AMA
AMERICAN MEDICAL ASSOCIATION

JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

ama-assn.org
t (312) 464-5000

February 18, 2019

The Honorable Bill Cassidy, MD
United States Senate
520 Hart Senate Office Building
Washington, DC 20510

The Honorable Tom Carper
United States Senate
513 Hart Senate Office Building
Washington, DC 20510

The Honorable Michael F. Bennet
United States Senate
261 Russell Senate Office Building
Washington, DC 20510

The Honorable Lisa Murkowski
United States Senate
522 Hart Senate Office Building
Washington, DC 20510

The Honorable Todd Young
United States Senate
400 Russell Senate Office Building
Washington, DC 20510

The Honorable Margaret Wood Hassan
United States Senate
330 Hart Senate Office Building
Washington, DC 20510

Dear Senators Cassidy, Bennett, Young, Carper, Murkowski, and Hassan:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing in response to your letter seeking feedback from stakeholders on surprise billing. The AMA agrees that surprise billing is a complex problem, and that effective legislation to address it will require input from key stakeholder groups, including physicians.

While we appreciate the opportunity to provide feedback and data, many of the questions included in the letter ask for data that is difficult for physician groups to obtain. For instance, it is important to recognize the complexity of the contracting processes between physicians and insurers, as well as hospitals and insurers. Some research estimates that physicians have about 12 contracts, on average, with insurers.[i] Other research suggests the number may be as high as 20 contracts.[ii] And these data do not take into account the different products that fall under each plan or payer. Where hospitals are juggling multiple physician contracts, multiple insurance contracts, and often multiple products offered by an insurer, identifying a physician or hospital as globally "in-network" or "out-of-network" may not be evident. As a result, it is difficult to obtain some of the data requested, such as determining what shares of hospital-based providers are out-of-network for commercially insured patients.

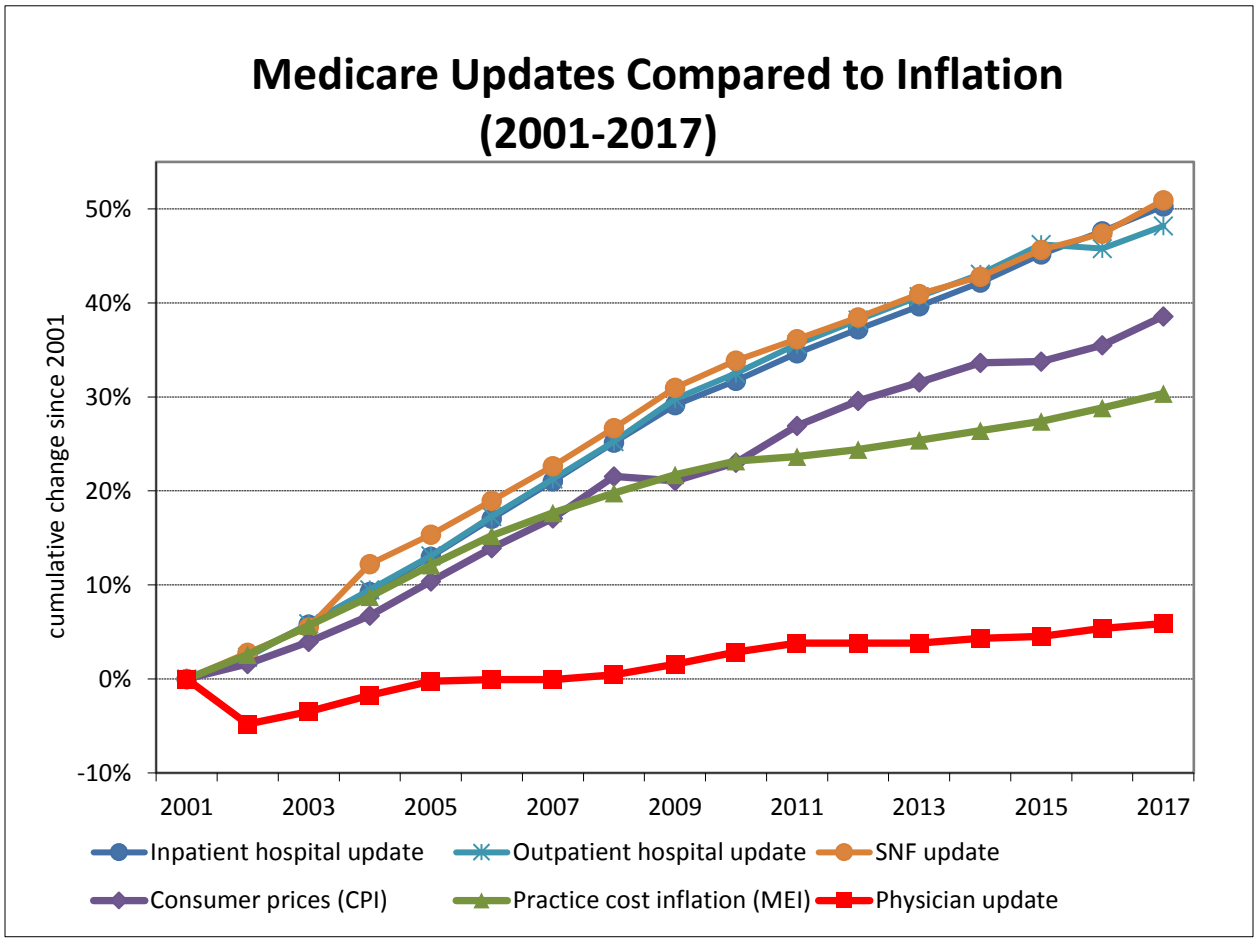
Payment Standards

In absence of data for the AMA to determine the fee schedules for all physicians, we note that there are databases, including FAIR Health, that have robust datasets, including charge data and allowables, for markets across the country.

Similarly, state All Payer Claims Databases (APCDs) may have such data. However, many APCDs are finding their datasets incomplete due to the Supreme Court's ruling in *Gobielle v. Liberty Mutual*,[iii] which prevents a state from requiring self-insured ERISA health plans to submit their data to the state's APCD. The AMA sees this as a significant barrier to state's collection of data—data that could assist in much more than just surprise billing solutions—and encourages congressional action to address this gap.

Medicare as a Payment Standard

In terms of data showing why Medicare rates are not an appropriate benchmark of out-of-network payments for physicians, the chart below provides a good visual of Medicare updates compared to inflation:



Sources: Federal Register, Medicare Trustees' Reports and U.S. Bureau of Labor Statistics

According to data from the Medicare Trustees, Medicare physician payment rates have barely changed over the last decade and a half, increasing just six percent from 2001 to 2017, or just 0.4 percent per year on average. And, under the Medicare Access and CHIP Reauthorization Act (MACRA), physician payment rates will be zero for calendars years 2020 through 2025.

In comparison:

- Medicare hospital payment rates have increased roughly 50 percent between 2001 and 2017, with average annual increases of 2.6 percent per year for inpatient services, and 2.5 percent per year for outpatient services.
- Medicare skilled nursing facility payment rates have increased 51 percent between 2001 and 2017, or 2.6 percent per year.
- The cost of running a medical practice has increased 30 percent between 2001 and 2017, or 1.7 percent per year. Inflation in the cost of running a medical practice, including increases in physician office rent, employee wages, and professional liability insurance premiums, is measured by the Medicare Economic Index, or MEI.
- Economy-wide inflation, as measured by the Consumer Price Index, has increased 39 percent over this time period (or 2.1 percent per year, on average).

Over time, the adequacy of Medicare physician payment rates has eroded significantly. Adjusted for inflation in practice costs, Medicare physician payment rates have declined 19 percent from 2001 to 2017, or by 1.3 percent per year on average. As such, the AMA opposes efforts to cap or benchmark out-of-network physician payments on a percentage of Medicare. Linking out-of-network rates to Medicare would eliminate any incentive for insurers to build adequate networks or offer physicians fair contracts.

Health Care Cost Institute Data

The letter references an article published by the Health Care Cost Institute (HCCI). To clarify, the HCCI "#HealthyByte" analysis does not include data on physician fees; it addresses spending for the facility portion of emergency room claims. It found that on a per-person basis, spending on emergency room facility fees almost doubled between 2009 and 2016 (98 percent increase).

Role of Hospitals

The letter asks for feedback regarding what role hospitals should play in combating surprise medical billing. Hospitals play an important role in terms of providing disclosure to patients prior to care, helping patients and physicians assemble teams of health care professionals to provide in-network care to patients prior to the provision of non-emergent care, and ensuring that any out-sourcing of their emergency departments are not financially harming patients. Hospitals, as well as physicians and insurers, have a role to play in reducing patients' unanticipated costs.

State Models

The letter asks several questions regarding state-specific data which we are unable to provide, such as identifying states where providers have a lower-than-average contracting rate. However, many states have taken action to address unanticipated out-of-network billing and we believe there are existing state models that have worked well to protect patients from surprise medical billing.

The AMA points to New York's balance billing law as a well-functioning model for several reasons, including:

- The law protects patients from unanticipated out-of-network bills.
- The law emphasizes the role of network adequacy in solving the "surprise" billing problem and puts in place new requirements to regulate networks and affords patients the right to an independent external appeal to be treated by a non-network provider if the network is inadequate.
- The law establishes a strong independent dispute resolution (IDR) process made by a reviewer with training and experience in health care billing, reimbursement, and usual and customary charges in consultation with a licensed physician in active practice in the same or similar specialty as the physician providing the service that is the subject of the dispute.
- The IDR process requires consideration of factors, including the rate that non-participating physicians charge for the service in the area based on independent data, usual and customary charge for the service based on independent data, the complexity of the case, and the physician's experience, training and education.
- There are no data that we know of that suggest that the law has resulted in either premium increases or a dramatic narrowing of networks.

The AMA also views the Connecticut law on unanticipated out-of-network care for emergency services as a potential model for all unanticipated out-of-network care situations because:

- The law protects patients from unanticipated out-of-network bills for care received at an in-network hospital.
- The law creates a solution by establishing a payment standard that incorporates charge data from an independent data source.
- There is no evidence that we know of that suggest law has resulted in premium increases, dramatic narrowing of networks, or higher rates of out-of-network physicians.

Facilitating In-Network Contracting

The most promising way for policymakers to facilitate contracting between providers and health plans is to ensure regulation of provider networks. Strong network adequacy requirements create a more balanced environment for all stakeholders where: insurers are incented to maintain meaningful access to in-network providers by offering providers competitive contracts; providers are incented to come to the table

knowing that it will be a fairer process; and patients will have access to in-network care and get greater value for their premiums paid.

While there has been a great deal of discussion about the growth of narrower provider networks, relatively little has been done to create or enforce network adequacy requirements, especially as they relate to hospital-based providers. Ensuring that, at a very minimum, in-network providers are available at in-network hospitals should be the first step for legislators and regulators in addressing unanticipated out-of-network care at in-network hospitals. Moreover, ensuring that patients have appropriate access to primary and specialty care will go a long way in preventing emergency department visits and other hospitalizations that may occasionally lead to unanticipated out-of-network bills.

The basis of network adequacy standards should be quantitative, measurable requirements on the front-end, before insurance products are brought to market. The quantitative standards should include minimum time and distance requirements, maximum patients-to-provider ratios, and maximum wait times. In addition, and specific for hospital-based specialties, it is critical that standards also measure access to in-network physicians at in-network hospitals.

Meaningful regulation of provider networks must also be ongoing. Consistent monitoring of the network's ability to provide in-network hospital-based care is particularly important, given that patients may not evaluate access to these providers simply through a directory or other tool, as is normally the case when choosing a provider. Moreover, given that many patients choose their health insurance products based on the provider network, it is critical that insurers ensure patient access to the same network available when they purchased the product, recognizing there may be occasions when a provider was terminated for cause or a provider leaves the network on their own accord for reasons such as excessive utilization management requirements, claims processing issues, or other reasons that makes network participation no longer financially workable.

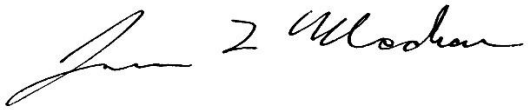
The AMA recognizes that even with the best regulatory structures in place to measure adequacy, there will be times, albeit hopefully very rarely, that a network may not fully meet the needs of a patient. Insurers have an obligation to provide in-network access to covered care and should work with patients and providers to make sure that such access is provided through alternatives network arrangements. The AMA also recognizes the opportunity to address the specific issue of unanticipated out-of-network care at in-network facilities through solutions that protect the patient financially and maintain important incentives for both payers and providers to come to the table and negotiate fair contracts.

Finally, it is important to recognize the connection between accurate provider directories and meaningful access to in-network providers for patients. The AMA encourages greater oversight of provider directories and stronger requirements that they be transparent and up-to-date. Patients need access to robust, up-to-date provider directories to enable them to determine which providers are in-network as they purchase their plans, and which providers continue to be in-network as their medical needs change. Additionally, providers need accurate information from health plans to allow for in-network referrals when further treatment is needed.

The AMA has worked closely with state policymakers to improve network adequacy standards. While some states—such as Illinois, Maryland, and others—have taken important steps forward on this issue, much work in terms of legislation, regulation, and especially enforcement remains to be done. We encourage a federal floor for network adequacy to protect all patients and encourage contracting between insurers and providers.

Thank you for the opportunity to offer our input. We look forward to working with you and your colleagues to help determine the best way to protect patients from costly surprise medical bills.

Sincerely,



James L. Madara, MD

---

[i] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3889938/
[ii] https://www.managedcaremag.com/archives/2005/3/what-do-physicians-want-health-plans
[iii] https://www.supremecourt.gov/opinions/15pdf/14-181_5426.pdf