AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Frank Pallone, Jr.
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Greg Walden
Ranking Member
Committee on Energy and Commerce
2322A Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pallone and Ranking Member Walden:

On behalf of our physician and medical student members, the American Medical Association (AMA) is compelled to oppose H.R. 3630, the "No Surprises Act," scheduled for mark up by the Committee on Energy & Commerce Health Subcommittee tomorrow.

As we have noted in previous correspondence, meetings, comment letters, and public statements, the AMA has long been concerned about the coverage gaps that occur when patients unknowingly or without a choice receive care from an out-of-network provider. We agree that the central tenet of legislation to address unanticipated out-of-network billing is to protect patients from the financial hardships associated with these coverage gaps. As such, we strongly support provisions in the No Surprises Act that would ensure that patients are only responsible for in-network cost-sharing when these surprise coverage gaps occur, and that their cost-sharing count toward deductibles and out-of-pocket maximums. We also support efforts to remove the patient completely from payment disputes between their health insurance plan and provider when an unanticipated gap in their coverage occurs.

However, a key component on which the bill is structured is fundamentally flawed and would essentially institute a federal government rate setting scheme for private sector payments and force physicians, hospitals, and other health care providers to accept unreasonable rates dictated by private health insurance companies. Moreover, the bill would fundamentally alter deeply rooted principles of freedom to contract by effectively placing all negotiating power in the hands of insurance companies. We do, however, believe the bill could be modified to create a more balanced and market-focused approach that retains strong protections for patients while preserving the viability of physician practices.

More specifically, the No Surprises Act fails to address some of the major drivers of surprise billing—deliberate decisions by health insurance companies to narrow their networks of providers available to patients, shift more and more costs on to patients by limiting or providing no coverage for out-of-network services, and employ utilization management programs such as prior authorization and step therapy. Instead, the bill takes a one-sided approach by erroneously assuming that all incentives need to be placed on providers to contract with health insurance companies, failing to recognize that many local health insurance markets are highly concentrated by a few health insurance companies that use their dominant negotiating power to offer take-it-or-leave-it contracts to providers. Any legislation to remedy the surprise billing issue must incentivize insurers to expand their networks and offer fair contracts to physicians. Without such incentives, insurers will continue to realize financial gains by constructing networks where patients have limited access to timely care.

Further, the payment solution offered in the legislation would make these fundamental problems worse. By establishing a federal government payment maximum at the individual plans' median in-network amount,

insurers will have even less incentive to negotiate private contracts with individual providers. Even with the provision that ties the in-network rate to CPI-U, the bill still poses a federal government rate setting scheme on private sector payment forcing providers to accept discounted, below market payments from health insurance companies without having ever negotiated any contract terms or reaching mutual agreement. Moreover, such a scheme alters freedom of contract principles by shifting all negotiating power into the hands of health insurance companies. 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 H.R. 3630:

- Establish benchmark rates that are fair to all stakeholders in the private market. Experience at the state level shows 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. Benchmark rates should include actual local charges as determined through an independent claims database. This model has worked in states like New York with no inflationary impact on bill charges or premiums.
- Establish a fair and independent dispute resolution (IDR) process to resolve disputes about payments from insurers to unaffiliated providers for services rendered out-of-network to their beneficiaries. The process should be structured to include a range of factors to be considered in the case of an appeal; not just the median rate paid by the insurer, but factors such as the complexity of the service rendered, the experience of the physician providing the service, and the rate that physicians charge for the service in a geographic area. We recommend the Subcommittee look to the states for examples of appeals processes that are working, where any cost to use the process is minimal, there is no adverse impact on premiums, consumer complaints have been reduced, there is no apparent bias in the appeals process for or against insurers or providers, and providers and insurers remain encouraged to reach agreements.
- Protect patients from out-of-network billing and preserve patient access to hospital-based care. Insurers must be held accountable for addressing their own contributions to the problem. Any legislation addressing surprise billing should also establish strong, measurable, and enforceable network adequacy requirements, as well as require stronger enforcement of federal mental health and substance use disorder 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. However, experience with Medicare's sustainable growth rate system has shown how difficult and costly it can be to enact remedies after flawed payment policies are enacted. We will continue to work with the leaders in the House and Senate to advance effective proposals to lower health care costs, protect patients from surprise bills, and promote greater access to in-network care.

Sincerely,

James L. Madara, MD