

October 16, 2019

The Honorable Nancy Pelosi  
Speaker  
U.S. House of Representatives  
H-222 U.S. Capitol  
Washington, DC 20515

The Honorable Kevin McCarthy  
Republican Leader  
U.S. House of Representatives  
H-204 U.S. Capitol  
Washington, DC 20515

Dear Speaker Pelosi and Republican Leader McCarthy:

The undersigned medical organizations remain committed to working with Congress to seek a balanced legislative solution to protect patients from unanticipated (“surprise”) medical bills that can occur when gaps in health insurance coverage lead them to receive care from out-of-network physicians or other providers. We represent hundreds of thousands of practicing physicians who provide care to millions of Americans every day in a variety of practice settings. We strongly believe that, in situations where a coverage gap occurs and patients unknowingly or without a choice receive care from an out-of-network physician or other provider, patients should be held harmless for any costs above their in-network cost-sharing, and their cost-sharing should count toward deductibles and out-of-pocket maximums. Patients should be completely removed from any subsequent payment disputes between their health insurance company and an out-of-network provider when they experience an unanticipated coverage gap.

After ensuring that patients are protected, it is essential that any legislation does not create new imbalances in the private health care marketplace. The health insurance market is already [heavily consolidated](#), which can result in artificially low payment rates and anticompetitive harms to both consumers and providers of care. We are highly concerned that the rate-setting provisions in current bills further shift marketplace leverage to health insurers at the expense of providers. As a consequence, this imbalance will likely lead to access problems for patients seeking hospital-based care from on-call specialists, as well as precipitate staffing shortages in rural areas and other underserved communities. Furthermore, according to the [Congressional Budget Office](#), “The vast majority of health care is delivered inside patients’ networks, and more than 80 percent of the estimated budgetary effects of title I [of the “Lower Health Care Costs Act” (S. 1895)] would arise from changes to in-network payment rates.” In other words, in-network providers who have not contributed to the problem will bear the impact of the rate-setting scheme. CBO reached the same conclusion in its analysis of [Title IV of H.R. 2328](#), the “No Surprises Act.”

As House committees continue to work toward a legislative solution, we believe there is strong evidence that pursuing a different, balanced approach would achieve the goal of protecting patients from surprise bills while maintaining their access to care in more competitive markets. This balanced approach includes a timely upfront, commercially reasonable payment for out-of-network services, and an efficient independent dispute resolution (IDR) process designed to incentivize health insurers to make a fair initial offer of payment for out-of-network care provided to their customers while also preventing bills from physicians or other providers that are outside generally acceptable ranges. It also should encourage, rather than discourage, health insurance companies and providers to contract for in-network care to avoid adverse market distortions or patient access problems.

The IDR process should be structured so that a range of factors is considered in determining a mutually fair payment—such as the complexity of the service rendered, the experience of the physician providing the service, the rate that physicians or other providers charge for the service in a geographic area, and

commercial insurance data from an independent and transparent source. There is strong, compelling evidence that this approach is successfully resolving out-of-network payment disputes between health insurance companies and out-of-network providers without negatively impacting patient access to hospital-based services or increasing insurance premiums.

In an October 1, 2019 [Op-Ed](#) in the *New York Daily News*, Linda Lacewell, the Superintendent of the New York State Department of Financial Services, said that from March 15, 2015 through the end of 2018, the New York out-of-network law has saved patients more than \$400 million in emergency services alone, reduced out-of-network billing in New York by 34 percent, and lowered in-network emergency physician payments by 9 percent. She said: “This law protects consumers from out-of-network bills from emergency physician services in a hospital and surprise bills in hospitals and other out-patient settings. It includes extensive consumer protections, including holding consumers harmless for costs beyond in-network deductibles, copays or coinsurance, improved disclosure, enhanced network adequacy requirements, expanded appeal rights, and easier claims submission. At the center of the law is a process called Independent Dispute Resolution (IDR), which removes consumers from billing disputes. Instead, providers and health plans settle billing, and use the IDR process for disputes.”

While some insurance companies have claimed that the proposed IDR process would be too cumbersome, that is not the case in reality. In New York, for example, the process essentially involves visiting [www.dfs.ny.gov](http://www.dfs.ny.gov) and filling out a two-page form. This contrasts with the often voluminous filing requirements necessary for physicians and other providers to obtain prior authorization from many health insurance companies just to provide covered benefits to their patients, even for mental health and substance use disorder treatments.

In July, the House Energy and Commerce Committee took a critical step forward by adopting an IDR process in Title IV of H.R. 2328, the “No Surprises Act,” as a backstop should the bill’s underlying payment methodology not result in a resolution that is acceptable to both parties. However, additional improvements should be made going forward to ensure that the bill has a fair, market-focused approach that retains strong protections for patients while preserving the viability of physician practices.

Specifically:

- The \$1,250 threshold to trigger the IDR process should be lowered; it is too high to ensure adequate reimbursement for claims that do not meet this amount. Any threshold should be set at a level that is realistic and based on the distribution and range of real-world claims and payments.
- The IDR threshold should allow for batching of claims that involve identical plans and providers and the same or similar procedures that occur within reasonable timeframes, with consideration given to the size and resources of the individual or group providing those services. This is to ensure that providers, regardless of specialty and cost of services, can benefit from a fair IDR process.
- The initial payment of a median in-network rate should be changed to reflect a commercially reasonable rate that is fair to all stakeholders in the private market; these rates should include actual local charges as determined through an independent claims database.

- Median in-network rates established by individual insurers are problematic because they do not rely on a known independent, transparent, and verifiable database. Insurer datasets cannot be relied on for these rates, as proven by the 2009 class action settlement against United Health Care for \$300 million in which the usual, customary, and reasonable database for determining out-of-network payments operated by its subsidiary, Ingenix, was found to be inaccurate and unreliable. More recent efforts by the Georgia Department of Insurance to collect plan-reported data on mean and median contracted payment rates yielded similar inconsistencies and was abandoned.

Finally, a balanced solution requires that insurers be held accountable for addressing their own contributions to the problem. Any legislation addressing surprise billing should also establish strong, measurable, and enforceable network adequacy requirements, as well as require stronger enforcement of federal mental health and substance use disorder parity and prudent layperson laws. This is essential to ensure that insurers maintain adequate provider networks and do not force patients to go out-of-network to access care that they need.

We look forward to working with the Congress to make these refinements as the process moves forward and ensure that any final bill represents a fair, market-based approach that treats all stakeholders equally while protecting patient access to care.

Sincerely,

American Medical Association  
American Academy of Allergy, Asthma & Immunology  
American Academy of Dermatology Association  
American Academy of Emergency Medicine  
American Academy of Facial Plastic and Reconstructive Surgery  
American Academy of Neurology  
American Academy of Ophthalmology  
American Academy of Otolaryngic Allergy  
American Academy of Otolaryngology- Head and Neck Surgery  
American Academy of Physical Medicine and Rehabilitation.  
American Association for Geriatric Psychiatry  
American Association of Child & Adolescent Psychiatry  
American Association of Hip and Knee Surgeons  
American Association of Neurological Surgeons  
American Association of Orthopaedic Surgeons  
American College of Cardiology  
American College of Cosmetic Surgery  
American College of Emergency Physicians  
American College of Gastroenterology  
American College of Obstetricians and Gynecologists  
American College of Osteopathic Surgeons  
American College of Physicians  
American College of Radiation Oncology  
American College of Radiology  
American College of Rheumatology  
American College of Surgeons

American Contact Dermatitis Society  
American Medical Women's Association  
American Orthopaedic Foot & Ankle Society  
American Osteopathic Association  
American Psychiatric Association  
American Society for Clinical Pathology  
American Society for Laser Medicine and Surgery  
American Society for Radiation Oncology  
American Society for Surgery of the Hand  
American Society of Anesthesiologists  
American Society of Cataract and Refractive Surgery  
American Society of Clinical Oncology  
American Society of Dermatopathology  
American Society of General Surgeons  
American Society of Hematology  
American Society of Neuroimaging  
American Society of Neuroradiology  
American Society of Nuclear Cardiology  
American Society of Plastic Surgeons  
American Society of Retina Specialists  
American Urological Association  
Association of American Medical Colleges  
Association of University Radiologists  
College of American Pathologists  
Congress of Neurological Surgeons  
Medical Group Management Association  
National Association of Spine Specialists  
North American Neuro-Ophthalmology Society  
Renal Physicians Association  
Society for Vascular Surgery  
Society of American Gastrointestinal and Endoscopic Surgeons  
Society of Critical Care Medicine  
Society of Hospital Medicine  
Society of Interventional Radiology  
Society of Thoracic Surgeons  
Spine Intervention Society

Medical Association of the State of Alabama  
Alaska State Medical Association  
Arizona Medical Association  
Arkansas Medical Society  
California Medical Association  
Colorado Medical Society  
Connecticut State Medical Society  
Medical Society of Delaware  
Medical Society of the District of Columbia  
Florida Medical Association Inc

Medical Association of Georgia  
Hawaii Medical Association  
Idaho Medical Association  
Illinois State Medical Society  
Indiana State Medical Association  
Iowa Medical Society  
Kansas Medical Society  
Kentucky Medical Association  
Maine Medical Association  
MedChi, The Maryland State Medical Society  
Massachusetts Medical Society  
Michigan State Medical Society  
Minnesota Medical Association  
Mississippi State Medical Association  
Missouri State Medical Association  
Montana Medical Association  
Nebraska Medical Association  
Nevada State Medical Association  
New Hampshire Medical Society  
Medical Society of New Jersey  
New Mexico Medical Society  
Medical Society of the State of New York  
North Dakota Medical Association  
Ohio State Medical Association  
Oklahoma State Medical Association  
Oregon Medical Association  
Pennsylvania Medical Society  
Rhode Island Medical Society  
South Carolina Medical Association  
South Dakota State Medical Association  
Tennessee Medical Association  
Texas Medical Association  
Utah Medical Association  
Vermont Medical Society  
Medical Society of Virginia  
Washington State Medical Association  
West Virginia State Medical Association  
Wisconsin Medical Society  
Wyoming Medical Society

cc: The Honorable Lamar Alexander, Chairman  
U.S. Senate Committee on Health, Education, Labor & Pensions  
  
The Honorable Pat Murray, Ranking Member  
U.S. Senate Committee on Health, Education, Labor & Pensions

Honorable Nancy Pelosi  
Honorable Kevin McCarthy  
October 16, 2019  
Page 6

The Honorable Frank Pallone, Jr., Chairman  
House Committee on Energy & Commerce

The Honorable Greg Walden, Ranking Member  
House Committee on Energy & Commerce

The Honorable Richard Neal, Chairman  
House Committee on Ways and Means

The Honorable Kevin Brady, Ranking Member  
House Committee on Ways and Means

The Honorable Bobby Scott, Chairman  
Committee on Education & Labor

The Honorable Virginia Fox, Republican Leader  
Committee on Education & Labor

October 16, 2019

The Honorable Mitch McConnell  
Senate Majority Leader  
United States Senate  
S-230 U.S. Capitol  
Washington, DC 20510

The Honorable Charles Schumer  
Democratic Leader  
United States Senate  
S-221 U.S. Capitol  
Washington, DC 20510

Dear Majority Leader McConnell and Democratic Leader Schumer:

The undersigned medical organizations remain committed to working with Congress to seek a balanced legislative solution to protect patients from unanticipated (“surprise”) medical bills that can occur when gaps in health insurance coverage lead them to receive care from out-of-network physicians or other providers. We represent hundreds of thousands of practicing physicians who provide care to millions of Americans every day in a variety of practice settings. We strongly believe that, in situations where a coverage gap occurs and patients unknowingly or without a choice receive care from an out-of-network physician or other provider, patients should be held harmless for any costs above their in-network cost-sharing, and their cost-sharing should count toward deductibles and out-of-pocket maximums. Patients should be completely removed from any subsequent payment disputes between their health insurance company and an out-of-network provider when they experience an unanticipated coverage gap.

After ensuring that patients are protected, it is essential that any legislation does not create new imbalances in the private health care marketplace. The health insurance market is already [heavily consolidated](#), which can result in artificially low payment rates and anticompetitive harms to both consumers and providers of care. We are highly concerned that the rate-setting provisions in current bills further shift marketplace leverage to health insurers at the expense of providers. As a consequence, this imbalance will likely lead to access problems for patients seeking hospital-based care from on-call specialists, as well as precipitate staffing shortages in rural areas and other underserved communities. Furthermore, according to the [Congressional Budget Office](#), “The vast majority of health care is delivered inside patients’ networks, and more than 80 percent of the estimated budgetary effects of title I [of the “Lower Health Care Costs Act” (S. 1895)] would arise from changes to in-network payment rates.” In other words, in-network providers who have not contributed to the problem will bear the impact of the rate-setting scheme. CBO reached the same conclusion in its analysis of [Title IV of H.R. 2328](#), the “No Surprises Act.”

As House committees continue to work toward a legislative solution, we believe there is strong evidence that pursuing a different, balanced approach would achieve the goal of protecting patients from surprise bills while maintaining their access to care in more competitive markets. This balanced approach includes a timely upfront, commercially reasonable payment for out-of-network services, and an efficient independent dispute resolution (IDR) process designed to incentivize health insurers to make a fair initial offer of payment for out-of-network care provided to their customers while also preventing bills from physicians or other providers that are outside generally acceptable ranges. It also should encourage, rather than discourage, health insurance companies and providers to contract for in-network care to avoid adverse market distortions or patient access problems.

The IDR process should be structured so that a range of factors is considered in determining a mutually fair payment—such as the complexity of the service rendered, the experience of the physician providing the service, the rate that physicians or other providers charge for the service in a geographic area, and

commercial insurance data from an independent and transparent source. There is strong, compelling evidence that this approach is successfully resolving out-of-network payment disputes between health insurance companies and out-of-network providers without negatively impacting patient access to hospital-based services or increasing insurance premiums.

In an October 1, 2019 [Op-Ed](#) in the *New York Daily News*, Linda Lacewell, the Superintendent of the New York State Department of Financial Services, said that from March 15, 2015 through the end of 2018, the New York out-of-network law has saved patients more than \$400 million in emergency services alone, reduced out-of-network billing in New York by 34 percent, and lowered in-network emergency physician payments by 9 percent. She said: “This law protects consumers from out-of-network bills from emergency physician services in a hospital and surprise bills in hospitals and other out-patient settings. It includes extensive consumer protections, including holding consumers harmless for costs beyond in-network deductibles, copays or coinsurance, improved disclosure, enhanced network adequacy requirements, expanded appeal rights, and easier claims submission. At the center of the law is a process called Independent Dispute Resolution (IDR), which removes consumers from billing disputes. Instead, providers and health plans settle billing, and use the IDR process for disputes.”

While some insurance companies have claimed that the proposed IDR process would be too cumbersome, that is not the case in reality. In New York, for example, the process essentially involves visiting [www.dfs.ny.gov](http://www.dfs.ny.gov) and filling out a two-page form. This contrasts with the often voluminous filing requirements necessary for physicians and other providers to obtain prior authorization from many health insurance companies just to provide covered benefits to their patients, even for mental health and substance use disorder treatments.

In July, the House Energy and Commerce Committee took a critical step forward by adopting an IDR process in Title IV of H.R. 2328, the “No Surprises Act,” as a backstop should the bill’s underlying payment methodology not result in a resolution that is acceptable to both parties. However, additional improvements should be made going forward to ensure that the bill has a fair, market-focused approach that retains strong protections for patients while preserving the viability of physician practices.

Specifically:

- The \$1,250 threshold to trigger the IDR process should be lowered; it is too high to ensure adequate reimbursement for claims that do not meet this amount. Any threshold should be set at a level that is realistic and based on the distribution and range of real-world claims and payments.
- The IDR threshold should allow for batching of claims that involve identical plans and providers and the same or similar procedures that occur within reasonable timeframes, with consideration given to the size and resources of the individual or group providing those services. This is to ensure that providers, regardless of specialty and cost of services, can benefit from a fair IDR process.
- The initial payment of a median in-network rate should be changed to reflect a commercially reasonable rate that is fair to all stakeholders in the private market; these rates should include actual local charges as determined through an independent claims database.



- Median in-network rates established by individual insurers are problematic because they do not rely on a known independent, transparent, and verifiable database. Insurer datasets cannot be relied on for these rates, as proven by the 2009 class action settlement against United Health Care for \$300 million in which the usual, customary, and reasonable database for determining out-of-network payments operated by its subsidiary, Ingenix, was found to be inaccurate and unreliable. More recent efforts by the Georgia Department of Insurance to collect plan-reported data on mean and median contracted payment rates yielded similar inconsistencies and was abandoned.

Finally, a balanced solution requires that insurers be held accountable for addressing their own contributions to the problem. Any legislation addressing surprise billing should also establish strong, measurable, and enforceable network adequacy requirements, as well as require stronger enforcement of federal mental health and substance use disorder parity and prudent layperson laws. This is essential to ensure that insurers maintain adequate provider networks and do not force patients to go out-of-network to access care that they need.

We look forward to working with the Congress to make these refinements as the process moves forward and ensure that any final bill represents a fair, market-based approach that treats all stakeholders equally while protecting patient access to care.

Sincerely,

American Medical Association  
American Academy of Allergy, Asthma & Immunology  
American Academy of Dermatology Association  
American Academy of Emergency Medicine  
American Academy of Facial Plastic and Reconstructive Surgery  
American Academy of Neurology  
American Academy of Ophthalmology  
American Academy of Otolaryngic Allergy  
American Academy of Otolaryngology- Head and Neck Surgery  
American Academy of Physical Medicine and Rehabilitation.  
American Association for Geriatric Psychiatry  
American Association of Child & Adolescent Psychiatry  
American Association of Hip and Knee Surgeons  
American Association of Neurological Surgeons  
American Association of Orthopaedic Surgeons  
American College of Cardiology  
American College of Cosmetic Surgery  
American College of Emergency Physicians  
American College of Gastroenterology  
American College of Obstetricians and Gynecologists  
American College of Osteopathic Surgeons  
American College of Physicians  
American College of Radiation Oncology  
American College of Radiology  
American College of Rheumatology

American College of Surgeons  
American Contact Dermatitis Society  
American Medical Women's Association  
American Orthopaedic Foot & Ankle Society  
American Osteopathic Association  
American Psychiatric Association  
American Society for Clinical Pathology  
American Society for Laser Medicine and Surgery  
American Society for Radiation Oncology  
American Society for Surgery of the Hand  
American Society of Anesthesiologists  
American Society of Cataract and Refractive Surgery  
American Society of Clinical Oncology  
American Society of Dermatopathology  
American Society of General Surgeons  
American Society of Hematology  
American Society of Neuroimaging  
American Society of Neuroradiology  
American Society of Nuclear Cardiology  
American Society of Plastic Surgeons  
American Society of Retina Specialists  
American Urological Association  
Association of American Medical Colleges  
Association of University Radiologists  
College of American Pathologists  
Congress of Neurological Surgeons  
Medical Group Management Association  
National Association of Spine Specialists  
North American Neuro-Ophthalmology Society  
Renal Physicians Association  
Society for Vascular Surgery  
Society of American Gastrointestinal and Endoscopic Surgeons  
Society of Critical Care Medicine  
Society of Hospital Medicine  
Society of Interventional Radiology  
Society of Thoracic Surgeons  
Spine Intervention Society

Medical Association of the State of Alabama  
Alaska State Medical Association  
Arizona Medical Association  
Arkansas Medical Society  
California Medical Association  
Colorado Medical Society  
Connecticut State Medical Society  
Medical Society of Delaware  
Medical Society of the District of Columbia

Florida Medical Association Inc  
Medical Association of Georgia  
Hawaii Medical Association  
Idaho Medical Association  
Illinois State Medical Society  
Indiana State Medical Association  
Iowa Medical Society  
Kansas Medical Society  
Kentucky Medical Association  
Maine Medical Association  
MedChi, The Maryland State Medical Society  
Massachusetts Medical Society  
Michigan State Medical Society  
Minnesota Medical Association  
Mississippi State Medical Association  
Missouri State Medical Association  
Montana Medical Association  
Nebraska Medical Association  
Nevada State Medical Association  
New Hampshire Medical Society  
Medical Society of New Jersey  
New Mexico Medical Society  
Medical Society of the State of New York  
North Dakota Medical Association  
Ohio State Medical Association  
Oklahoma State Medical Association  
Oregon Medical Association  
Pennsylvania Medical Society  
Rhode Island Medical Society  
South Carolina Medical Association  
South Dakota State Medical Association  
Tennessee Medical Association  
Texas Medical Association  
Utah Medical Association  
Vermont Medical Society  
Medical Society of Virginia  
Washington State Medical Association  
West Virginia State Medical Association  
Wisconsin Medical Society  
Wyoming Medical Society

cc: The Honorable Lamar Alexander, Chairman  
U.S. Senate Committee on Health, Education, Labor & Pensions

Honorable Mitch McConnell  
Honorable Charles Schumer  
October 16, 2019  
Page 6

The Honorable Pat Murray, Ranking Member  
U.S. Senate Committee on Health, Education, Labor & Pensions

The Honorable Frank Pallone, Jr., Chairman  
House Committee on Energy & Commerce

The Honorable Greg Walden, Ranking Member  
House Committee on Energy & Commerce

The Honorable Richard Neal, Chairman  
House Committee on Ways and Means

The Honorable Kevin Brady, Ranking Member  
House Committee on Ways and Means

The Honorable Bobby Scott, Chairman  
Committee on Education & Labor

The Honorable Virginia Fox, Republican Leader  
Committee on Education & Labor