September 4, 2019

The Honorable Richard Neal
Chairman
House Committee on Ways and Means
1102 Longworth House Office Building
Washington, D.C. 20515

The Honorable Kevin Brady
Ranking Member
House Committee on Ways and Means
1139 Longworth House Office Building
Washington, D.C. 20515

The Honorable Bobby Scott
Chairman
Committee on Education and Labor
2176 Rayburn House Office Building
Washington, DC 20515

The Honorable Virginia Foxx
Ranking Member
Committee on Education and Labor
2101 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Neal, Ranking Member Brady, Chairman Scott, and Ranking Member Foxx:

The undersigned organizations are committed to our shared goal of protecting the patients we serve from surprise medical bills, and keeping them out of the middle of any billing disputes that might arise between insurers and physicians. As your Committees develop a legislative solution to protect patients from surprise medical bills, we urge you to keep in mind the potential for unintended consequences of congressional action to impact patient access to care, particularly in rural and underserved communities. In order to minimize such consequences, we urge you to include the following policy considerations in your legislative proposals.

Limits are placed on patient responsibility. Patients should be protected from surprise medical bills when they unknowingly receive services from out-of-network providers in in-network facilities, and should be out of any payment disputes between physicians and insurers that can arise. In such situations, patients should only be responsible for in-network cost-sharing, with balance billing prohibited. Such cost-sharing protection should apply to copays, coinsurance, *and* deductibles.

Rate-setting is avoided. A payment process for out-of-network care needs to be established that is keyed to the market value of physician services and that maintains a level-playing field for future in-network contract negotiations. A benchmarked rate would provide insurers with access to a discounted contract rate without providing physicians with the corresponding benefits of contracting in exchange. It then further erodes the value of the insurance coverage that policyholders have purchased by allowing insurers to shift even more costs to them in the form of higher deductibles and other cost-sharing. As physicians, we believe our patients benefit most when we are in network with as many insurers as possible.

Upfront payment is ensured. Any payment process for out-of-network care should ensure that timely (i.e. within 30 days of claim submission), upfront payment is made from the insurer that is of an amount that is commercially reasonable and in line with the services provided by the physician. If any guardrail(s) is specified around this upfront payment in legislation, it must be ensured that it will not disincentivize

insurers from negotiating fair contracts to bring physicians in-network. HHS should provide annual reports to Congress regarding the impact of this payment process, or any such guardrails, on patient access to care, network adequacy, and insurer-provider negotiations.

A robust independent dispute resolution avoids payment disputes from the start. Legislation should provide for a robust independent dispute resolution (IDR) mechanism that incentivizes all parties to act fairly and reasonably from the start in setting charges and payment amounts, without ever needing to be invoked. Then for those circumstances where the insurer's up-front payment is insufficient (whether due to factors such as the complexity of the patient's medical condition, the special expertise required, comorbidities, or other factors unique to that provider or geographic area), the IDR process itself will allow for a quick, efficient, and easy resolution, without the need for attorney involvement or costs to the federal government.

Specifically, the IDR process should:

- Be accessible for all physicians who provide out-of-network care. Legislation should avoid using a "threshold" for IDR eligibility if there is no corresponding protection to ensure adequate reimbursement for claims that do not meet it. If a threshold must be used, it should be set at a level that is realistic in the context of the distribution and range of real-world claims and payments.
- Use a "baseball-style" approach in which the IDR entity can select only between either party's final offers, and the non-prevailing party must bear the costs of the process. This will further minimize the frequency in which IDR is needed to be invoked by either party.
- Allow for "batching" of claims that involve identical plan or issuer and providers, the same or similar procedures, and that occur within reasonable timeframes, with consideration given to the size and resources of the individual or group providing those services.
- Require for certain criteria to be considered during the IDR process, including:
    - The training, experience and specialization of the provider, as well as the provider's quality and outcome metrics;
    - The circumstances and complexity of the case(s) under dispute;
    - Commercially reasonable amounts for comparable services or items in the same geographic area, which reflect the market value of services provided;
    - Demonstration of good-faith efforts (or lack of good faith efforts) made by the out-of-network provider or the plan to contract, and any prior negotiated rates, if applicable;
    - The market share held by the out-of-network health care provider or that of the plan or issuer;
    - Other relevant economic aspects of provider reimbursement for the same specialty within the same geographic area, including those reported by an independent benchmarking database that is unaffiliated with any insurance carrier, as specified by the Secretary.

Allow for elective out-of-network care with patient consent. We believe patients should have the opportunity to knowingly receive care from the out-of-network provider of their choice for elective services. Providers should be forthcoming with their network status during consultations with the patient, just as carriers should properly inform patients about which physicians are within their network.

Following these discussions, patients who fully research their healthcare options and make an informed decision to choose an out-of-network provider should be able to receive a direct bill for that care. This encourages patient choice and empowers patients to determine what is best for their medical needs, while also fostering greater access to care.

Network adequacy is strengthened. Overly narrow network design by insurers has contributed significantly to the current problem. Therefore, strong oversight and enforcement of network adequacy is needed from both federal and state governments. 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.

Insurer transparency is ensured. Provider directories must be accurate and updated regularly by insurers 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.

As you continue to develop legislation to address this important issue, we appreciate your thoughtful approach and offer our assistance and experience to you and your staff. Please do not hesitate to contact Laura Wooster, Associate Executive Director of Public Affairs, at lwooster@acep.org or (202) 370-9298 with any questions.

Sincerely,

American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Emergency Physicians
American College of Radiology
American College of Surgeons
American Medical Association
American Society of Anesthesiologists
American Society of Plastic Surgeons
College of American Pathologists
Congress of Neurological Surgeons