Medical Group Management Association®

July 10, 2019

The Honorable Frank Pallone, Chairman
Committee on Energy and Commerce
2107 Rayburn House Office Building
Washington, DC 20515

The Honorable Greg Walden, Ranking Member
Committee on Energy and Commerce
2185 Rayburn House Office Building
Washington, DC 20515

The Honorable Anna Eshoo, Chairwoman
Subcommittee on Health
Committee on Energy and Commerce
202 Cannon House Office Building
Washington, DC 20515

The Honorable Michael Burgess, Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
2161 Rayburn House Office Building
Washington, DC 20515

Subject: No Surprises Act (H.R. 3630)

Dear Chairman Pallone, Ranking Member Walden, Chairwoman Eshoo, and Ranking Member Burgess:

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 on the No Surprises Act (H.R. 3630), introduced on July 9 and scheduled for markup on July 11. We appreciate your leadership on this important issue and the steps you and the Committee on Energy and Commerce 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 No Surprises Act where we have established policy and where it impacts our members and the care they provide to patients.

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 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 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.

The No Surprises Act would establish a fixed payment rate for certain out-of-network care set at the health plan's median contracted rate. While supporting the central tenet of the legislation to provide relief to patients from unexpected medical costs and remove them from payment disputes, **MGMA firmly opposes the use of benchmark payments set at the median in-network rate when patient protections apply. Rather than government-set payment rates, hospitals, providers, and plans should be permitted to negotiate fair reimbursement rates with each other, with an option to pursue independent dispute resolution when necessary.**

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.

Conclusion

We appreciate the opportunity to comment on your 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