

## **DURING THE COVID-19 PANDEMIC, PHYSICIANS URGE CONGRESS TO NOT ENACT SURPRISE BILLING LEGISLATION THAT:**

- **FURTHER DESTABILIZES PHYSICIAN PRACTICES & JEOPARDIZES ACCESS TO CARE**
- **EXACERBATES DISRUPTIONS IN OUR HEALTH CARE SYSTEM**
- **FAVORS AN INSURANCE INDUSTRY THAT IS SETTING ALL-TIME RECORD PROFITS**

Physicians appreciate Congress' continued efforts to work toward a more balanced surprise medical billing solution that protects patients from surprise bills, holds insurers accountable, and prevents harm to physician practices to ensure continued patient access to care. As the COVID-19 public health crisis persists, most physician practices have been stressed to unprecedented levels. The economic foundations of physician practices across the country have been damaged. Patient access to physician care is in jeopardy at a time when we need physicians more than ever. Therefore, this would be the worst possible time to adopt lop-sided surprise billing legislation that further destabilizes physician practices, jeopardizes access to care, and erodes the physician safety net that patients need in an emergency.

Physicians continue to seek a balanced solution that incentivizes both physicians and insurers to contract and avoids government rate-setting by providing a fair, independent dispute resolution process that allows arbiters to consider, among other things, market rates.

### **PHYSICIANS ARE CONCERNED WITH THE NEW UNRELEASED HOUSE E&C COMMITTEE AND SENATE HELP COMMITTEE PROPOSAL THAT FAVORS THE INSURANCE INDUSTRY OVER PHYSICIANS AND PATIENTS**

Recently, the physician community became aware of Congressional discussions regarding a new surprise billing proposal from the House Energy and Commerce (E&C) Committee and the Senate HELP Committee. Unfortunately, neither a written summary nor the legislative language for this proposal has been made public, and providers have not been given the opportunity to formally review the proposal. **However, based on our understanding, we have concerns that the new proposal does not provide a fair process to resolve payment disputes between insurers and physicians. It continues to harm physicians and our patients to the benefit of insurers.**

Listed below is our understanding of the key elements of the new E&C and HELP Committee Proposal:

#### **Unreleased House E&C/Senate HELP Committee Proposal Summary:**

- Protects patients from surprise bills;
- Requires insurers to make an upfront payment at the median in-network rate for out-of-network care;
- Establishes an independent dispute resolution (IDR) process;
- If either party disputes the up-front payment, there is a 90-day cooling-off period before they can initiate the IDR process;
- Sets a \$750 monetary claims threshold for physicians to access IDR and allows physicians to batch similar claims to reach the \$750 threshold;
- As part of the IDR process, the arbiter shall consider the median in-network payment rate first and then shall also consider other factors, including prior contracting history between the insurer and provider as of January 1, 2019; and
- Establishes January 1, 2021, as the effective date for banning surprise bills. However, the IDR process does not take effect until January 1, 2022. During 2021, insurers may pay out-of-network providers at the median in-network rate, with an audit process and modest civil monetary penalties for insurers that do not comply.

**Based on our understanding, we offer the following recommendations:**

- **Protecting Patients from Surprise Medical Bills.** Patients must be protected and should only be responsible for their in-network cost-sharing amounts, including deductibles, when receiving unanticipated medical care.
- **Median In-Network Payment Rates for Out-of-Network Services.** Applying the median in-network payment rate as both the initial/interim payment *and* as a primary consideration for the arbiter within the IDR process is unreasonable and disincentivizes insurers to improve network participation. **A median in-network rate on both the front end and back end of the out-of-network payment resolution process will have a strong government rate-setting influence and result in a de facto payment benchmark. Such an approach creates an obstacle to fair and reasonable payments for both out-of-network and in-network physicians by unfairly strengthening the position of insurance companies in their negotiations with physicians.** As the Congressional Budget Office (CBO) reported, previous proposals from the E&C and HELP Committees would result in a 15-20% payment cut for all out-of-network and in-network providers. Especially during the COVID-19 pandemic, Congress should be protecting the viability of physician practices and patient access to care rather than rewarding insurers currently experiencing record profits.
- **Base Payment Year.** To ensure that rates are not artificially reduced in anticipation of the new law, insurers must be required to calculate the median in-network contracted payment rates in effect prior to December 31, 2018, verifiable from an independent commercial claims database. The rate of increase should be indexed to the rate of consumer price index medical inflation.
- **Monetary Threshold for Accessing Independent Dispute Resolution (IDR).** **The IDR process should not include artificial thresholds and barriers to accessing dispute resolution for all instances when an insurer is paying unreasonable rates.** An artificial monetary threshold for claims to be eligible for IDR limits the ability of physicians to access this process. Coupled with other barriers in the process, the proposal would make it difficult for providers to appeal certain claims. **As such, any thresholds or barriers should be eliminated.** The bipartisan Ways and Means Committee legislation, H.R. 5826, the “Consumer Protections Against Surprise Medical Bills Act of 2020,” — which passed the Ways and Means Committee — does not include arbitrary thresholds or barriers and still saves money. Such arbitrary barriers merely allow insurers to game the system and pay even lower rates knowing they cannot be appealed. As CBO opined, there are minimal savings achieved by establishing a threshold to access IDR, and therefore, it is an unfair and unnecessary barrier to IDR.
- **Factors for Arbiter Decision-Making.** **All of the Committee bills appropriately include a baseball-style IDR process, which has been successful in the states that have adopted this approach. Furthermore, to ensure the process is equitable and that payments reflect the marketplace, language should be added to direct the arbiter to give equal consideration to all IDR payment factors.** Such factors should include, among other things, the previous contracting history and all in-network rates for a given marketplace, not just those for that particular insurer and product. For example, the elements included in Section 7 of the bipartisan H.R. 5826 referenced in (j)(5)(B)(ii) and (iii) allows providers to submit to the arbiter for required consideration any information relating to the payment dispute. This is one effective way to ensure that a fair and reasonable decision is reached. Alternatively, S. 1531, the “Stopping The Outrageous Practice of Surprise Medical Bills Act of 2019” — introduced by Senators Cassidy and Hassan and boasting 32 bipartisan cosponsors — lists specific arbitration factors that include commercially reasonable rates, prior contracting history, and other relevant economic aspects of provider reimbursement for the same specialty within the same

geographic area, as another sensible approach. Finally, all rate information should be obtained from an independent database of commercial rates.

- **Access to an IDR Process Prior to Full Implementation.** The implementation date of the IDR process (January 1, 2022) is more than a year after the effective date of the ban on surprise medical bills (January 1, 2021). Therefore, during the 2021 interim implementation year, payments to out-of-network physicians will be based on median in-network rates with no ability to adjudicate disputes on this rate. **We strongly oppose this bifurcated implementation process and recommend aligning the implementation dates.**
- **Network Adequacy.** To date, none of the Congressional surprise billing legislation addresses the adequacy of insurance company provider networks, which is the crux of the problem. Patients would be much less likely to face “out-of-network” surprise bills if insurers were held accountable and required to have sufficient access to providers to meet their enrollee’s medical needs — including geographic, specialty and subspecialty access — in a timely manner. Insurers must also maintain accurate and up-to-date provider directories. Furthermore, patients must be allowed to access elective out-of-network care when they so choose. Finally, legislation must mandate enforceable network adequacy requirements for ERISA plans.

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