



May 28, 2019

The Honorable Frank Pallone
Chair, House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Greg Walden
Ranking Member, House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Pallone and Ranking Member Walden:

On behalf of the more than 9,000 oral and maxillofacial surgeons (OMSs) in the United States, AAOMS is pleased to provide comments on the committee's discussion draft of the "No Surprises Act," which seeks to protect patients from unexpected surprise medical billing during emergency scenarios or when patients cannot reasonably select their providers.

OMSs are an integral part of hospital systems – including emergency department coverage and members of trauma teams throughout the country – and also perform complex procedures at hospitals. OMSs want to prevent patients from being unfairly surprised by an out-of-network bill while ensuring that providers are reimbursed at a fair and reasonable rate. AAOMS applauds your efforts to address this important issue and requests you consider the following comments as you work to finalize this legislation.

Provider Networks

AAOMS agrees that insurers need to maintain adequate networks for providers and patients. The gradual narrowing, or tiering, of provider networks by insurers has resulted in a growing number of out-of-network providers performing procedures at in-network hospitals. Such practices limit access to providers and subject the patient to potential out-of-network services. In effect, costs have been shifted from the insurer to the patient. Even if patients do their due diligence to ensure they receive services from an in-network provider at an in-network facility, they may still receive services necessary to appropriately treat the patient, such as anesthesia or pathology, from out-of-network providers without any prior knowledge or control. When patients receive the bills for these services, insurance pays only a fraction of the provider's fee and well below the usual and customary rate for the geographic region. In such instances – and where permitted by state and federal law – patients are typically billed for the amount not paid by insurers, which may be unexpected. Patients and providers should not be penalized for an insurers' failure to maintain adequate provider networks and give reasonable payments.

In response to the committee's request for feedback on how to ensure networks are meeting the needs of individuals, we recommend – at a minimum – that insurers be required to maintain accurate participating provider directories that are updated in real-time so that facilities, providers and patients have a full picture of what the patient's out-of-pocket costs might be and allow the patient to make any changes in the provision of their care whenever possible to minimize these costs. While the ACA requires federal marketplaces to ensure adequate networks are measured by geographic access standards, provider-to-enrollee ratios and wait times, the federal government might be able to help address this issue by incentivizing those remaining states that have not yet taken action.

State All-Payer Claims (APC) Databases

AAOMS supports the draft legislation's provisions encouraging states to establish All-Payer Claims Databases if they do not already have one. AAOMS believes these databases can be more beneficial than other types of datasets because they are not controlled by a particular entity – such as an insurer – which may have the incentive to manipulate data in their favor. They also can capture more data because they span across multiple payers – both public and private – and care sites – both facility type and geographic location. Nearly 30 states have developed or are in the process of developing APC databases.¹ A federal grant program would incentivize the remaining states to complete the database development process. Additionally, as providers who bill both medical and dental insurers, we appreciate the committee including dental claims in the bill's definition of "All Payer Claims Database" to ensure that all healthcare data is captured.

Resolving Out-of-Network Payment Disputes Between Providers and Insurers

AAOMS supports the draft legislation's efforts to prohibit patients receiving emergency care from being billed beyond the in-network rate because adequate notification of their provider's network status is not feasible. We also agree patients should not be billed beyond the in-network rate when receiving non-emergency care by out-of-network providers at in-network facilities when adequate consent is not provided. We generally support the draft legislation's notification requirements but request clarification on whether the facility or provider is required to provide such notification and who is penalized if one or more entities involved in the patient's care does not comply with the notification requirements. For example, a patient might make an appointment with an OMS to have a hospital-based procedure done. At the time the appointment is booked, the OMS is able to notify the patient of their own network status, but the OMS may not know who the anesthesiologist will be for the procedure – much less their network status – until the day of the procedure.

We recommend bill language be clarified to specify that the primary surgical provider – such as the OMS in the above example – only be required to provide notification on their own network status at the time the patient makes the appointment and be allowed to direct the patient to the facility for the network status of other potential providers involved in the patient's care. Should the facility not comply with the legislation's notification requirements and the patient receives care from an out-of-network provider such as anesthesiologist or pathologist, then the facility is penalized but the primary surgical provider is not.

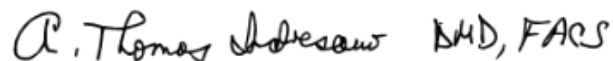
The bill proposes to establish a minimum payment standard of the median contracted (in-network) rate to resolve out-of-network payment disputes between providers and insurers. We believe that arbitration –

¹ All-Payer Claims Database Council. APCD Legislation by State. <https://www.apcdouncil.org/apcd-legislation-state>. Accessed May 21, 2019.

rather than a minimum payment standard such as the median contracted rate proposed in the draft legislation – provides the most balanced approach for out-of-network providers to negotiate fair reimbursement with insurers. Additionally, we are concerned that the committee’s draft legislation does not specify the methodology insurers must use in determining the median contracted rate and leaves it up to regulatory officials to determine. If Congress pursues the use of a minimum payment standard such as a median contracted rate to resolve payment disputes between providers and insurers in lieu of an arbitration process, the payment standard should be defined in statute and be based on the service for a similarly credentialed practitioner providing services in the same geographic region as determined by an independent database not affiliated with any insurer such as FAIR Health. Furthermore, if the median contracted rate is used as the payment standard, Congress should require insurers to send payment directly to the out-of-network provider – rather than the patient – and allow these providers the ability to appeal disputes regarding payment. Out-of-network providers in these scenarios will essentially be treated as in-network providers for purposes of payment so AAOMS believes the insurers should afford them similar benefits.

Thank you again for the opportunity to comment on this important legislation. Please contact Jeanne Tuerk, manager of the AAOMS Department of Governmental Affairs, at 800-822-6637 or jtuerk@aaoms.org for additional information.

Sincerely,

A handwritten signature in black ink that reads "A. Thomas Indresano DMD, FACS". The signature is written in a cursive style.

A. Thomas Indresano, DMD, FACS
AAOMS President