Dear all:

For the last four years, the Medical Association of Georgia has vigorously advocated for solutions to the Surprise Billing issue. While we have been unable to achieve our goals of protecting the patient while ensuring a fair minimum payment standard for the physician, Congress is now tackling the health insurance industry created problem of surprise billing.

Earlier this week, the Senate Committee on Health, Education, Labor and Pensions (HELP) released a bill, the “Lower Health Care Costs Act” that will be voted on by the committee on Wednesday, June 26. This legislation will further distort the incentives for private health insurance plans to offer fair, market based rates in provider contracts.

Under this bill, out-of-network physicians would be paid at the plan’s median in-network rates and be prohibited from balance billing the patient in situations where the patient did not have the opportunity to choose an in-network physician.

This payment standard – allowing the plans to use their median-in-network rate – is flawed for the following reasons:

- Median in-network rates do not fairly reflect the cost of providing services by all providers.
- Median in-network rates do not capture outer benefits that go hand-in-hand with being in-network, such as additional incentive payments as part of value-based contracts, prompt and direct payment by plans, listing in provider directories, etc.
- Median-in-network rates as determined by the health insurance plans are not verifiable.
- Median-in-network rates do not provide incentives for the health insurance industry to build adequate networks or offer fair rates to physicians.

In 2016/2017, then Georgia Commissioner of Insurance Ralph Hudgens attempted to collect this vary data from the health insurance plans. After many months of collection and a prepared report, all parties and legislators determined the data was unusable. Please see the following that was noted in the report and/or our experts:

- The data was self-reported by the insurers and not audited or verified.
- There was a greater than expected variability noted in the data submitted.
- There were discrepancies in amounts reported by insurers when compared to actual benchmarks determined by FAIR Health.
- In several instances, the insurers did not provide information as requested in mean and median contract amounts fields.
- The information in the Mean Contracted Amount by Count and the Median Contracted Amount by Count fields are not considered to be reliable.
- Inconsistencies were noted where some insurers provided both facility and physician pricing for reported CPT codes while others appear to have provided only one pricing structure.
- Medicare rates reported are based upon the sum of facility and physician where possible.
- The report itself had a disclaimer on all of the Count Weighted fields, rendering them effectively useless.
Given our experience in Georgia, we cannot expect that a benefit standard determined by the health insurance industry will be reliable or fair to the patients and their physicians.

The AMA, MAG and other physician organizations agree that patients who do not have an opportunity to select an in-network provider should be protected from their plan’s failure to contract with an adequate number of physicians and only be liable for what they would have paid in-network.

However, this legislation protects the interests of health insurance plans, instead of requiring the plan to negotiate a fair payment with the out-of-network physician either directly or through an independent dispute resolution process that considers physician charges and other factors.

Given this current payment standard, MAG and AMA cannot support the language in the “Lower Health Care Costs Act” as it is pertains to surprise bills. We have contacted Senator Isakson and noted our objection as well as what we support. Senator Isakson’s office has requested that physicians contacting his office on this issue use the following link - https://www.isakson.senate.gov/public/index.cfm/email-me.

In your note to Senator Isakson, please let him know the following:

- At no point should negotiated, discounted in-network rates be used as a benchmark to determine fair payment to out-of-network physicians, and at every point commercial data from independent sources should inform the payment standard.
- When the minimum payment from the payer for out-of-network care is insufficient, an independent dispute resolution (IDR) process should be developed to determine a fair payment by the health insurance company for the care provided. The IDR should be structured with clear factors that an arbiter, familiar with health care billing, must consider when deciding such as the complexity of the case, the experience of the physician, and the rate that physicians charge for that service in the area.
- To ensure that patients are completely protected, benefits should be assigned to the physician or other providers so that they may pursue payment for services provided directly with the insurer without further involving the patient. This is to ensure that games that have been played by insurers, such as making periodic payments directly to the patient, are not allowed and that the patient is fully kept out of the middle.
- It is imperative that any federal bill include strong and enforceable network adequacy requirements based on measurable standards and that federal parity laws be enforced to ensure patients have access to in-network physicians to prevent surprise bills before they happen.

Thank you for your attention to this matter and the AMA for taking the lead.

Donald

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