



July 16, 2019

The Honorable Frank Pallone, Jr.
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Greg Walden
Ranking Member
Committee on Energy and Commerce
2322A Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pallone and Ranking Member Walden:

On behalf of the American Osteopathic Association (AOA) and the more than 145,000 osteopathic physicians and medical students we represent, thank you for your commitment to addressing unanticipated medical expenses and removing patients from billing disputes. The AOA appreciates the opportunity to comment on the “No Surprises Act” as the legislative process has progressed. However, we continue to have strong concerns with the bill’s median in-network “benchmarking” approach and urge you to include a benchmarking model that incorporates actual local charges, and an appeals process between physicians and insurers.

Additionally, while the AOA is encouraged by efforts to reauthorize the Teaching Health Center Graduate Medical Education (THCGME) program, we are deeply concerned about the negative impact on medical education and access to care in rural America by flat funding for the next four years. Reauthorizing the THCGME program at its current funding level for the next four years could jeopardize up to 56 medical residency positions in rural and underserved communities, risking the growth and stability in strengthening the health care workforce and access to care in communities that need it most.

The following are our comments and recommendations on both proposals.

Surprise Medical Billing

Core principles of osteopathic medicine emphasize providing patient-centered, coordinated care across the healthcare continuum. This also serves as the foundation for the AOA’s perspective on the legislation being considered by this committee. The AOA is focused on promoting patient access and fairness for patients and physicians. This includes patient access to high quality physician-led care wherever they live and fairness for patients and physicians when dealing with out-of-network charges for emergency services. Ideally, a solution to this problem would address network adequacy issues and incentivize payers and providers to negotiate equitable resolutions to payment disputes. However, at a minimum, it is important that any legislation intended to address unanticipated medical expenses or surprise bills being sent to patients accomplish at least two things: removing patients from billing disputes and promoting good faith negotiations between payers and providers on payment for medical services.

The AOA recognizes that healthcare stakeholders, across the United States, share the responsibility of promoting reform and policies to ensure individuals and families will have access to coverage and care when and where they need it. In an emergency, patients and their families do not have time to review their health insurance policies to confirm if their care will be in-network. Out of network patients are often expected to pay their entire bill, despite the fact that they have insurance. To this end, we support the committee’s commitment to recognize deductibles as cost-sharing for emergency care. This will ensure that patients in need of emergent and urgent care are not financially punished should they receive emergency care out-of-network.

Since 2010, the number of DOs has increased by 54%. Today, more than 65% of all DOs are under the age of 45, and if current trends continue, DOs are projected to represent more than 20% of practicing physicians by 2030. Additionally, more than 40% of active DOs practice in non-primary care specialties. The increasing share of DOs across the physician workforce, along with our longstanding commitment to practicing in rural and underserved areas provides us with a unique and important perspective on the delivery of healthcare in our nation.



While we support efforts to address surprise medical billing, we want to highlight our concern with the proposed utilization of in-network median rates for out-of-network care.

Unsustainable, low, in-network rates from some insurers can create obstacles to physicians' ability to participate in the insurers' networks. When such an insurer is the only carrier in an area, physicians are particularly disadvantaged by having no other networks to join, which can further exacerbate the lack of specialty physicians in rural and underserved communities. In some cases, these rates are insufficient to cover the cost of health care delivery by the provider.

We would also urge the committee to take the mandate placed on physicians under the Emergency Medical Treatment and Labor Act (EMTALA) into account, which guarantees access to emergency medical care, regardless of a patient's insurance status or ability to pay. Creating a dual mandate where providers are required to provide care while also accepting a low payment ceiling, should they not agree to an insurance company's proposed terms, will disincentivize physicians from practicing in areas where they are most needed by making medical practice economically unsustainable. The impact of this would likely be hardest felt in rural communities already facing challenges in obtaining plan networks.

We remain fearful that the benchmarking formula in H.R. 3630 will diminish the need for insurers to negotiate contracts in good faith and would effectively set a benchmark ceiling, even if adjusted for inflation. This would also further disincentivize insurers from developing contracts to expand their network, as they would know that any physician unwilling to take the median contracted rate would have no effective leverage, and thus, reflects only the illusion of fair negotiation.

While we believe that alternatives to benchmarking would result in more productive negotiations between physicians and insurers, we would request that, at a minimum, the committee adopt a benchmarking approach that is fair to all stakeholders in the private market. Currently, the benchmarking formula in H.R. 3630 only takes into account contracted rates in a geographic region. We strongly encourage the Committee to modify the legislation to include actual local charges, as determined through an independent claims data base, in the benchmarking formula. The inclusion of actual local charges in a benchmarking formula would remove the incentive insurers have to drive reimbursement rates to unsustainably low levels because there will no longer be a benchmark ceiling created by the median in-network rate.

In addition, we are requesting the inclusion of an appeals process in the legislation to address disputes that may arise between insurers and physicians. Currently, several states have implemented laws aimed at protecting patients from surprise bills when procedures are performed by non-participating (out-of-network) physicians, while also supporting the sustainability of physician practices.

For example, New York's appeals process has reduced the rate of out-of-network billing for emergency department services from 20.1% in 2013 to 6.4% in 2015, a near 70 percent reduction¹. Additionally, the process has completely removed patients from the middle of any dispute. This process allows patients to receive needed care without being burdened with unexpected medical bills, and supports physicians in focusing on treating patients.

Further, we encourage the committee to strengthen health insurance network adequacy. In recent years, more patients have found themselves in plans with narrow provider networks as employers have chosen to shift to plans with skinnier networks² and narrower network options are offered on state exchanges³. Quite simply, narrow networks result in more physician being driven out of network. These plans limit choice for consumers, create access challenges to affordable care, and contribute to the issue of patients being forced to accept out-of-network care in emergency rooms.

¹ Cooper, Z.; Morton, F.S.; and Shekita, N. (2017). *Surprise! Out-of-Network Billing for Emergency Care in the United States*. National Bureau of Economic Research, <http://www.nber.org/papers/w23623.pdf>.

² https://www.aap.org/en-us/Documents/gettingpaid_emergingtrends_private_insurance.pdf

³ <https://avalere.com/press-releases/health-plans-with-more-restrictive-provider-networks-continue-to-dominate-the-exchange-market>



Overly narrow provider networks contribute significantly to out-of-pocket costs and access challenges. Strong oversight and enforcement of network adequacy is needed from federal and state governments. A study published in *JAMA* in 2015 found that nearly 15% of health plans were specialist deficient, and beneficiaries of specialist deficient plans had high out-of-network costs. More than a quarter of these plans did not cover out-of-network services and the remainder required 50 percent cost sharing⁴. This is especially concerning in rural areas where access to both providers and coverage options are limited.

Strengthening network adequacy standards will protect patients and lower out-of-pocket costs. Robust network adequacy standards include, but are not limited to, an adequate ratio of emergency physicians, other hospital-based physicians, and on-call specialists and subspecialists to patients, as well as geographic and driving distance standards and maximum wait times.

Teaching Health Center Graduate Medical Education Program

We appreciate the committee’s commitment to reauthorize the Teaching Health Center Graduate Medical Education (THCGME) program. As you may know, residents who train in THC programs are far more likely to specialize in primary care and remain in the communities where they train. Data shows that, when compared to traditional postgraduate trainees, residents who train at THCs are more likely to practice primary care (82% vs. 23%) and remain in underserved (55% vs. 26%) or rural (20% vs. 5%) communities⁵. The program also tackles the issue of physician maldistribution, and helps address the need to attract and retain physicians in rural areas and medically underserved communities.

A well-designed THCGME program not only plays a vital role in training our next generation of primary care physicians, but helps to bridge our nation's physician shortfall. To this end, we are concerned with the committee’s proposal to reauthorize the THCGME program for the next four years without adjustment for inflation.

The THCGME program is currently funded to support 737 primary care residencies in rural and underserved communities. As currently written, the reauthorizing legislation being considered by the subcommittee will diminish the program’s buying power by more than \$9 million over the next four years.

THCGME		Currently Proposed Reauthorization Funding Level			
PROPOSED FUNDING		2020 Funding -2% Inflation	2021 Funding -2% Inflation	2022 Funding -2% Inflation	2023 Funding -2% Inflation
2019 Current Funding	116,500,000	114,170,000	111,886,600	109,648,868	107,455,891
- HRSA's 5% Administrative Fee	\$5,825,000	\$5,708,500	\$5,594,330	\$5,482,443	\$5,372,795
Remaining Balance Available to Programs	\$110,675,000	\$108,461,500	\$106,292,270	\$104,166,425	\$102,083,096
Number of Funded Residency Slots	737	723	709	694	681
Potential Reduction in Residency Slots		-14	-28	-43	-56

In academic year 2013-2014, residents in the 26 THCs provided a total of 269,773 patient visits. In the next five years, 70 residency positions will be in jeopardy. This would mean delayed care for people who need it most, and missed opportunities for early diagnosis and preventative care among those who become unable to access care. We encourage the committee to

⁴ Dorner SC, Jacobs DB, Sommers BD. Adequacy of Outpatient Specialty Care Access in Marketplace Plans Under the Affordable Care Act. *JAMA*. 2015;314(16):1749–1750. doi:10.1001/jama.2015.9375

⁵ <http://aathc.org/know-the-facts/>



reconsider the provision, and recommend that H.R 2815, the “Training the Next Generation of Primary Care Doctors Act of 2019,” be considered in its stead.

We greatly appreciate your efforts to not only improve access to care and coverage, but to also improve public health. We look forward to continuing our work with the Committee to ensure our patients’ access to high quality, affordable health care. Please reach out to the AOA through John-Michael Villarama, Senior Director of Congressional Affairs, if we can assist your efforts in any way.

Sincerely,

A handwritten signature in cursive script that reads "William Mayo, DO".

William Mayo, DO
President