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June 5, 2019

The Honorable Lamar Alexander
Chair, Senate Health, Education, Labor and Pensions Committee
428 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Patty Murray
Ranking Member, Senate Health, Education, Labor and Pensions Committee
428 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Alexander and Ranking Member Murray:

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 "Lower Health Care Costs Act," which seeks to deliver better healthcare outcomes and better healthcare experiences at lower costs by tackling surprise billing instances, healthcare pricing transparency, prescription drug prices and the exchange of health information.

AAOMS applauds your efforts to address these important issues and requests the committee consider the following comments as it works to finalize this legislation.

Surprise Billing

OMSs are an integral part of hospital systems by providing emergency department coverage, serving as members of trauma teams throughout the country and also performing 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.

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 in Sec. 102 that the facility – not the provider – is penalized if it does not give adequate notice to the

patient about the provider's out-of-network status prior to receiving post-emergency services at their facility. For example, the hospital might call in an OMS to treat an infection or fracture in a non-emergency situation once the patient is stabilized. The OMS should not be penalized – or forced to forfeit the out-of-network reimbursement – because the hospital did not comply with the legislation's notification requirements.

The committee seeks comment on three possible options outlined in Sec. 103 to resolve out-of-network payment disputes between providers and insurers. If Congress pursues the use of a minimum payment standard such as a median contracted rate to resolve payment disputes between providers and insurers – similar to the options outlined in Subtitles A or C, in lieu of an arbitration process – the payment standard should be defined *in statute*. We are concerned the 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. AAOMS also believes the payment standard should 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.

Network Adequacy

One of the primary causes of the increased rate with surprise billing is the gradual narrowing – or tiering – of provider networks by insurers, which has resulted in a growing number of out-of-network providers performing procedures at in-network hospitals. Such practices limit access to providers and subjects 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 their individual needs – 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 appropriately pay said providers at reasonable rates.

We support the inclusion of language in Sec. 304 that requires health plans to maintain accurate participating provider directories that are updated in real-time. This ensures that facilities, providers and patients have a full picture of what the patient's out-of-pocket costs might be and allows the patient to make any changes in the provision of their care, whenever possible, to minimize these costs. There are instances in which the insurer fails to update the directory and a patient selects a provider based on an outdated directory, whereby a patient may unknowingly choose an out-of-network provider. While AAOMS agrees that the provider should not charge the patient for any costs above the in-network rate, AAOMS requests that clarification be made whereby the provider is able to seek reimbursement from the insurer above the in-network contracted rate.

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Price transparency

AAOMS supports the committee's overall efforts to address anticompetitive contract terms under Sec. 302. We are concerned about language that would allow insurers to direct or steer patients to certain healthcare providers or offering incentives to enrollees to utilize certain healthcare providers, who may or may not be equally qualified to provide said services. We strongly believe that beneficiaries – our patients – should have access to all eligible providers. We support language in this section that prevents "most-favored-nation" clauses between contracts and providers. Such contract language limits health insurer competition by allowing advantageous pricing to the dominate insurer in an area. Many states already have laws prohibiting such practices, but they do not apply to ERISA plans.

In relation to anticompetitive behavior by insurers, we respectfully request the committee consider including language in the draft legislation from the "Competitive Health Insurance Act" (S. 350). This bipartisan legislation – which aligns well with the committee's efforts to lower healthcare costs – would amend the McCarran-Ferguson Act to revoke the exemption from federal antitrust law for health and dental insurers. Amending the McCarran-Ferguson Act – thereby involving the federal government in antitrust enforcement – would increase competition in the health insurance marketplace, driving health plans to compete more aggressively and creating policies with low premiums yet robust benefits for consumers.

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,

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