Statement for the Record

of the

American Medical Association

for the record

U.S. House of Representatives Committee on Education and Labor
Subcommittee on Health, Employment, Labor and Pensions

Re: Examining Surprise Billing: Protecting Patients from Financial Pain

April 2, 2019

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The American Medical Association (AMA) appreciates the opportunity to present our views to the U.S. House of Representatives Committee on Education and Labor, Subcommittee on Health, Employment, Labor and Pensions concerning unanticipated medical bills. As health insurance plans increasingly rely on narrow and often inadequate networks of contracted physicians, hospitals and pharmacies to control costs, even patients who are diligent about seeking care from in-network physicians may face unanticipated medical bills from out-of-network providers that participate in their care. Physicians are limited in their ability to help patients avoid these unanticipated costs because like patients, they may not know in advance who will be involved in an episode of care, let alone other providers' contract status with all the insurance plans in their communities. Health insurers must be incentivized to negotiate fair contracts with physicians to ensure that networks are sufficiently robust.

The problem of unanticipated out-of-network bills is complex and requires a balanced approach to resolve. The AMA agrees that any solution must keep patients out of the middle of payment rate negotiations and ensure that when patients seek emergency care or otherwise do not have the opportunity to select their provider, they should not be responsible for cost sharing beyond what they would face if they had seen an in-network provider. Any proposed solutions should also require both providers and insurers to be transparent about anticipated charges and the amount of those charges that insurance will cover. We also agree that if balance billing is banned, there must be a process in place to ensure that providers receive fair reimbursement for their services.

The AMA encourages Congress to look to states that have already acted to address unanticipated medical bills, specifically those state laws that have functioned well such as New York and Connecticut. The AMA is committed to working with Congress to find a workable solution for all stakeholders that protects patients from unanticipated out-of-network bills.

Key Principles in Addressing Unanticipated Medical Bills

There are several key principles that must be a part of any solution proposed to address unanticipated out-of-network medical bills. First, oversight and enforcement of network adequacy is needed. Robust network adequacy standards include, but are not limited to, an adequate

ratio of emergency physicians, hospital-based physicians, and on-call specialists and subspecialists to patients, as well as geographic and driving distance standards and maximum wait times. Provider directories must also be accurate and updated regularly to be useful to patients seeking care from in-network providers. In addition, insurers should be held to complying with the prudent layperson standard in existing law for determining coverage for emergency care, so that insured patients are not liable for unexpected costs simply because they were unable to accurately self-diagnose ahead of time whether their symptoms were, in fact, due to an emergency medical condition.

Any solution to address unanticipated medical bills must also require transparency so that all patients who choose in advance to obtain scheduled care from out-of-network physicians, hospitals or other providers are informed prior to receiving care about their anticipated out-of-pocket costs. When scheduling services for patients, providers should be transparent about their own anticipated charges, and insurers should be transparent about the amount of those charges they will cover.

In general, the AMA urges Congress to avoid any solutions that arbitrarily cap payment for physicians treating out-of-network patients. If pursued, guidelines on what out-of-network providers are paid should reflect actual charge data for the same service in the same geographic area and should not be based on a percentage of Medicare rates, which have become increasingly inadequate in covering overhead costs or be based on in-network rates, as either standard would eliminate the need for insurers to negotiate contracts in good faith.

The AMA could support a legislative solution that provides for a mediation or sequential alternative dispute resolution (ADR) process for those circumstances where the minimum payment standard is insufficient due to factors such as the complexity of the patient's medical condition, the special expertise required, comorbidities, and other extraordinary factors. Arbiters should not be required to consult in-network or Medicare rates when making final determinations regarding appropriate reimbursements.

Finally, as noted previously, the AMA strongly supports solutions that keep patients out of the middle of payment rate negotiations. Patients should only be responsible for in-network cost-sharing amounts when experiencing unanticipated medical bills.

Successful State Models

Many states have acted to address unanticipated out-of-network billing and there are several 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

It is important to recognize that most physicians want to be included in payers' networks, if fair contracts are offered. However many physicians are in a weak bargaining position relative to commercial health insurers. Therefore, Congress must incentivize insurers to come to the negotiating table with physicians and offer fair contracts. 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 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 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.

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.

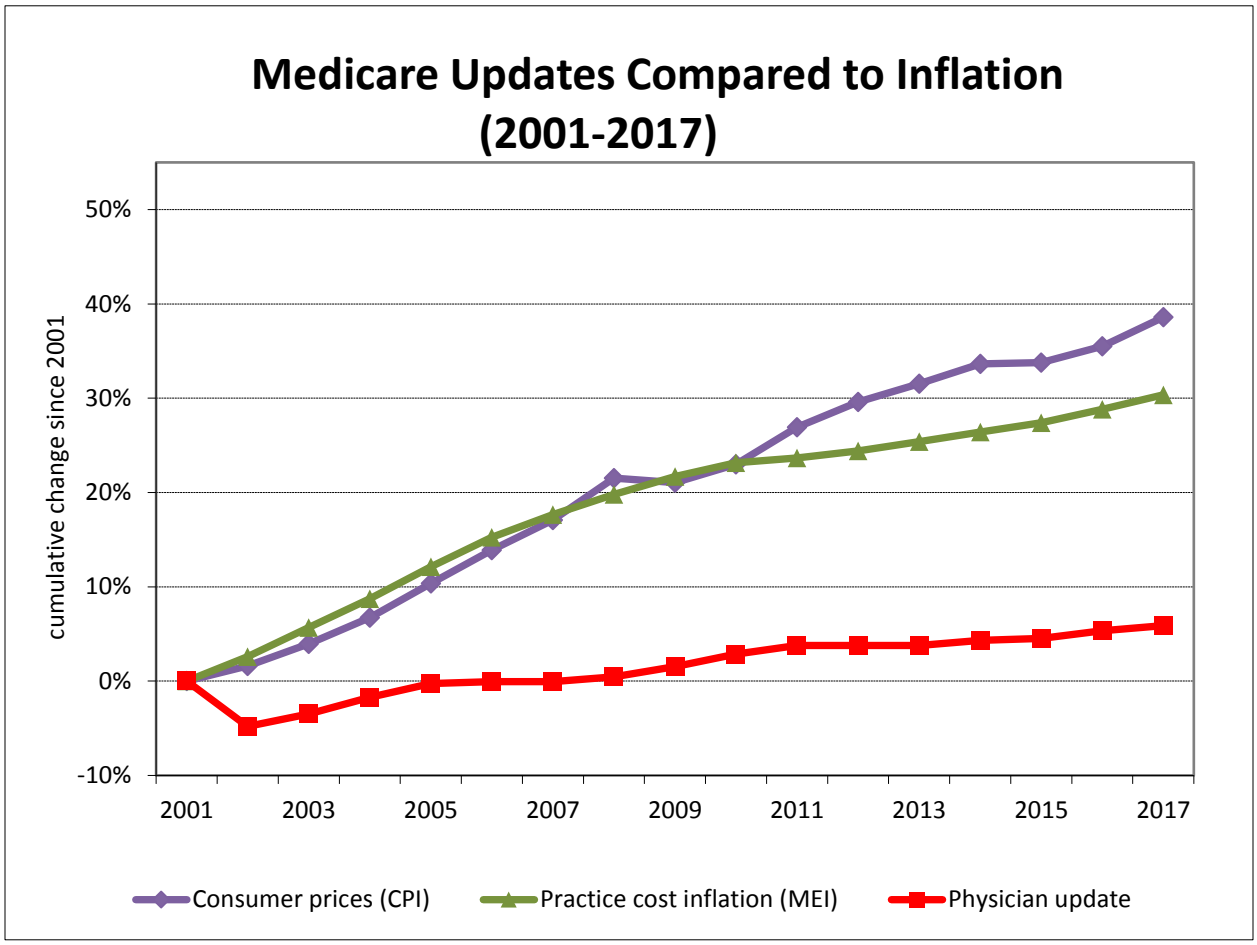
Payment Standards

As AMA has repeatedly pointed out, Medicare payment rates do not reflect the costs of providing care, especially in the commercial market where the population varies greatly. Medicare uses the resource-based relative value scale (RBRVS) system to establish physician payments, determined by the resource costs associated with the total amount of physician resources required to provide a specific service. However, before Medicare rates are finalized, they go through adjustment and conversion processes to meet federal budgetary requirements. Adjustments are done in a budget neutral manner, meaning that if an adjustment increases the payment for one service, it must account for this increase by decreasing payment in another. This establishes artificial decreases in payment for many physician services ever year. And before the final Medicare payment is set, geographically adjusted values are multiplied by a conversion factor - a monetary payment determined by Medicare each year that changes based on the Medicare economic index, adjustments pertaining to budget neutrality and other adjustments stipulated by legislation. After everything is complete, the resulting payment rates are not reflective of markets rates for physician services.

As illustrated by the chart below, Medicare physician payments have not kept up with inflation over the past decade. 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 frozen for calendars years 2020 through 2025.

In comparison:

- 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).



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

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.

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.