American College of Physicians
Leading Internal Medicine, Improving Lives

May 28, 2019

The Honorable Frank Pallone
Chair
House Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Greg Walden
Ranking Member
House Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Pallone and Ranking Member Walden:

On behalf of the American College of Physicians (ACP), I am writing to express our support for your bipartisan efforts to protect health care consumers/patients from the growing problem of "surprise billing." The College appreciates this opportunity to comment on your discussion draft, as released on May 14th entitled the *No Surprises Act*, which addresses billing and insurer practices that often leave patients with unexpected, high out-of-pocket costs in connection with care provided in situations they cannot reasonably avoid. We appreciate your leadership on this issue and believe that the discussion draft represents a positive step forward in addressing this problem. We are pleased to provide ACP's perspective and suggestions on certain provisions of the draft where we have established policy and where it impacts our patients and the care we provide as internists.

The American College of Physicians is the largest medical specialty organization and the second largest physician group in the United States. ACP members include 154,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

**OVERVIEW AND ACP POLICY**

Surprise billing, or unexpected bills patients receive as the result of receiving care from an out-of-network physician or facility or unexpected in-network service charges, can be a financial burden on patients that can contribute to medical/consumer debt. Medical debt is a growing concern, even for those who are insured. The Kaiser Family Foundation found more than 25 percent of adults reported that they or someone in their household have challenges created by medical debt, including 20 percent of insured individuals under the age of 65.

Reports of high and unanticipated "surprise" medical bills, especially in emergency situations for patients who do have health insurance coverage and are being treated at in-network facilities, have resulted in calls for the federal government to take both legislative and regulatory action. We appreciate that lawmakers in both chambers, as well as the administration, are now heeding this call and are working in a bipartisan fashion to develop legislation to address this growing problem.

ACP's guiding policy on surprise medical bills is outlined in its position paper entitled, "Improving Health Care Efficacy and Efficiency Through Increased Transparency." Specifically:

> *ACP supports efforts to provide greater protections for patients from unexpected out-of-network health care costs, particularly for costs incurred during an emergency situation or medical situation in which additional services are provided by out-of-network clinicians without the patient's prior knowledge. While the College reaffirms the right of physicians to establish their own fees and to choose whether or not to participate as an in-network clinician, ACP supports establishing processes to reduce the risk for "surprise" bills for out-of-network services for which a patient was unable to obtain estimates for services prior to receipt of care or was not given the option to select an in-network clinician. Health plans also have an affirmative obligation to pay fairly and appropriately for services provided in- and out-of-network, and regulators should ensure network adequacy in all fields, including emergency care.*
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> *Efforts to reduce the negative impact of surprise billing should be made at the state and federal levels. Legislation aiming to limit surprise billing should, at a minimum, include one or more of the following components:*
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> *• Support for increased pricing and out-of-pocket cost transparency;*
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> *• Dispute resolution process;*
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> *• Assessment of economic impact on patients, clinicians and non-physician providers, and payers.*

**ACP COMMENTS ON DISCUSSION DRAFT**

The discussion draft eliminates surprise out-of-network billing for emergency services across different sites of care (e.g., hospitals, ambulatory surgery centers, freestanding emergency departments). It also eliminates surprise billing for out-of-network nonemergency services received at an in-network facility from "facility-based providers," which the draft defines to include anesthesiologists, radiologists, pathologists, neonatologists, assistant surgeons, hospitalists, intensivists, and any additional "provider" types specified by the Secretary of Health and Human Services (HHS). The draft achieves this by applying the following patient protections to the settings/services above: it requires the health plan to treat the out-of-network service as if it were in-network for purposes of enrollee cost-sharing, deductibles, and out-of-pocket limits; it sets a minimum payment amount that the health plan must pay to the out-of-network "provider"; and it prohibits out-of-network "providers" from "balance billing" patients -- that is, from billing the patient any amount above the patient's in-network cost-sharing. " (While the term "provider" is used throughout the draft, as is customary for legislation, ACP for its own purposes uses the term *physician* when referring to physicians, or *clinician* when referring to physicians and other health care professionals; accordingly, we have put "providers" in quotes in the following comments to clarify when we are referring to the language of the discussion draft).

**Emergency/Nonemergency Situations**: The discussion draft essentially holds patients harmless from surprise medical bills in emergency situations and some nonemergency situations, as so defined in the draft, and holds them responsible only for the in-network rate. ACP supports this approach. In emergency situations, there simply is not enough time for the patient to know which clinicians are in- or out-of-network and in nonemergency situations, it is critical that a patient be given the knowledge up front that a clinician he/she will see is out-of-network so that the patient can make an informed choice before the care is rendered.

**Ambulatory Services**: The discussion draft does not include patient protections applicable to ambulatory services in either emergency or nonemergency situations, which is of concern to ACP. ACP policy supports patient protections from unexpected out-of-network health care costs, particularly for costs incurred during an emergency situation or medical situation in which additional services are provided by out-of-network clinicians without the patient's prior knowledge. Patients do not have the clinical expertise to be able to diagnose their condition and determine whether or not they need an ambulance, especially in a perceived emergency situation where minutes could mean the difference between life or death. Because ambulatory services are often delivered out-of-network, this could result in surprise medical bills for patients needing those services. We urge you to make the patient protections in the discussion draft applicable to ambulatory services, certainly in the case of emergency situations.

**Median Contracted Rate:** The discussion draft includes a patient protection that sets a minimum payment amount that the health plan must pay to the out-of-network "provider." More specifically, it establishes a minimum payment standard set at the median contracted (in-network) rate for the service in the geographic area the service was delivered. It directs the Secretary of HHS to determine (through the rulemaking process) the methodology the plan or issuer will use to determine the median contracted rate, the information the plan or issuer will share with the non-participating "provider" involved when making a determination, and the geographic regions applied. It also preserves a state's ability to determine its own payment standards for plans regulated by the state. ACP policy reaffirms the right of physicians to establish their own fees and to choose whether or not to participate as an in-network physician. ACP prefers that caps on payment for physicians treating out-of-network patients be avoided, preferably by establishing an arbitration process that would allow an independent arbitrator to establish an appropriate and fair payment level between the insurers' in-network rate and the clinician's charge. Should Congress choose to establish guidelines or limits on what out-of-network clinicians are paid, such limits or guidelines should reflect the actual charge data for the same service in the same geographic area from a statistically significant and wholly independent database. They should not be based on a percentage of Medicare rates, which have become increasingly inadequate in covering overhead costs, nor should they be based on in-network rates, which would eliminate the need for insurers to negotiate contracts in good faith.

**Balance Billing/Informed Consent**: The discussion draft prohibits balance billing by out-of-network emergency and facility-based clinicians and non-physician "providers", as so defined in the draft. It also requires that patients receiving scheduled care be given written and oral notice at the time of scheduling about the clinician's or "provider's" network status and any potential charges they could be liable for if treated by an out-of-network clinician or "provider." If a patient does not sign a consent form acknowledging that the clinician or "provider" is out-of-network, the patient cannot be balance billed. ACP supports establishing ways to hold patients harmless for "surprise" bills for out-of-network services for which a patient was unable to obtain estimates for services prior to the receipt of care or was not given the option to select an in-network clinician or "provider." ACP believes health plans and health care facilities should clearly communicate to a consumer whether a clinician or "provider" is in-network or out-of-network and the estimated out-of-pocket payment responsibilities of the consumer.

**State All-Payer Claims Databases**: The discussion draft provides $50 million in grants for states looking to develop or maintain an all-payer claims database (APCD). ACP supports efforts to help states

establish all-payer claims databases and to require private and public health plans to submit data in a standardized manner to such databases. The APCD approach aggregates claims data from all relevant sources within the state, and this larger degree of transparency in health care information can be used for such purposes as creating tools for consumers and purchasers to compare prices and quality across payers as they make health care decisions or to provide statewide information on costs, quality, utilization patterns, and both access and barriers to care to inform health care policy decisions. APCDs directly address the current problem of silos of health care information—information is available from some, but not all, relevant public and private sources and is not reported in a standard manner that would facilitate use by multiple stakeholders. In order to expand the use, function, and benefit of APCDs, policymakers and systems architects should structure APCDs to ensure the ability to link the system to additional sources of information like vital statistics databases and health information exchanges.

**Network Adequacy:** The discussion draft is silent on the issue of network adequacy as a possible contributing factor in surprise medical billing. How network adequacy and the fair payment of services for physicians may contribute to the increase in patients receiving out-of-network care should also be examined to ensure an appropriate number of available in-network physicians, especially in the emergency setting. Health plans also have an affirmative obligation to pay fairly and appropriately for services provided in- and out of-network, and regulators should ensure network adequacy in all fields, including emergency care. Evidence exists that narrow networks contribute to out-of-network costs. Adequate access to all types of care in the health plan's network could help reduce surprise billing and the need for out-of-network services. Many patients may have no choice but to utilize out-of-network facilities and services, such as in emergency situations. The Department of Health and Human Services Notice of Benefit and Payment Parameters for 2017 included a provision related to network adequacy and cost sharing. The rule requires issuers to "count the cost sharing charged to the enrollee for certain out-of-network services at an in-network facility by an ancillary provider toward the enrollee's annual limitation on cost sharing," effective starting in 2018. ACP has long encouraged stringent quantitative network adequacy criteria; ongoing monitoring and oversight of "provider" networks; transparent "provider" network development criteria; accurate, easily accessible and up-to-date "provider" directories; and requirements that QHPs should be prohibited from excluding health care clinicians whose practices contain substantial numbers of patients with expensive medical conditions. Further consideration of proposals to ensure levels of network adequacy is needed.

In closing, thank you for your shared commitment in wanting to address the growing problem of surprise medical billing. As you continue to garner feedback from stakeholders on this important issue, and further refine this discussion draft for introduction, we look forward to providing additional input as needed. If you have any questions, please contact Jonni McCrann at jmccrann@acponline.org.

Sincerely,

Robert M. McLean, MD, FACP
President