

January 21, 2020

The Honorable Richard Neal, Chair
Committee on Ways and Means
U.S. House of Representatives
2309 Rayburn House Office Building
Washington, DC 20515

The Honorable Kevin Brady, Ranking Member
Committee on Ways and Means
U.S. House of Representatives
1011 Longworth House Office Building
Washington, DC 20515

Dear Chairman Neal and Ranking Member Brady,

On behalf of the undersigned medical organizations, we want to thank you for your efforts to craft a balanced, bipartisan solution to end unanticipated medical bills. The framework you released in December was promising, and we look forward to working with the Ways and Means Committee to develop a more detailed proposal. The medical community remains committed to working with Congress to seek an evenhanded legislative solution to protect patients from unanticipated (“surprise”) medical bills that can occur with narrow health insurance networks and when gaps in health insurance coverage lead them to receive care from out-of-network physicians or other providers, while at the same time facilitating a process to quickly, efficiently and fairly resolve physician and health plan billing disputes.

As conversations regarding a final compromise solution continue, physicians strongly believe that the following provisions are essential to any surprise medical billing legislative solution to ensure patients’ continued access to quality care:

- ❖ **Protecting Patients.** Patients must be protected and should only be **responsible for their in-network cost-sharing amounts**, including deductibles, when receiving unanticipated medical care.
- ❖ **Truly Keeping Patients Out-of-the-Middle.** To keep patients out-of-the-middle of any payment disputes between health plans and providers, **provide physicians with direct payment/assignment of benefits** from the insurer. Under proposals currently being considered in Congress, patients will continue to receive confusing bills from multiple providers following a hospitalization.
- ❖ **Ensuring Reasonable Provider Payment Rates.** Following the delivery of out-of-network medical care, a **reasonable payment should be paid directly to providers**. A benchmark payment rate set at median or mean in-network contract rates or some percentage of Medicare is insufficient because this could increase health care costs by accelerating consolidation in the health care market, jeopardize the emergency care safety net and restrict patient access to in-network physicians.
- ❖ **Establishing a Fair, Accessible and Equitable IDR Process.** If the provider determines that the insurer’s payment is not reasonable, there must be a fair, accessible and equitable IDR process to resolve payment disputes.

An accessible IDR process **must not be restricted to claims above a specific dollar amount/ threshold**. Nor should providers be limited in accessing the IDR process only after a “cooling off” period. To maximize administrative efficiency, providers **should be allowed to “batch” claims** for the same or similar service under the same insurance provider.

Per the IDR process, both the provider and the health plan would submit their final offer to the arbiter, and in a baseball-style manner, the arbiter would select one or the other offers, without additional negotiation. In determining the appropriate payment rate, the **arbiter must consider the following elements:**

- Commercially reasonable rates for comparable services in the same geographic region based on commercial insurance rates from an independent and transparent commercial insurance claims database;
 - Previous contracting history;
 - Demonstration of good-faith efforts (or lack thereof) made by the out-of-network provider or the health plan to enter into network contracts; The market share held by the out-of-network health care provider or the health plan;
 - Level of training, education, experience, outcomes and quality metrics of the physician providing the service;
 - The complexity of the services rendered;
 - Individual patient characteristics; and
 - Other relevant economic and clinical factors.
- ❖ **Supporting a commercial payer claims database.** Commercial insurance data from an independent source that includes ERISA plan data should be used to determine commercially reasonable rates.
- ❖ **Safeguarding Patient Access to Care.** Health plans should be held accountable for **provider networks that are appropriate to meet patients' medical needs** — including ensuring access to specialists and subspecialists on a timely basis, including in a facility. Health plans must also ensure that that **provider directories are up-to-date and accurate**. Patients must be allowed to **access elective out-of-network care** when they so choose.

Thank you for considering our views as you develop bipartisan legislation that will protect patients from surprise medical bills.

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
National Association of Spine Specialists