AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Lamar Alexander
Chairman
Committee on Health, Education, Labor and Pensions
428 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Patty Murray
Ranking Member
Committee on Health, Education, Labor and Pensions
428 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Alexander and Ranking Member Murray:

On behalf of the physician and medical student members of the American Medical Association, I am writing to encourage Congress to protect patients from unanticipated health care costs. Unanticipated, or "surprise," medical bills can arise when patients reasonably believe the care they received would be covered by their health insurance company, but was not. This can occur in the facility setting where a patient went to an in-network hospital but was seen by physicians who were not included in the plan's network and where the patient did not have a reasonable opportunity to choose a physician, such as in emergency situations, or when scheduled care involves physicians providing ancillary services. There are also instances where patients receive bills for care that they reasonably believed would be covered by their health insurance company. Fifty-seven percent of those surveyed by the non-partisan and objective research organization NORC at the University of Chicago responded that they have been surprised by a medical bill they thought their insurer would pay.[1] In developing solutions to protect patients from unanticipated bills, we urge policymakers to examine the full range of situations that cause patients to receive bills for care their health insurance plan will not cover.

Health Insurance Market Concentration, Narrow Provider Networks, and Increasing Surprise Bills

For those who have experienced a surprise bill, 58 percent believe that their health insurer was "very responsible," while only 24 percent felt the same way about their doctor.[2] Physicians frequently have little leverage to negotiate fair contracts with health insurance plans given the highly concentrated nature of health insurance markets. For 2017, 73 percent of health insurance markets were highly concentrated according to federal guidelines.[3] A recent GAO report reached similar conclusions.[4] In these cases, patients should not suffer the consequences of their health plan's failure to contract with an adequate number of providers to meet their needs. Patients should only be responsible for the amount they would have paid had an in-network provider been available, and the remainder of the charges should be worked out between the health plan and the provider. We continue to welcome the opportunity to work with policymakers to protect these patients.

[1] http://www.norc.org/PDFs/Health%20Care%20Surveys/Surprise%20Bills%20Survey%20August%202018%20Topline.pdf
[2] Ibid.
[3] https://www.ama-assn.org/system/files/2018-11/competition-health-insurance-us-markets_1.pdf
[4] https://www.gao.gov/assets/700/697746.pdf

One of the major drivers of surprise bills is the deliberate decision by health insurance plans to narrow the networks of providers available to their insureds. Core network adequacy requirements should be an essential component of any solution. This is especially true in the individual market where 73 percent of plans have more restrictive network designs, including health maintenance organizations (HMOs) and Exclusive Provider Organizations (EPOs),[5] that tightly limit policyholders' access to providers. Plans have also taken other steps to limit access to providers even when consumers diligently select plans that include their preferred providers, such as removing entire physician groups from networks without cause after the beginning of the plan year, when the consumer is already locked in.[6] State regulators have taken steps to enforce network adequacy laws in egregious cases,[7,8] but state requirements are often limited or unenforced. Shrinking networks increase the likelihood that patients may receive care from an out-of-network provider, particularly in emergency situations, and merit a closer look.

Health Insurance Plans Shifting Costs to Patients

Beyond shrinking provider networks, health insurance plans are also shifting additional costs to patients for the limited out-of-network care they do cover. In the individual market, the percentage of health insurance plans providing out-of-network coverage shrank from 58 percent in 2015 to just 29 percent in 2018.[9] And patients who still have coverage for out-of-network care are shouldering more of the costs out of their own pockets through separate, larger deductibles and higher co-pays. The median out-of-network deductible in the individual market is $12,000, with deductibles of more than $20,000 for almost a third of individual health insurance plans.[10] Limited networks of providers and unaffordable deductibles for care outside those networks can expose patients to high out-of-pocket costs.

Denying Care Through Utilization Management/Prior Authorization Increases Costs for Patients

Other instances of surprise bills have nothing to do with network adequacy. Seventy-nine percent of patients who received bills for services they thought their insurance companies would cover report that those bills were not the result of their doctor not being included in their health plan's network.[11]

Utilization management programs, such as prior authorization and step therapy, are significant cost containment strategies used by health insurance companies that, in many cases, can result in patients having to pay out-of-pocket for medically necessary care that their plan has denied. Physicians report that in the last five years, the burden of prior authorization has increased significantly. Physicians on average complete 31 prior authorizations consuming almost 15 hours of staff time, or about two full business

[5] https://avalere.com/press-releases/plans-with-more-restrictive-networks-comprise-73-of-exchange-market
[6] https://www.beckershospitalreview.com/payer-issues/lawsuit-anthem-s-deceptive-marketing-made-patients-think-wellstar-emory-in-network.html
[7] https://www.insurance.wa.gov/sites/default/files/documents/Coordinated-Care-Final-Consent-Order-No-17-0477.pdf
[8] https://www.tdi.texas.gov/news/2018/tdi10082018.html
[9] https://www.rwjf.org/en/library/research/2018/10/percent-of-plans-with-out-of-network-benefits.html
[10] Ibid.
[11] http://www.norc.org/PDFs/Health%20Care%20Surveys/Surprise%20Bills%20Survey%20August%202018%20Topline.pdf

days, every week.[12] These requirements add significant costs to the health care system and, in many cases, for patients who must assume the cost of necessary care themselves.

Mental Health Disparity, Retroactive Denials, and Formulary Changes Increase Costs for Patients

On issues of mental health and substance abuse treatment, patients can feel particularly squeezed by their health insurance plan. Payment disparities by plans for behavioral health has led to a substantially greater reliance on out-of-network care despite federal parity requirements.[13] Plans frequently require prior authorization for substance abuse care, even when time is of the essence to get a patient into treatment. In many cases, patients denied coverage are forced to seek out care and pay for it out of their own pocket, if they are able. Unfortunately, the record is replete with stories where care was out of reach with devastating consequences.

There have also been a number of recent examples of health insurance plan actions to retroactively deny claims for emergency care, even in instances where a prudent layperson could reasonably believe that there was a medical emergency requiring immediate care.[14]

Health plan formulary changes made mid-year, after a patient is already locked into a plan, can also endanger patient health by restricting access to treatments that have already stabilized their condition or force them to pay out-of-pocket to continue treatment while new step therapy or prior authorization requirement overrides are obtained. Under Medicare Part D, plans making negative mid-year formulary changes are required to exempt enrollees currently taking the affected drug for the remainder of the plan year. Physicians, pharmacists, hospitals, and health insurers have all agreed that similar protections are needed for all patients.[15] We encourage policymakers to work with interested parties to ensure that patients do not shoulder the burden of health insurance company cost containment efforts.

Remedies Must Keep Patients Out of the Middle and be Based on Unbiased Claims Data

In developing remedies to protect patients from costs that should have been covered by their health insurer, it is critical that efforts be focused on ways to resolve differences between health insurers and providers without burdening patients. In cases where there was no reasonable opportunity to select an in-network provider, patients should only be required to pay charges they would have faced had they seen an in-network provider, with plan benefits being assigned to the provider. A system that relies on unbiased claims data and a mechanism to arrive at a fair payment amount should be enacted. Such a system is in place in New York and has been successful in protecting consumers and encouraging determinations of fair payments by plans and providers with no resulting evidence of premium increases.

Beyond the need to enact similar protections at the federal level, we urge policymakers to take a holistic approach to these and other factors that are increasingly shifting costs from insurers to our patients. Millions of Americans do not have the ability to reach into their pocket and pay for a treatment that their

[12] https://www.ama-assn.org/system/files/2019-02/prior-auth-2018.pdf
[13] http://www.milliman.com/uploadedFiles/insight/2017/NQTLDisparityAnalysis.pdf
[14] https://www.modernhealthcare.com/article/20180913/NEWS/180919940/hhs-work-on-anthem-s-emergency-coverage-policy-leaves-senators-dissatisfied
[15] https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf

plan has delayed or denied, or to cover a high deductible for out-of-network care because they were unable to access an in-network provider. Physicians' number one priority is making sure our patients are able to access the care they need, regardless of whether they have been included in the health insurer's network. We look forward to working with you to level this playing field and ensure that patients receive the care their premium dollars are supposed to provide.

Sincerely,

James L. Madara, MD