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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 Senate Office Building
Washington, DC 20510

Dear Chairman Alexander and Ranking Member Murray

I am writing today on behalf of the physician and medical student members of the American Medical Association (AMA) regarding S. 1895, the “Lower Health Care Costs Act,” which the Senate Committee on Health, Education, Labor and Pensions is scheduled to take up tomorrow. While the AMA supports many of the provisions in your legislation, we must strongly oppose *Title I—Ending Surprise Medical Bills*.

As we have noted often in previous correspondence, meetings, comment letters, and public statements, the AMA supports ensuring that patients are only responsible for in-network cost-sharing in situations when they are unable to select an in-network physician, as addressed in your bill. We also support efforts to remove the patient completely from payment disputes between their health insurance plan and their doctor when an unanticipated gap in their coverage occurs.

However, the approach outlined in S. 1895 fails to address some of the fundamental reasons why surprise billing occurs—inadequate provider networks, higher patient-cost sharing requirements for out-of-network services, and non-competitive local markets that empower plans to offer take-it-or-leave-it contracts.

Further, the payment solution offered in the legislation promises to make these fundamental problems worse. By setting a payment maximum at the individual plans’ median in-network amount, insurers will have even less incentive to negotiate contracts with individual providers. They can drive down the median in-network amount by simply dropping from their networks providers who are currently paid above the median. Or, they can simply stop negotiating altogether, knowing that their financial obligation is limited to their own median in-network payment amounts.

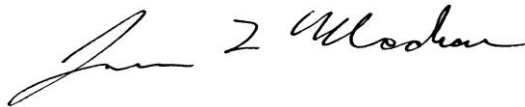
At a time when large insurer mergers are drawing increasing scrutiny for their anticompetitive impact on local markets, with 73 percent of markets in 2017 characterized as highly concentrated according to federal government guidelines, this is not the time to grant still more market power to such a dominant industry.

The AMA recommends the following improvements to S. 1895:

- When the out-of-network payment from an insurer is insufficient, an independent dispute resolution (IDR) process should be used to determine a fair payment by the health insurance company for the care provided. The IDR should be structured with clear factors that an independent arbiter must consider when deciding, such as the complexity of the case, the experience of the physician, and the rate that physicians charge for that service in the area. The state of New York uses such a system, with no adverse impact on premiums. Cost is minimal, consumer complaints are greatly reduced, there has been no apparent bias in arbiter decisions for or against insurers or providers, and providers and payers have become more willing to reach agreements outside of arbitration process. The New York experience has been characterized as a success by all stakeholders. It makes little sense for the Committee to ignore the clear evidence from this system that balances the interests of both sides, protects the patient, and does not threaten access to care.
- Benchmark rates for the arbiter to consider should never be based on negotiated, discounted in-network rates as reported by the insurer. Experience has shown that insurer-reported data is frequently inaccurate, as demonstrated by the class action lawsuit against United Health Care, settled for \$350 million in 2009, in which its Ingenix usual, customary, and reasonable database for determining out-of-network payments was found to be inaccurate and unreliable. More recent efforts by the state of Georgia's Department of Insurance to collect plan-reported data on mean and median contracted payment rates yielded similar inconsistencies and was abandoned. Instead, benchmark rates should reflect actual local charges as determined through an independent claims data base such as FAIR Health, which was created in response to the Ingenix case.
- Insurers must be held accountable for addressing their own contributions to the problem by creating strong and enforceable network adequacy requirements and enforcing federal parity and prudent layperson laws.

The AMA shares the Committee's goal of treating patients fairly and assuring that their health insurance plans actually deliver the benefits that were promised and that their premium payments were expected to cover. We will continue to work with leaders in the Senate and the House to achieve this goal while preserving competitive local markets.

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is fluid and cursive, with a large initial "J" and "M".

James L. Madara, MD