Medicaid or uninsured populations whose ability to overcome this threshold through the use of batching and bundling

[12] *Id*.

commercial insurer claims is extremely limited. Moreover, it is unlikely that financially strained practices would be able to withstand an IDR loss and cover the increasing IDR fees in addition to the administrative fee, making pursuit of the dispute resolution process too financially risky.

Over the long term, higher fees and resulting inaccessibility of the IDR process means that the careful balance of the NSA's statutory scheme is thrown off once again. If physician practices have no resolution process available to them when they are consistently underpaid by health plans, the underpayment will persist. Moreover, there will be even less incentive by health plans to offer these physician practices a fair contract, or keep contracted physicians in their networks, because their ability to underpay these physicians while out-of-network is now even easier. These results have major implications for patients' access to care. For these reasons, it is imperative that the IDR process remains financially accessible to all physicians.

Failure of plans to make payments upon an IDR decision

It seems nothing could serve to delegitimize the IDR more than having decisions ignored by losing health plans. But it is the AMA's understanding that many physicians are not receiving payment from health plans within the statutory 30-day time period following an IDR decision in their favor, and in fact many physicians are reporting receiving no payment at all. A recent survey by the Emergency Department Practice Management Association (EDPMA)[13] reported that 87 percent of payers did not pay in accordance with the IDRE's decision. Surely Congress did not intend physicians to have to pursue health plans in court following an IDR decision in their favor.

To be clear, health plans are blatantly ignoring binding IDR decisions, continuing to collect interest on money owed to physicians, and threatening the financial stability of thousands of physician practices across the country. Moreover, their actions, or lack thereof, are rendering the IDR process meaningless and, as a result, the backstop that the process is supposed to serve as under the statute is not having the effect of encouraging fair contract negotiations. The current situation is unacceptable and immediate action must be taken because without a meaningful and enforced IDR process, the NSA's careful balance and consideration of competing market forces falls apart.

The AMA has asked that the Administration work closely with state regulators to ensure that once an IDRE makes a final determination, payment is made to the prevailing party within the 30-day statutorily required timeframe. Should a party not comply with a required timeframe, a financial penalty should be applied and compounded over the course of the delay. Another option that the Administration might consider, especially for repeat offenders, is a requirement that payment be made up front and held by the IDRE, along with the IDR fee, and refunded with the IDR fee if the party wins or paid to the winning party when appropriate. The AMA urges Congress to work with the Administration to ensure that health plans are not ignoring IDRE decisions and are paying physicians within the required timeframe.

Complaints, audits, and reports

Complaints

The AMA has heard from many physicians that overall enforcement of NSA dispute resolution requirements is lacking, including but not limited to plan failure to pay post-IDR decision, to pay

[13] Emergency Department Practice Management Association, "No Surprises Act Independent Dispute Resolution Effectiveness," available at https://edpma.org/wp-content/uploads/2023/04/EDPMA-Data-Analysis-No-Surprises-Act-Independent-Dispute-Resolution-Effectiveness-FINAL.pdf.

administrative fees, provide the QPA with the initial payment, etc., and that when physicians encounter enforcement issues, there is not a reliable way to quickly have concerns resolved.

While we appreciate tools such as the NSA Help Desk set up by the Administration and email addresses for provider questions, we also understand that in many cases it takes several weeks for physicians to even receive confirmation that the request has been received or is being addressed. In addition to being frustrating and financially impactful for physician practices, such delayed responses undercut a system that was set up with clear timelines and requirements and perpetuate disregard by certain parties for the rules. Accordingly, the AMA has urged the Administration, working closely with state regulators, to establish a more functional and responsive process for physicians to report compliance issues and ask questions and receive a timely response.

Audits and reports

Congress wisely included minimum auditing of health plan requirements in the statute, recognizing the opportunities that exist for error in implementation of this major new law. The AMA understands that some statutorily required audits are being performed, however, little if any of this information has been made public to date. The NSA requires HHS to submit an annual report to Congress on the number of plan audits that were conducted during such year, starting in 2022. To our knowledge, such a report has not yet been submitted. The AMA has urged HHS to submit this report with all due expediency and to make the report available to the public. HHS is also expected to issue a report on downcoding and other such payer behaviors. We similarly ask that this report be made available to the public.

Conclusion

The AMA appreciates this Committee's focus on addressing the NSA implementation flaws that are, ultimately, a threat to patient's access to physician care. We reiterate that these flaws are largely correctable through improved regulation and guidance.

We continue to be committed to ensuring the NSA is implemented in manner consistent with the statutory text Congress so heavily debated and ultimate enacted. We stand ready to work with this Committee, Congress and the Administration to ensure patients are protected from surprise medical bills while physician practices of all sizes, in all areas of the country and serving all populations are able to remain financially stable in order to provide needed care to patients.