



## Analysis and Recommendations

### **H.R. 5826 - Consumer Protections Against Surprise Medical Bills Act of 2020**

*February 11, 2020*

Physicians for Fair Coverage (PFC) is pleased the U.S. House Ways and Means Committee has taken steps to address surprise medical billing and to do so with bipartisan support. We applaud the robust patient protections and transparency provisions included in the legislation and appreciate the overall framework in H.R. 5826, the Consumer Protections Against Surprise Medical Bills Act of 2020.

However, we strongly oppose the requirement that median in-network contracting rates be universally considered in the independent dispute resolution process. We are concerned that in effect, this will function as a unilaterally determined, broadly applied benchmarking standard for payment that will threaten the sustainability of patient care in many communities.

After careful review of the proposal, we suggest the following improvements for a more balanced approach:

- **INTERIM PAYMENT.** It is critical to require an interim payment be made within 30 days of claim submission. This ensures business continuity for physicians and employees, especially those in smaller independent practices providing access to care in underserved areas.
  - i. Payments by the payor for provider services should be made directly to the provider.
  - ii. Failure by the payor to make a payment within the required timeframe should result in full payment of charges and accrued interest.
  - iii. Failure by the payor to make any payment should result in the assessment of civil monetary penalties similar to the penalties required of providers by this legislation.
  
- **INDEPENDENT DISPUTE RESOLUTION (IDR) PROCESS.** The provisions creating an IDR process to settle disputes between providers and payors are currently inadequate, are significantly imbalanced in favor of payors, and would result in limited access to the process for most claims. There are additional unintended consequences of the process as currently proposed. For example, limiting the mediation reimbursement considerations to the median in-network contracting rate would establish a functional benchmark and create downward pressure on future in-network contracting rates. To ensure an accessible and meaningful appeals process, we recommend:
  - i. Batching language clearly defined allowing providers to include different CPT codes from an entire provider group over an adequate time period of 180 days.
  - ii. **Removing language that the arbiter must always (or only) consider the median in-network contracting rate.**
  - iii. Enhanced criteria for an arbiter to consider that includes:
    - the history of previous in-network contracting with the payor (this will encourage both parties to negotiate fair and reasonable contracts moving forward and thus strengthen networks);
    - commercially reasonable rates or another appropriate range of commercial rates for similar services that avoids a benchmark;
    - differentiating elements such as quality, complexity, site of care and efficiency; and/or
    - substituting the bill's IDR criteria for provisions similar to those outlined in S.1531, the bipartisan STOP Surprise Medical Bills Act, which is already supported by nearly one-third of the U.S. Senate.
  - iv. Including a requirement that the losing party pay the prevailing party within 10 business days.

- **ADDITIONAL CONSIDERATIONS.** To better protect patients and ensure access to care, the bill should also:
  - i. strengthen and expand payor-provider networks;
  - ii. create penalties for payors who fail to meet transparency standards;
  - iii. clarify language referring to timelines from “days” to “business days;” and,
  - iv. require only commercial rates be considered when calculating the median in-network rate.
    - Managed Medicaid and Medicare Advantage plans must be clearly excluded to insure data integrity and accuracy.