June 25, 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 (S. 1895)

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 on the revised version of the Lower Health Care Costs Act (S.1895) released on June 19. 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. There are, however, several changes to the Lower Health Care Costs Act that we believe are necessary to achieve reasonable and workable solutions. **We write to comment on specific aspects of the legislation to encourage your reconsideration of two provisions: (1) use of a benchmark payment methodology set at the median in-network rate in instances of surprise medical bills and (2) implementation of a 45-calendar day timeline for practitioners and facilities to transmit medical bills to patients.**

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.

Ending Surprise Medical Bills

MGMA applauds this Committee for your commitment to protecting patients from healthcare costs their insurance will not cover. MGMA is also committed to finding policy solutions that protect patients from out-of-network medical bills that result from unexpected gaps in coverage. While there is widespread agreement across stakeholders regarding patient protections, there is disagreement around solutions, including how to establish a fair payment rate to providers when protections apply.

The Lower Health Care Costs 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 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

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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.

MGMA recommends including legislative language that will 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 providers due to closed networks or plans offering less-than-market rates for in-network fee schedules. When billing disputes do arise, MGMA recommends use of an independent dispute resolution process, rather than a fixed in-network payment rate.

Improving Transparency in the Healthcare Market

Section 305: Timely Bills for Patients

The legislation[1] would require facilities and practitioners to send adjudicated bills to patients within 45 calendar days of discharge, or the patient is not required to pay; non-compliance would result in civil monetary penalties starting at $10,000. There are two discretionary safe harbors under which the Secretary of the Department of Health & Human Services could waive penalties or extend the allowable timetable for submitting bills to patients. The safe harbors may apply if a practitioner or facility: (1) Makes a good faith effort to send a bill within 30 days but the patient's address is incorrect or (2) under extenuating circumstances, as defined by the Secretary, that delay delivery of a timely bill. **MGMA firmly opposes the requirement that all bills be sent within 45 calendar days.** While we support efforts to improve the patient experience and to introduce greater transparency into healthcare costs, this timeline and mandate is far too aggressive and does not consider a multitude of variables beyond a practitioner's control.

A 45-day window to complete the claims processing and patient billing cycle is unreasonable. While there are certain improvements in the legislation released June 19 from the discussion draft, these modest modifications are not sufficient to overcome the overarching issue that claims processing is complex and there are many factors beyond a practitioner's control that may delay the process.

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. 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

[1] Sec. 399V-7(a)(2).

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 could begin, but at this point the practice may already be running up against a 45-day period. A safe harbor in the instance of incorrect addresses would not protect practitioners when incorrect health coverage information is supplied.
- **Cyclical, monthly billing is a common approach used in group practice billing.** Some MGMA 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 45-calendar day requirement would cause many practices to completely overhaul their billing systems, or risk facing civil monetary penalties.

While Sec. 2729D would require certain health plans to have business practices in place to facilitate practitioner compliance with the 45-day requirement, there is no enforcement mechanism or penalty for health plan non-compliance. Moreover, it is unclear what business practices would satisfy this requirement, and if they would even meaningfully assist practitioners in meeting their 45-day deadline.

Physician group practices are sometimes unable to provide patients with bills within 45 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 recommends striking sections related to the 45-calendar day billing requirement, or at least substantially increasing the timetable and removing the possibility for civil monetary penalties.**

Conclusion

Thank you for your consideration of our comments. 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

CC: Members of the Committee on Health, Education, Labor & Pensions