



**Statement**

**For the Record**

**of the**

**American Medical Association**

**to the**

**U.S. House of Representatives**  
**Committee on Energy and Commerce**  
**Subcommittee on Health**

**Re: No More Surprises: Protecting Patients from**  
**Surprise Medical Bills**

**June 12, 2019**

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**June 11, 2019**

The American Medical Association (AMA) appreciates the opportunity to provide testimony to the U.S. House of Representatives Committee on Energy and Commerce for the hearing on “No More Surprises: Protecting Patients from Surprise Medical Bills,” and to 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 focus of most congressional discussions and state legislative efforts has been on the specific coverage gap that occurs when a patient unexpectedly receives out-of-network care during a scheduled procedure at an in-network hospital or receives out-of-network care in an emergency situation. As such, our testimony offers solutions that address those narrow situations.

It is important, however, to view this issue as a subset of the coverage gaps and unanticipated medical bills that are plaguing patients and families. Recent efforts to lower health care premiums have induced the rise of high deductible, narrow network, and other limited plan options that may increasingly leave patients with health care bills their insurer will not pay. Moreover, patients are increasingly coming face-to-face with payer policies that attempt to inappropriately narrow the scope of the coverage they purchased. For example, a major health insurer implemented a policy in several states last year that forced patients to pay out-of-pocket for emergency care if the insurer retroactively determined that the patient was not, in fact, experiencing an emergency based on the final diagnosis.

The problem of unanticipated out-of-network bills is complex and requires a balanced approach to resolve. Like this Committee, **the AMA strongly 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.** We also agree

that in these cases balance billing the patient should be restricted if there is a process in place to ensure that providers receive fair payment for their services. Any proposed solutions should also require both providers and insurers to be transparent about anticipated charges, especially for out-of-network care, and insurers must be able to communicate to patients the amount that their insurance will cover.

Specific to the issue of surprise billing, the AMA has long been working with our colleagues in the states, calling for patient-centered solutions that prevent patients from receiving unanticipated out-of-network care and balance bills associated with that care. The AMA encourages Congress to look to states that have already acted to address unanticipated medical bills, specifically those state laws that are functioning well such as New York. The AMA is committed to working with Congress to find a fair solution for all stakeholders that protects patients from unanticipated out-of-network bills.

### **Key Principles in Addressing Unanticipated Out-of-Network Medical Bills**

Fair and workable solutions to unanticipated out-of-network care can come in many forms. The AMA believes that the best solutions have several common principles at their cores.

- **Protect patients.** The AMA supports solutions that keep patients out of the middle of payment rate negotiations. In situations where patients do not have the opportunity to select an in-network provider, they should not be charged any more than the in-network amount. Moreover, payments should count toward their deductibles and out-of-pocket maximums.
- **Network regulation.** Critical to any solution is a focus on increasing the adequacy of provider networks, especially when it comes to hospital-based providers. Network adequacy standards should require, at a minimum, an adequate ratio of physicians, including hospital-based physicians and on-call specialists and subspecialists, to patients, as well as geographic and driving distance standards and maximum wait times. Regulation should also include the active evaluation of networks to determine access to in-network, hospital-based care at participating hospitals.
- **Fair payment to providers.** To ensure that appropriate market incentives remain in place, any solution must incorporate a mechanism to ensure fair payment to providers. Such mechanisms could include a minimum payment standard based on physicians' rates and/or a binding arbitration process that requires the consideration of a number of market-related factors.
- **Transparency.** 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, scope of their coverage, and breadth of their provider network. When scheduling services for patients, providers should be transparent about their own anticipated charges.

Nearly all stakeholders agree that patients should be financially protected from these specific out-of-network bills and that transparency is an important component of a solution, though not a solution in-and-of-itself. However, disagreement among stakeholders has most heavily surrounded the two middle principles we identify above. As such, we would like to provide additional detail as to the importance of addressing these issues in any federal legislation.

## **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. The majority of health insurance markets are highly concentrated and characterized by insurers with high market shares of patients.<sup>1</sup> This increases the risk of those insurers exercising monopsony power and paying physicians below competitive levels. Moreover, given that 56.5 percent of physicians providing patient care are in practices with 10 or fewer physicians, physicians are regularly in a weak bargaining position relative to commercial health insurers.<sup>2</sup> We therefore urge Congress to 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 incited to maintain meaningful access to in-network providers by offering providers competitive contracts; providers are incited 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. 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.

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 the

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<sup>1</sup> American Medical Association. Competition in Health Insurance, A Comprehensive Study of U.S. Markets, 2018 Update. [https://www.ama-assn.org/system/files/2018-11/competition-health-insurance-us-markets\\_1.pdf](https://www.ama-assn.org/system/files/2018-11/competition-health-insurance-us-markets_1.pdf). Published 2018.

<sup>2</sup> Kane C. Updated Data on Physician Practice Arrangements: For the First Time, Fewer Physicians are Owners Than Employees. Policy Research Perspectives, 2019. <https://www.ama-assn.org/system/files/2019-05/prp-fewer-owners-benchmark-survey-2018.pdf>. Published May 2019.

network failure. However, we believe this is an oversimplified view and devalues the goal of reducing the frequency of surprise bills. Our views are shared by the nation’s insurance regulators, who prominently addressed the issue of unanticipated out-of-network care in the National Association of Insurance Commissioners’ (NAICs) recently revised model legislation on network adequacy regulation.<sup>3</sup> The NAIC noted that the revised model legislation “establishes strong standards for network adequacy, while balancing the need for states to establish specific standards that are effective for their markets and geography.”<sup>4</sup>

### **Payment for out-of-network providers**

In general, the AMA urges Congress to avoid any solutions that set minimum payment standards for out-of-network care at noncompetitive rates. Any guidelines on out-of-network provider payment 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 such a standard would eliminate the incentive for insurers to create adequate networks and negotiate contracts in good faith.

#### ***Negotiated rates***

Some proposals to establish a payment standard point to in-network rates as a benchmark for provider payment. Such 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 increased patient volume, being listed in the plan’s provider directory, and prompt payment of claims.

It is also important to recognize that as policymakers and other stakeholders are encouraging value-based contracting, and the frequency of such contracts is growing, aggregated baseline in-network rates become less representative of contract agreements between insurers and physicians, as such rates may not reflect the incentive payments.

Setting out-of-network payments at discounted network rates would place physicians at a competitive disadvantage when the attempt to negotiate a fair contract, especially when the repercussions of limited networks on plans have been removed. It also further disrupts the increasing market imbalance favoring health insurers. Moreover, proposals often use the “average” in-network rate or a percentage of the in-network rate. This is incredibly problematic for those physicians who have negotiated contracts for amounts above the mean, as a health plan would have an incentive to quickly drop a physician from the plan’s network knowing they could use the physician’s services for less when the physician is outside their network.

#### ***Medicare rates***

Medicare payment rates should not be considered as a benchmark standard. Medicare payment rates would be even more problematic than using in-network rates in terms of incenting insurers to fairly contract—they simply 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 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

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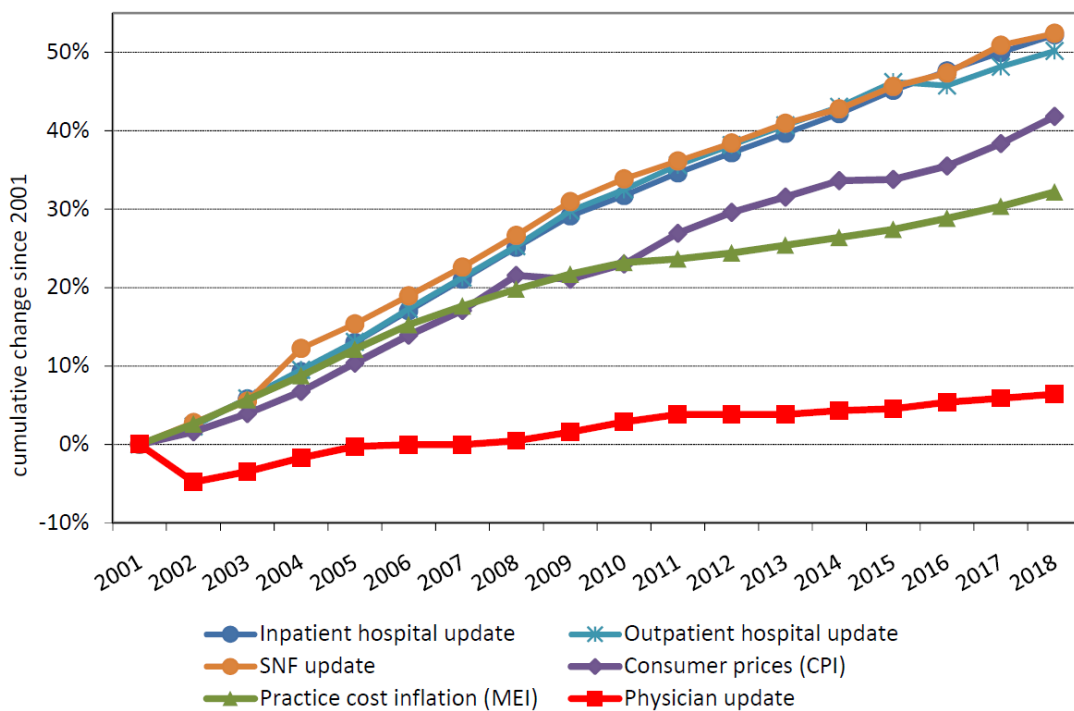
<sup>3</sup> <https://www.naic.org/store/free/MDL-74.pdf>.

<sup>4</sup> [https://www.naic.org/cipr\\_topics/topic\\_network\\_adequacy.htm](https://www.naic.org/cipr_topics/topic_network_adequacy.htm).

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 for another service. 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 pay has barely changed over the last decade and a half, increasing just six percent from 2001 to 2018, 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.

**Medicare Updates Compared to Inflation (2001-2018)**



In comparison, the cost of running a medical practice increased 32 percent between 2001 and 2018, or 1.7 percent per year.<sup>5</sup> In addition economy-wide inflation, as measured the Consumer Price Index, increased 42 percent over this time period (or 2.1 percent per year, on average). Over time, the adequacy of Medicare physician payment rates has eroded significantly. Adjusted for inflation in practice costs, Medicare physician pay declined 19 percent from 2001 to 2018, 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

<sup>5</sup> 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.

of Medicare. Linking out-of-network rates to Medicare would eliminate any incentive for insurers to build adequate networks or offer physicians fair contracts.

### ***Arbitration***

The AMA urges consideration of a structured binding independent dispute resolution (IDR) or arbitration process to help determine a fair payment, either as a backstop when a set payment standard is inappropriate for a particular case, or potentially as a way to achieve fair payment when informal negotiations between insurers and providers fail. Successful implementation of this approach would require an arbiter to have expertise in medical billing and the health care system, as well as guidelines that includes reference to a percentile of charges for the particular service in the same geographic area as reported by an independent database. A solution that incorporates arbitration, including so-call “baseball style” arbitration, also has the potential to encourage parties to reach agreement outside of and before the arbitration process if structured appropriately. We encourage the Committee to work with providers on an arbitration model that considers a number of market-related factors, such as the complexity of the patient’s medical condition, the special expertise required, comorbidities, and other extraordinary factors. Perhaps the most successful state law addressing surprise billing, New York’s 2014 law, uses an arbitration-based model. and has an impressive track record in protecting both patients and incentives for physicians and plans to negotiate.

Specifically, the law:

- Protects patients from unanticipated out-of-network bills.
- 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.
- 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.
- Requires that the IDR process incorporate the 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.

A study released by Georgetown University Health Policy Institute and the Robert Wood Johnson Foundation, reports that New York state officials have seen a dramatic decline in consumer complaints about balance billing since enactment, with one regulator stating to researchers that the law has “downgraded the issue from one of the biggest [consumer concerns out call center receives] to barely an issue.”<sup>6</sup>

Meanwhile, the study points to nearly evenly split numbers in IDR decisions among physicians and insurers and reports among stakeholders that physicians and insurance are incented to work out their payment disputes before filing with IDR. And, importantly, the study notes that regulators report there has not been any indication of an inflationary effect in insurers’ annual premium rate filings.

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<sup>6</sup> <https://georgetown.app.box.com/s/6onkj1jaiy3f1618iv7j0gpzdoew2zu9>

### ***Independent data***

The AMA is concerned with proposals that allow insurers to develop benchmarks using internal data or data controlled by health insurance plans. Such proposals represent a significant step backwards in efforts to promote fairness and transparency in the health care system, especially with health care costs.

Moreover, using insurer-controlled data to determine out-of-network benchmarks opens the door for manipulation and consumer harm. For example, in 2009 a report from the New York Attorney General and a preceding settlement between United Health Group and the AMA, the Medical Society of the State of New York, and the Missouri State Medical Association, illustrated the dangers of using data controlled by insurers to set benchmarks for reimbursement rates. The New York Attorney General concluded that, because United Health Group owned Ingenix (the database used nationwide by health plans to set out-of-network benchmarks), there was an inherent conflict of interest. By using a flawed and conflicted database to determine reimbursement rates for out-of-network care, insurers were increasing profits at the expense of patients and physicians. In order to avoid this conflict, the report stated that “market rates for health care charges should be determined by an independent third party free of conflicts of interest, using a fair, objective, and reliable database.”<sup>7</sup> Given this history of data manipulation, the AMA urges Congress to require that an independent data source be used for any benchmarking that is including in a surprise billing solution.

The AMA was pleased to see funding in the Chairman and Ranking Member’s draft legislation for state all payer claims databases (APCDs). The AMA believes that APCDs have the potential to play an important role in establishing out-of-network payment benchmarks and advancing price transparency, as well as assisting policymakers in understanding price variation, trends in costs and gaps in coverage. Beyond the scope of this legislation, APCDs’ data can also be excellent tools for studying utilization trends, health care disparities, alternative payment models and population health. As such, we would encourage your committee to allow states to mandate submission of data from federally-regulated health plans to APCDs. We believe that states’ ability to create complete datasets that include data from federally regulated plans is critical to the viability of these databases.

### **Conclusion**

The AMA thanks the Committee for this hearing and for your commitment to addressing the problems associated with unanticipated out-of-network care. We welcome the opportunity to work with the Committee and Congress to draft legislation that will both protect patients and promote greater access to in-network care.

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<sup>7</sup> [https://ag.ny.gov/sites/default/files/pdfs/bureaus/health\\_care/FINALHITIngenixReportJan.13,%202009.pdf](https://ag.ny.gov/sites/default/files/pdfs/bureaus/health_care/FINALHITIngenixReportJan.13,%202009.pdf)