AMA
AMERICAN MEDICAL ASSOCIATION

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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, Bennet, Young, Carper, Murkowski, and Hassan:

On behalf of the American Medical Association (AMA) and our physician and student members, I appreciate the opportunity to provide our comments on the "Stopping the Outrageous Practice of Surprise Medical Bills Act," and offer our perspective on the important issue of unanticipated out-of-network care and solutions to protect patients from the financial impact of "surprise" coverage gaps.

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 applaud your leadership in addressing this problem and the process you have established to seek input from a broad spectrum of stakeholders. We believe your proposal provides a foundation for advancing a reasonable and workable solution. There are, however, several changes we believe are essential to achieve a truly balanced approach to resolve this complex issue and urge you to modify the bill to reflect our comments below.

The AMA agrees that **the central tenent of legislation to address unanticipated out-of-network billing must be to protect the patients from the financial hardships associated with these coverage gaps**. We strongly support provisions in your discussion draft 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 in-network deductibles and out-of-pocket maximums.

We also support your focus on transparency. We agree that patients should have access to cost-of-care estimates and believe that insurers, hospitals, and physicians have a responsibility to be as transparent as possible when it comes to cost information for patients. We appreciate the notice provisions required of plans to providers when a new insurance product is available. We also agree that a study would help identify the challenges associated with a single bill for hospital-based care and would look forward to

providing the physician perspective and experience to be included in such a report. The AMA is also pleased to see provisions in your proposed legislation to allow providers who mistakenly or unknowingly balance bill a patient the opportunity to reimburse the patient without penalty.

Additionally, **we support efforts to use an independent dispute resolution (IDR) process as a back-stop when physicians or insurers think a payment rate is not appropriate.** Moreover, we believe that the structured, baseball style arbitration process outlined in your legislation holds potential given the positive results seen in New York where a similar model has been established. While we have serious concerns (see below) with some of the factors the IDR entity must consider when determining a fair payment, we appreciate that several of the allowed factors are relevant to determining payment rates (e.g., the provider's level of training, education, and experience). Additionally, we appreciate that IDR claims can be batched—saving plans and physicians time and money.

While the discussion draft lays out a workable foundation to advance a solution to the surprise billing problem, we have serious concerns with several of the details in the proposal that we believe would ultimately result in patients facing greater network deficiencies.

First, the **AMA believes that establishing a minimum payment standard at the median in-network rate will have a negative effect on fair contracting and the adequacy of provider networks**. Most health insurance markets are heavily concentrated making it difficult for physicians to negotiate fair contracts. While some suggest that physicians can simply not accept contracts they do not believe are fair, in areas where a single health insurer can hold 50, 60, or 70 percent of the market, physician contracts are largely take-it-or-leave-it. And, despite the popular but false narrative that physicians can choose to be in or out of networks, the decision more frequently rests with the insurers who are creating narrower and often inadequate networks. As such, it is very important that any solution to surprise billing not exacerbate the market imbalance that already exists.

The AMA strongly recommends the legislation be amended to include the use of charge-based data in setting a payment standard for out-of-network care, rather than the median in-network rate. In-network rates are negotiated by physicians and insurance plans during the contracting process and physicians agree to significantly discount their fees in exchange for contracted benefits, such as patient volume, increased administrative and billing efficiencies, being listed in the plan's provider directory, and prompt payment of claims. Setting out-of-network payments at those discounted rates would place physicians at a competitive disadvantage when they attempt to negotiate a fair contract, especially when the repercussions of limited networks on plans have been removed. Insurers would also have a financial incentive to drop from their networks providers who have negotiated contracts with rates above the median, which means that patients end up receiving more care out-of-network and benefiting less from the efficiencies and protections that result when their insurer contracts with their physician.

The more effective solution is to incorporate charge data into the minimum payment standard, which would allow for consideration of the physician's fee schedule before the negotiation of rates and the discounting that occurs in exchange for network inclusion. In addition to establishing a fairer payment

rate, this process should provide at least some incentive for health insurers to bring physicians into their network and develop collaborative relationships to benefit patients.

The same logic would apply to the structured IDR process outlined in the discussion draft. **The AMA believes that it is critical that the guidelines or "relevant factors" the arbiter should consider when determining a fair payment specifically include physician charges for the same or similar services in the same region.** Limiting the ability of the arbiter to consider anything beyond the median in-network rates when determining a fair payment essentially establishes those discounted rates as a ceiling for out-of-network payments. Again, this leaves little incentive for insurers to incorporate these providers into their networks and every incentive for insurers to establish contract terms more favorable to them or to drop existing network providers.

It is also essential that **any data used in determining payment or establishing benchmarks come from an independent source** to avoid the type of inherent conflicts we see with insurer-owned databases, such as those discovered in 2009 with United Health Group's Ingenix database. National databases such as FAIR Health are already being used for these purposes, and other databases such as state All Payer Claims Databases (APCDs) have the potential to be used for these purposes as well.

The AMA questions the purpose of including a provision in the discussion draft that would allow insurers to incorporate expenses associated with arbitration into their medical loss ratio calculations. Under the draft's IDR structure, as it is in New York and other states that have established similar processes, there is an inherent risk for a party in taking a claim to arbitration given that the non-prevailing party is responsible for the costs. This incentivizes parties to present reasonable and fair offers and avoid going to arbitration—a positive result of strong IDR policies. However, removing much of that risk for insurers by reducing the financial impact of "losing" will significantly throw off the balance of the IDR process in favor of insurers and could result in an increased number of claims brought to arbitration that could have been solved through informal negotiations.

As mentioned above, the AMA strongly supports 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, scope of their coverage, and breadth of their provider network. We are concerned, however, with the provision in section 6 that would place an unrealistic and unreasonable mandate on providers to provide certain information as a condition of contracting with an insurer. We believe that it is impractical to hold physicians responsible for providing information that is the responsibility of the insurer to maintain, especially when this information may be incomplete, unreliable, inaccurate, and not timely. Moreover, the implementation of this provision is impractical. At the time of scheduling an elective appointment, a physician—without seeing the patient—must identify the insurance of the patient, whether the physician has a contract with that patient's specific insurance plan, the services the patient will reasonably receive, the negotiated amount of those services, and whether the service is in- or out-of-network (which may require discussions with the health plan). On the other hand, the discussion draft provides that insurers—who actually have this information—must provide cost-sharing information to enrollees only when requested by the enrollee, within 48 hours (instead of immediately at the time of scheduling). We also raise the question as to why providers must

give an "expected enrollee cost-sharing" while an insurer would only be required to provide an enrollee with a "good faith estimate of the enrollee's cost-sharing."

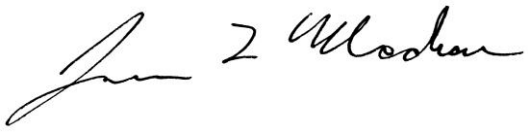
We also believe that section (a)(2) and (b) on page 19 of the discussion draft would need to be piloted, tested, and validated before considering whether the structure of section (a)(1) could be applicable to health care providers. The AMA has serious concerns that these provisions, combined with the proposed minimum payment standards and substantial insurer market power discussed above, would disincentivize insurers from offering fair contract terms to providers, resulting in less patient access to in-network care.

Finally, **the AMA strongly recommends including legislative language aimed at stopping surprise billing before it happens via strong network adequacy requirements.** The AMA supports federal and state legislation that requires, at a minimum, an adequate ratio of physicians to patients (including hospital-based physicians and on-call specialists and subspecialists), as well as geographic and driving distance standards and maximum wait times. Legislation or regulations should also require the active evaluation of networks to determine access to in-network hospital-based care at participating hospitals. In addition to increasing the likelihood that patients will have access to an in-network physician when receiving hospital-based care, strong and enforced network adequacy requirements will ensure that patients can access preventative care, reducing the likelihood they will need hospitalization at all.

Some have recently attempted to separate the issue of network adequacy with that of surprise billing, suggesting that surprise billing solutions should solely be stopgap measures, retroactively addressing network failures. However, we believe this is an oversimplified view and devalues the goal of reducing the frequency of surprise bills and urge you to incorporate stronger network adequacy measures into the legislation.

The AMA appreciates your commitment to addressing the problems associated with unanticipated out-of-network care. We welcome the opportunity to work with you on the recommendations we outlined above to advance legislation that will protect patients and promote greater access to in-network care.

Sincerely,



James L. Madara, MD