Unanticipated medical bills

Patients, physicians, and policymakers are deeply concerned about the impact that unanticipated medical bills are having on patient out-of-pocket costs and the patient-physician relationship. Health insurance plans are increasingly relying on narrow and often inadequate networks of contracted physicians, hospitals, pharmacies and other providers as one mechanism for controlling costs. As a result, even those patients who are diligent about seeking care from in-network physicians and hospitals may find themselves with unanticipated out-of-network bills from providers who are not in their insurance plan’s network—and this can happen simply because they had no way of knowing or researching in advance all the individuals ultimately involved in their care.

Physicians and other providers are limited in their ability to help patients avoid these unanticipated costs because they, too, may not know in advance who will be involved in an episode of care, let alone other providers’ contract status with all the insurance plans in their communities.

Given the public’s frustration with this situation, both federal and state governments have been exploring options for addressing it. The following principles are intended to help guide the development of policy in this area.

- **Insurer accountability.** Since overly narrow provider networks contribute significantly to this problem, strong oversight and enforcement of network adequacy is needed from both federal and state governments. Robust network adequacy standards include, but are not limited to, an adequate ratio of emergency physicians, hospital-based physicians, and on-call specialists and subspecialists to patients, as well as maximum wait times and geographic and driving-distance standards. Provider directories must be accurate and updated regularly to be useful to patients seeking care from in-network providers. In addition, insurers should be held to complying with the prudent layperson standard in existing law for determining coverage for emergency care, so that insured patients are not liable for unexpected costs simply because they were unable to accurately self-diagnose ahead of time whether their symptoms were, in fact, due to an emergency medical condition.

- **Patient responsibility.** Patients should only be responsible for in-network cost-sharing rates when experiencing unanticipated medical bills.

- **Transparency.** All patients who choose in advance to obtain scheduled care from out-of-network physicians, hospitals or other providers, should be informed prior to receiving care about their anticipated out-of-pocket costs. When scheduling services for patients, providers should be transparent about their own anticipated charges, and insurers should be transparent about the amount of those charges they will cover.

- **Universality.** In general, any federal legislation to address unanticipated out-of-network bills should also apply to ERISA plans.

- **Setting benchmark payments.** In general, caps on payment for physicians treating out-of-network patients should be avoided. If pursued, guidelines or limits on what out-of-network providers are paid should reflect actual charge data for the same service in the same geographic area from a statistically significant and wholly independent database. They should not be based on a percentage of Medicare rates, which have become increasingly inadequate in covering overhead costs. Nor should they be based on in-network rates,
which would eliminate the need for insurers to negotiate contracts in good faith. Any prohibition, whether state or federal, on billing from out-of-network providers not chosen by the patient should be paired with a corresponding payment process that is keyed to the market value of physician services.

• **Alternate dispute resolution.** Legislation should also provide for a mediation or sequential alternative dispute resolution (ADR) process for those circumstances where the minimum payment standard is insufficient due to factors such as the complexity of the patient’s medical condition, the special expertise required, comorbidities and other extraordinary factors. ADR must apply to states and ERISA plans. Arbiters should not be required to consult in-network or Medicare rates when making final determinations regarding appropriate reimbursements.

• **Keep patients out of the middle.** So that patients are not burdened with payment rate negotiations between insurers and providers, physicians should be provided with direct payment/assignment of benefits from the insurer.

*Ask your member of Congress to ensure that any legislation addressing unanticipated medical bills incorporated these principles.*
Prescription drug pricing, costs and transparency

Physicians experience and see first-hand the difficulty and burden high pharmaceutical costs have imposed on our patients, on physician practices, and on the broader health care system. Patients delay, forgo, or ration their medication when treatments are cost prohibitive, putting their health at risk. At a time of significantly increasing drug prices, the American Medical Association believes that increased competition and fair and transparent markets are more important than ever. The AMA looks forward to working with Congress and the administration to develop and implement well-crafted and effective public policy solutions to address the rising cost of prescription drugs that will improve access, lower costs, and reduce the administrative burdens without stifling innovation.

The AMA urges Congress to consider advancing the policies outlined below.

Increase pharmaceutical market competition and combat anticompetitive practices

The AMA continues to vigorously support expanded authority and funding for the Federal Trade Commission (FTC) in a number of areas to address anticompetitive practices as well as to advance consumer protections. The AMA strongly supports increased resources and direction to:

• Stop patent pay-for-delay settlements, whereby a brand-name pharmaceutical manufacturer pays a potential generic competitor to abandon its patent challenge and delay offering a generic drug product for a number of years for anti-competitive purposes.

• Limit efforts by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections.

• More rigorously and expansively evaluate the impact of mergers and consolidations among pharmaceutical companies on competition as well as consumer access by, among other things, expanding clinical expertise within the FTC and consulting with the relevant national medical specialty societies.

• Recommend enforcement action against manufacturers that engage in anticompetitive actions to the U.S. Department of Justice.

The AMA also continues to support measures to address the misuse of Food, Drug, and Cosmetic Act (FDCA) provisions for anti-competitive purposes while at the same time advocating for modifications to FDCA to increase access to some of the most-costly prescription medications: biologicals. The AMA strongly urges action to:

• End the ability of generic manufacturers to indefinitely “park” the 180-day exclusivity period authorized by the FDCA by delaying final approval of their application by the U.S. Food and Drug Administration (FDA) as part of a settlement agreement with a brand manufacturer.

• Further expand the ability of the FDA to address anticompetitive abuse of risk evaluation and mitigation strategies by brand manufacturers—particularly voluntary elements to assure safe use that involve proprietary measures that pose barriers to use by generic competitors.

• Make necessary refinements to law to prevent the inappropriate extension of the exclusivity and patent life of pharmaceuticals.
Finally, the AMA urges Congress to shorten the exclusivity period for biological products. The AMA was an early and strong supporter of establishing a pathway for follow-on biologicals. The reduction in the exclusivity period is warranted to spur competition while not decreasing the impetus to innovate.

**Require pharmaceutical supply chain transparency**

The second component of AMA advocacy has been to encourage transparency throughout the pharmaceutical supply chain. The ability of patients and physicians to have the information they need to make key decisions regarding medication, and of policymakers to craft viable solutions to high and escalating pharmaceutical costs, has been hampered by the often byzantine and confidential arrangements that are driving increased medication prices without a clear and justifiable reason. The practices and policies of pharmaceutical manufacturers, pharmacy benefit managers (PBMs), and health insurers warrant steps by Congress to interject much needed transparency. To that end the AMA strongly supports:

- Requiring pharmaceutical manufacturers to provide public notice before increasing the price of any drug by 10 percent or more each year or per course of treatment and provide justification for the price increase.
- Requiring pharmaceutical manufacturers to publicly disclose a variety of information, which could include research and development costs, expenditures on clinical trials, total costs incurred in production, and marketing and advertising costs.
- Requiring PBMs to apply manufacturer rebates and pharmacy price concessions to drug prices at the point-of-sale to ensure that patients benefit from discounts as well as eliminate some incentives for higher drug list prices.
- Requiring insurers to provide increased transparency in formularies, prescription drug cost-sharing, and utilization management requirements for patients and physicians at the point-of-prescribing as well as when beneficiaries make annual enrollment elections.
- Prohibiting removal of drugs from a formulary or moving to a higher cost tier during the duration of the patient's plan year unless a change is made for safety reasons.

**Urge your senators and your representative to support legislation to combat anticompetitive pharmaceutical company practices and improve drug price transparency throughout the distribution chain.**
Preventing gun violence: Background checks

“Since the inception of the Gun Violence Prevention Task Force after the shooting at Sandy Hook, we have been working across the aisle to help prevent gun violence. Today we take a decisive step forward to help save lives right away. As a gun owner, hunter and supporter of the Second Amendment, I am honored to join with Democratic and Republican colleagues to introduce my universal background checks bill that will help keep guns out of the hands of people who should not have them.”

—Rep. Mike Thompson (D-CA)

“There is no single law that can put an end to mass shootings or gun violence, but there are certainly proactive steps we can take to keep guns out of the hands of felons, domestic abusers, and the dangerously mentally ill. When background checks are used, they keep guns out of the hands of people we all agree shouldn’t have guns.”

—Rep. Peter King (R-NY)

The American Medical Association supports H.R. 8, the Bipartisan Background Checks Act of 2019, introduced by Rep. Mike Thompson (D-CA), Rep. Peter King (R-NY), and others.

One key element of reducing gun violence must be ensuring that those who are not legally permitted to purchase firearms are not able to do so.

- According to a recent Quinnipiac Poll, 97 percent of all Americans, including 97 percent of all gun owners support subjecting all gun purchases to a background check.

- The Department of Justice has reported that between 1994 and 2015, 3 million individual applications were denied because of the background check requirement.

However, background checks are currently only required for purchases from federally licensed firearms dealers. There are no such federal requirements for purchases from gun-shows, over the internet or through private sales. H.R. 8 would close these loopholes and institute a federal requirement for background checks for all gun sales.

**Urge your representative: Cosponsor and support enactment of H.R. 8, the Bipartisan Background Checks Act of 2019.**
Gun violence research

Gun violence is a public health crisis in the United States with firearms accounting for more than 30,000 deaths annually, including accidents and suicides.

As such, there is a critical need for comprehensive, multi-faceted public health solutions.

A key element of an enhanced public health response to preventing gun violence is improved surveillance and epidemiological research studying the causes and risk factors associated with gun violence, as well as interventions that might work. Determining the root causes—through federally-funded research—of this epidemic is critical to solving it.

For many years, the Centers for Disease Control and Prevention has faced threats from powerful opponents of such research who spread fear that the only likely result of such work would be recommendations to severely curtail firearm ownership. Under the threats to defund other critical injury prevention activities, research on gun violence prevention has languished.

In recent years, however, following a string of highly visible mass shootings in the United States, a greater awareness of the need to better understand the epidemiology of gun violence and how it can be prevented has arisen.

Though legislative riders generally prevent CDC from advocating “gun control,” the agency itself has recently confirmed that there is no prohibition on the conduct of such research—only a lack of funding.

Public health is focused on preventing disease and injury in communities and populations on a larger scale and promoting public safety. Addressing the high number of gun-related homicides, suicides and injuries—many of which are preventable—is as much a public health issue as is addressing tobacco use, underage drinking, alcohol and substance use disorders, vaccinations, safety belt use, pool safety, and helmet use for bicyclists and motorcyclists.

The AMA believes that a specific funding allocation for federal gun violence research, including for the Centers for Disease Control and Prevention, is a necessary first step to reversing the course on gun violence.

Urge your senators and your representative to support specific funding for the CDC to conduct epidemiological research on gun violence as part of Fiscal Year 2020 appropriations process.
Continue efforts on substance use disorder

Over several years, Congress has authorized dozens of grant programs to help to turn the tide of the continuing epidemic of substance use disorder, particularly opioids. It is critical that congressional appropriators ensure these programs receive the necessary funds to support and increase access to treatment and prevention through both federal and federally-supported state and local efforts.

Beyond critically needed funding, there are additional steps that federal and state elected officials can take to increase access to treatment and prevention. Among them:

**Remove prior authorization, step therapy, and other inappropriate administrative burdens or barriers that delay or deny care for medication-assisted treatment for opioid use disorder.**
- Medication-assisted treatment is a proven medical model to support recovery and save lives. All payers, including federally regulated self-insured plans, Medicare, and Medicaid should end prior authorization and other unnecessary utilization management protocols for the treatment of opioid use disorder.

**Remove administrative and other barriers to comprehensive, multimodal, multidisciplinary pain care.**
- Patients must have access to the right treatment at the right time without administrative barriers or delay.
- To continue reducing prescriptions for opioid medications, payers must increase access to non-opioid alternatives—and patients, physicians and other providers should take advantage of enhanced education to determine appropriate alternative pain treatments (including pharmaceutical alternatives), restorative therapies such as physical or occupational therapy, interventional procedures and behavioral health approaches.
- A detailed regulatory review should be conducted of formulary and benefit design by payers and pharmacy benefit managers to ensure that patients have affordable, timely access to non-opioid pharmacologic and non-pharmacologic alternatives.

**Enforce meaningful oversight and enforcement of state and federal mental health and substance use disorder parity laws.**
- Insurers must be held accountable for complying with their legal obligations to have mental health and substance use disorder parity coverage that is on par with medical and surgical benefits, as well as addiction medicine available and psychiatric physicians not only in the network but also accepting new patients.
Conrad 30 Waiver program

Currently, resident physicians from other countries working in the U.S. on J-1 visas are required to return to their home country after their residency has ended for two years before they can apply for another visa or green card. The Conrad 30 program allows these physicians to remain in the U.S. without having to return home if they agree to practice in an underserved area for three years. Many communities, including rural and low-income urban districts, have problems meeting their patient care needs and depend on the physicians in this program to provide health care services. With communities across the country facing physician shortages, the Conrad 30 program ensures that physicians who are often educated and trained in the U.S. can continue to provide care for patients.

Legislation is needed to reauthorize and improve the Conrad 30 Waiver program to protect patient access to care in medically underserved areas.

Physician green card backlog

There is currently a sizable backlog of international medical graduates (IMGs), primarily from India and China, seeking green cards for permanent residency in the U.S. These physicians are actively practicing in the U.S., but have been waiting to receive their green card due to a massive backlog caused by the per-country limitations imposed by law. Many of these have physicians served in the Conrad 30 program.

These IMG physicians provide important medical services to communities in need. They often choose primary-care specialties and work in areas of the country with higher rates of poverty.

Not only does the backlog present a problem for physicians who are waiting on their residential status—some of whom have been waiting for several years—but workforce experts have predicted that the U.S. will face a significant physician shortage for both primary care and specialty physicians in the decade to come due to the growth of the aging population. This will disproportionately affect areas of the country that are already experiencing a physician shortage.

Patient access and Conrad 30 reauthorization legislation

Ask your senators and representatives to support legislation to reauthorize and improve the Conrad 30 program by requiring more transparency in employment contract terms, creating additional waivers per states, and protecting spouses and children of physicians in the program.

Further, such legislation should address the current physician green card backlog by allowing physicians who work in underserved areas or a VA medical facility for five years to be eligible for a green card and exempt from the current per-country cap on employment-based green cards.

This legislation would help to alleviate growing physician shortages and improve patient access to care in underserved communities.

Ask your senators and representatives to support legislation to reauthorize and improve the Conrad 30 program by requiring more transparency in employment contract terms, creating additional waivers per states, and protecting spouses and children of physicians in the program.