CHAMBER OF COMMERCE
OF THE
UNITED STATES OF AMERICA

KATIE MAHONEY
VICE PRESIDENT
HEALTH POLICY

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March 5, 2019

The Honorable Bill Cassidy
United States Senate
Washington, D.C. 20510

The Honorable Michael Bennet
United States Senate
Washington, D.C. 20510

The Honorable Todd Young
United States Senate
Washington, D.C. 20510

The Honorable Tom Carper
United States Senate
Washington, D.C. 20510

The Honorable Lisa Murkowski
United States Senate
Washington, D.C. 20510

The Honorable Maggie Hassan
United States Senate
Washington, D.C. 20510

Dear Sens. Cassidy, Bennet, Young, Carper, Murkowski, and Hassan,

The U.S. Chamber of Commerce appreciates and supports your continued bipartisan efforts to not only protect patients from surprise bills but also provide certainty for payers and employers. In particular, we are grateful for your appreciation of the complex problems that arise when certain facility-based physicians' charges result in unknowing patients receiving out-of-network surprise bills. While we are not able to provide the data and state specific information you have requested, the Chamber wanted to provide some clarification as to the problem and offer a proposed solution while also preserving and encouraging market-based negotiations.

Clarifying the Parameters of the Problem

The particular instances that are most egregious that we urge you to address, and to which our suggested solutions solely pertain, are those in which a patient is seeking treatment at an in-network facility (hospital, clinic, ambulatory surgery center) but receives ancillary services provided by a facility-based physician who is out-of-network.

Patients typically do everything they can to seek and receive treatment from in-network providers. However, because of the way many facility-based physicians (most typically **E**mergency room physicians, **R**adiologists, **A**nesthesiologists, and **P**athologists) interface with patients, there is virtually no way for an individual patient to choose which facility-based physician provides their treatment. As a result, when patients receive these ancillary services from an out-of-network facility based physician, they are faced with a surprise medical bill after the fact. Even more frustrating for patients, these "ERAP doctors" oftentimes provide ancillary services behind the scenes, reading x-rays, images, or lab tests and providing feedback to the

treating physician, etc., so they may not even meet with or see the patient in person, which leads to further befuddlement when an out-of-network surprise bill is received.

Two Components Must be Addressed

First, it is clear that a solution must be achieved that protects the patient. Patients should not receive surprise bills. The Chamber strongly supports the ability of employers and other payers to structure benefit and plan designs that protect patients from high out-of-network copayments or coinsurance, but patients should not be subjected to surprise bills submitted by facility-based physicians who do not join networks.

However, the Chamber also urges you to simultaneously consider the underlying challenge that would remain even after the patient is protected. To avoid one-off litigation, negotiation, or arbitration, the Chamber suggests you consider an alternative that provides flexibility to reflect geographic differences in the cost of services, recognizes the amount of uncompensated care provided by these facility-based doctors, and increases predictability for employer plan sponsors.

Offering a Viable Solution

One solution may be to create a benchmark that allows issuers to reimburse facility-based ERAP doctors for out-of-network services based on the average in-network reimbursement for that same service.

For example, an individual covered by Insurer X has a scheduled caesarian section with her in-network OBGYN at an in-network facility where the OBGYN has admitting privileges. The individual has a lab report that an out-of-network pathologist reads and interprets. The patient's insurer and the facility-based physician should agree to reimbursement that is based on the average in-network rate for that same service (reading and interpreting the lab report) in that geographic area. This would tie the reimbursement to the average market rate in a geographic area for the same service and provide an incentive for the facility-based ERAP doctor to try to negotiate a better in-network rate.

Dangers of Some Proposals

While well intended, there are some other proposals that have been offered to address out-of-network surprise bills from physicians that raise concerns for the business community.

- Flaws of Relying of Medicare Rates
  We do not support proposals to tie reimbursement to Medicare. Given the cost shifting to the private market that already occurs to account for Medicare's lower reimbursements, we do not propose solutions that would add to or exacerbate this problem. Furthermore, the solution to the problem does not rest with additional rate setting by the government.

- Flaws of a Fixed Dollar Amount
  Similarly, as proponents of the free market system and supporters of the private sector, we take issue with proposals that would set a specific dollar amount in statute. Costs to provide services vary greatly across the country for a variety of reasons.

- Flaws of a Percent of Billed Charges
  We believe that tying out-of-network reimbursement to billed charges could be manipulated by inflating those charges.

- Flaws of a Higher than In-Network Rate
  Finally, there are concerns that reimbursing an out-of-network provider at a rate that is higher than in-network providers (i.e. 125% of in-network reimbursement or allowed in-network amount) would undermine the entire purpose of contracting.

- Flaws of Improperly Expanding the Scope
  In contrast to some of the facility-based clinicians discussed above, our understanding is that hospitals broadly pursue in-network strategies. The suggestions offered here are intended to only apply to and address a very narrow and discrete problem that arises when a facility-based physician provides ancillary services on an out-of-network basis at an in-network facility. The suggestions are intended to achieve several goals in these precise scenarios: protect the patient; reduce unpredictability and unnecessary one-off resolution costs for the employer or payer; encourage facility-based physicians to join networks, and; fairly compensate physicians for their services to protect access in the future.

Instead of these flawed proposals, we favor a solution that reflects the private market's established rate for a service in a particular geographic area. Ideally, the solution will provide certainty and a fair rate while also encouraging parties to try to arrive at a mutually beneficial rate that does not drive up the cost of health care nor serve as a disincentive to physicians joining health plan networks.

The Chamber again thanks you for your efforts to resolve the issue of surprise bills and remains committed to patient-centered health care that relies on our private sector to increase efficiency and affordability.

Sincerely,

Katie Mahoney