Medical Group Management Association®

June 5, 2019

The Honorable Lamar Alexander, Chairman
Health, Education, Labor & Pensions Committee
United States Senate
455 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Patty Murray, Ranking Member
Health, Education, Labor & Pensions Committee
United States Senate
154 Russell Senate Office Building
Washington, DC 20510

Subject: Lower Health Care Costs Act

Dear Chairman Alexander and Ranking Member Murray:

On behalf of our member medical group practices, healthcare executives, and other healthcare leaders, the Medical Group Management Association (MGMA) is writing to provide comments and recommendations on your discussion draft entitled the Lower Health Care Costs Act, which addresses rising healthcare costs. We appreciate your leadership on this important issue and the steps you and the Committee are taking to develop solutions that first and foremost protect patients and their access to care.

MGMA is the premier association for professionals who lead medical practices. Since 1926, through data, people, insights, and advocacy, MGMA empowers medical group practices to innovate and create meaningful change in healthcare. With a membership of more than 45,000 medical practice administrators, executives, and leaders, MGMA represents more than 12,500 organizations of all sizes, types, structures, and specialties that deliver almost half of the healthcare in the United States.

We appreciate that this Committee and lawmakers in both chambers are working in a bipartisan manner to develop legislation to address important issues such as unexpected medical costs, drug prices, public health, and transparency. We are pleased to provide our perspective on certain provisions of the legislative draft where we have established policy and where it impacts our members and the care they provide to patients.

Title I: Ending Surprise Medical Bills

MGMA is committed to protecting patients from out-of-network medical bills that result from unexpected gaps in coverage and from healthcare costs their insurance will not cover. As the Committee evaluates potential legislative solutions to this issue, MGMA developed the following policy framework that we urge you to consider:

- **Limit patient financial responsibility.** Patients should be protected from the financial impact of unanticipated gaps in insurance coverage when accessing emergency services outside their network and do not have the ability to select such services from an in-network healthcare professional.
- **Protect patients from payment disputes.** Health plans should be responsible for paying the out-of-network provider directly so that patients are not burdened with payment rate negotiations.
- **Ensure network adequacy.** Overly narrow networks contribute significantly to the problem of unanticipated medical bills; thus, any policy solution should ensure that health plans meet appropriate network adequacy standards, including access to hospital-based physician specialists.

- **Require health plan transparency.** Health plans must be transparent and proactive in informing patients about benefits and potential cost obligations. Health plans should also be required to regularly update and verify the accuracy of provider directories.
- **Preserve private negotiation.** In general, the government should not establish a fixed payment amount for out-of-network services. A fixed payment rate could undermine patient access to in-network care because health plans have less incentive to contract in-network clinicians if they can rely on a default out-of-network payment rate.

In addition to providing strong patient protections, we believe the principles set forth above would improve transparency, promote access to appropriate medical care, and avoid creating disincentives for insurers and healthcare providers to negotiate network participation contracts in good faith.

While there is widespread agreement across stakeholders regarding patient protections, there is disagreement around network regulation and establishing a fair payment rate to providers when protections apply. The development of a policy framework facilitating network adequacy and fair payment for provider services is a challenging and complex task, and any solution requires a balanced approach.

At the outset, we encourage this Committee to consider policies that facilitate network adequacy and tackle the issue of narrow networks, a central reason that physicians practice out-of-network. Network participation is not always an option, or a viable option, for physicians due to closed networks or plans offering less-than-market rates for in-network fee schedules. MGMA members report continued good faith efforts to negotiate contracts for network participation with health plans but face growing resistance from plans. For example, during contract negotiations, a plan may offer a physician or practice extraordinarily low rates, which may be below market value. This intentional business decision by the health plan forces physicians out of the network, resulting in narrower networks and less patient choice. Plans narrowing networks as a cost saving strategy is a legitimate and significant concern that must be addressed in any solution around unexpected healthcare costs. Furthermore, network adequacy requirements in all fields, including emergency care, must not only be strengthened, but also enforced.

Unexpected medical bills can occur in many situations, including when a patient is in-network. The increasing prevalence of high deductible plans contributes to patients receiving unexpected medical bills for in-network care they thought their health plan would cover. When developing solutions to protect patients from unexpected medical costs, we urge this Committee to consider and examine the full range of situations that cause patients to receive bills for care their health plan will not cover.

In addition to the foregoing, we would like to provide additional detail on the specific provisions of the legislative draft as follows.

Option One: Network Matching

The first option outlined in Section 103 of the draft bill would require that all practitioners furnishing care through a hospital either join the hospital's networks or bill through the hospital instead of sending their own bill. These so-called "network matching" and "bundled billing" approaches are problematic, and **we firmly oppose this option.**

Network matching will have a significant and negative impact on the physician community. This type of coercive contracting is a direct intrusion into private commercial contracts. Moreover, this approach would generally force hospital-based practitioners to accept whatever payment rate is offered through the hospital's contract. Insurers, knowing that hospital-based practitioners must accept their in-network rates, will experience increased market power, which could in turn be used as leverage to set below-market reimbursement rates.

According to this draft, practitioners that do not participate in-network at a hospital would be prohibited from billing separately for their services and instead be required to bill through the hospital. The hospital

and health plan would contract for a "bundle" of services that includes practitioner fees. Bundled billing in this setting is untested and would constitute a marked change from the current approach to practitioner reimbursement. Implementation of this type of approach raises significant administrative, operational, and legal concerns and complexities. Moreover, requiring that all reimbursement for hospital-based services be paid entirely from the hospital exacerbates existing concerns over consolidation, loss of medical group practice independence, and anti-competitive policies.

While some stakeholders have suggested that hospitals may subsidize lower physician reimbursement resulting from such an approach, in addition to raising additional legal concerns, this approach risks pushing physicians away from safety net hospitals that may already operate on a limited margin into hospitals capable of offering more lucrative subsidies or compensation packages.

It is unclear how this option would impact physicians that are not employees of a hospital, such as independent physicians that furnish clinical services to hospital patients through a physician service arrangement.

Lastly, we oppose use of a federal benchmark payment based on the median of negotiated contract rates and urge you to reject this proposal as well.

Option Two: Independent Dispute Resolution

MGMA is pleased that one of the options included in this legislative draft includes an independent dispute resolution (IDR) process to determine fair payment rates when patient protections apply.

A solution that incorporates IDR, including "baseball style" arbitration, encourages a balanced and reasonable approach to payment disputes. In a baseball style arbitration process, such as the one used in the State of New York, an independent arbitrator chooses between a health plan and a provider's best offer to determine an appropriate reimbursement rate, rather than calculating the amount independently. We encourage the Committee to work with the physician community on an arbitration model that promotes consideration of market-related factors, the complexity of the patient's medical condition, the special expertise required, comorbidities, and other factors.

While we view this option as the most favorable of the three outlined in the legislative draft, we recommend revising references to and endorsement of a benchmark based on median contracted rates, which this option includes for bills under $750. For the reasons set forth below, we oppose establishing a payment benchmark at the median rate for claims of any value. We encourage this Committee to refine this aspect of option two, considering feedback from the physician community.

Option Three: Fixed Payment Rates

MGMA urges this Committee to reject the approach outlined in option three, which would establish a fixed payment rate for certain out-of-network care set at the health plan's median contracted rates.

Utilizing a benchmark set at the median of in-network claims disincentivizes fair and equitable contract rate negotiations by the health plan and will have a ripple effect impacting the broader market. When providers contract with a plan to participate in a network, they offer discounted rates for services in exchange for contracted benefits, such as being listed in the provider directory and increased patient volume. A policy that sets out-of-network payments at or near those discounted rates significantly disadvantages a provider's ability to engage in good faith negotiations with the health plan.

The impact of this is not insignificant, as it will ultimately extend beyond contractual relationships between providers and payers and has the potential to have the opposite effect of what this legislation intends to resolve. Plans could drop providers from existing contracts and either further narrow their networks by excluding them all together or demand contracts at less than market rates. Rather than encouraging more robust networks, which would mitigate out-of-network bills at the outset, a rate setting

approach could lead to narrower networks and less patient choice. Any policy solution must ultimately encourage both providers and plans to contract with one another.

The important takeaway is that the issue with this approach is not over the reimbursement rate of a specific claim impacted by this policy, but rather what impact this policy would have on the broader relationship between plans and providers. In other words, the issue is not one of money but of market dynamics.

Title III: Improving Transparency in the Healthcare Market

Section 305: Timely Bills for Patients

The draft bill would require practitioners to send bills to patients within 30 days, or the patient is not required to pay; non-compliance would result in civil monetary penalties starting at $10,000. **This policy is unreasonable, and we firmly oppose Section 305 in its entiret**y.

Of all the requirements included in this section, a 30-day window to complete claims processing is particularly untenable. Practitioners and group practices endeavor to complete the claims management cycle as quickly as possible, which means transmitting invoices to patients in a timely and expeditious manner. However, claims processing entails many steps and protocols at every phase of the process. Throughout the claims cycle, there are a multitude of scenarios outside the practice's control that may slow down the process. Consider the following:

- **The claims process is exceedingly complex and involves many steps.** When a patient is seen by a practitioner, they provide their insurance information, which may be verified at the point of care if the health plan accepts and provides HIPAA transaction standards for eligibility and benefit parameters. When the practitioner furnishes care, they document what services took place. Next, a medical coder or a member of the practitioner's staff inputs this data and additional relevant information into the claim form, including diagnoses codes; code descriptors; and information pertaining to the patient, practitioner, and insurance plan. Typically, the claim is then submitted to a clearing house or the plan itself for adjudication. During the adjudication phase, the health plan has its own administrative workflow involving a multi-step process, which culminates in the transmission of an explanation of benefits (EOB) and remittance advice (RA) to the practitioner and patient. Once received, the practice or its billing entity will review the EOB and RA for accuracy, and at that point can begin applying payments and invoice the patient for any amounts owed.
- **Patients may inadvertently supply incorrect or outdated insurance information to group practices or practitioners.** A patient may have changed insurance policies or have different coverage parameters from what is presented at the point of care. Despite best efforts on behalf of group practices to track down updated and accurate information from the patient, this process can take days or weeks if the patient cannot be reached. Once accurate information is obtained, the claims cycle described above could begin, but at this point the practice may already running up against a 30-day period.
- **Cyclical, monthly billing is a common approach used in group practice billing.** Some of our members report processing bills cyclically, meaning that they bill all patients seen within a given calendar month once a month. For example, for the entire month of April, a practice may bill all patients on April 30. Medical practices utilize this billing cycle as a cost-containment strategy, because it permits groups that outsource billing to employ medical billers for just one or two days a month, or alternatively saves staff time if the billing is done in-house. The process of creating

the bills takes many hours, requires oversight, and is expensive. The 30-business day requirement would cause many practices to completely overhaul their billing systems, or risk facing civil monetary penalties.

Physician group practices are sometimes unable to provide patients with bills within 30 days due to reasons outside of their control. It is already in the practice's best interest to timely bill patients, as any outstanding patient cost sharing amounts impacts the practice's bottom line. MGMA strongly opposes this section of the draft bill.

Section 309: Ensuring Enrollee Access to Cost-sharing Information

When scheduling services for patients, MGMA agrees that providers should be transparent about their own anticipated charges, and insurers should be transparent about the amount of those charges they will cover. While supporting these broader efforts to facilitate greater transparency, **MGMA opposes the "provider disclosures" provision of the draft bill,** which states that providers must agree to give an enrollee the expected cost-sharing amount for specific healthcare services within 48 hours of an enrollee's request or at the time of scheduling a service. Although a provider can offer a patient information about their co-pay and deductible, a provider does not have access to the final out-of-pocket expense—claim adjudication by the patient's health plan must come first, which as explained above can take a significant amount of time. For this reason, it is unreasonable to require a provider to offer good faith estimates of these expected out-of-pocket expenses.

Conclusion

We appreciate the opportunity to comment on your draft legislation. As the voice for the country's medical group practices, MGMA remains committed to promoting policies that enhance the ability of our members to provide high-quality, cost-effective care to the millions of patients they serve. Should you have any questions, please contact Mollie Gelburd at mgelburd@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg, MGA
Senior Vice President, Government Affairs