



AMERICAN COLLEGE OF SURGEONS

Inspiring Quality:
Highest Standards, Better Outcomes

100+ years

Chicago Headquarters

633 N. Saint Clair Street
Chicago, IL 60611-3211

Voice: 312-202-5000

Fax: 312-202-5001

E-mail: postmaster@facs.org

Washington Office

20 F Street, NW Suite 1000
Washington, DC 20001

Voice: 202-337-2701

Fax: 202-337-4271

E-mail: ahp@facs.org

facs.org

OFFICERS

President

Ronald V. Maier, MD, FACS
Seattle, WA

Immediate Past-President

Barbara L. Bass, MD, FACS
Houston, TX

President-Elect

Valerie W. Rusch, MD, FACS
New York, NY

First Vice-President

Mark C. Weissler, MD, FACS
Chapel Hill, NC

First Vice-President-Elect

John A. Weigelt, MD, FACS
Sioux Falls, SD

Second Vice-President

Philip R. Caropreso, MD, FACS
Keokuk, IA

Second Vice-President-Elect

F. Dean Griffen, MD, FACS
Shreveport, LA

Secretary

Edward E. Cornwell III, MD, FACS
Washington, DC

Treasurer

William G. Cioffi, Jr., MD, FACS
Providence, RI

Executive Director

David B. Hoyt, MD, FACS
Chicago, IL

Chief Financial Officer

Gay L. Vincent, CPA
Chicago, IL

BOARD OF REGENTS

Chair

Gerald M. Fried, MD, FACS, FRCS
Montreal, QC

Vice-Chair

James K. Eisey, MD, FACS
Atlanta, GA

Anthony Atala, MD, FACS
Winston-Salem, NC

John L. D. Atkinson, MD, FACS
Rochester, MN

James C. Denny III, MD, FACS
Alexandria, VA

Margaret M. Dunn, MD, FACS
Fairborn, OH

Timothy J. Eberlein, MD, FACS
Saint Louis, MO

Henri R. Ford, MD, FACS
Miami, FL

James W. Gigantelli, MD, FACS
Omaha, NE

B.J. Hancock, MD, FACS, FRCS
Winnipeg, MB

Enrique Hernandez, MD, FACS
Philadelphia, PA

Lenworth M. Jacobs, Jr., MD, FACS
Hartford, CT

L. Scott Levin, MD, FACS
Philadelphia, PA

Fabrizio Michelassi, MD, FACS
New York, NY

Lena M. Napolitano, MD, FACS
Ann Arbor, MI

Linda G. Phillips, MD, FACS
Galveston, TX

Kenneth W. Sharp, MD, FACS
Nashville, TN

Anton N. Sidawy, MD, FACS
Washington, DC

Beth H. Sutton, MD, FACS
Wichita Falls, TX

Gary L. Timmerman, MD, FACS
Sioux Falls, SD

Steven D. Waxner, MD, FACS
Weston, FL

Douglas E. Wood, MD, FACS
Seattle, WA

Michael J. Zinner, MD, FACS
Miami, FL

BOARD OF GOVERNORS

Chair

Steven C. Stain, MD, FACS
Albany, NY

Vice-Chair

Daniel L. Dent, MD, FACS
San Antonio, TX

Secretary

Ronald J. Weigel, MD, PhD, FACS
Iowa City, IA

June 5, 2019

Honorable Lamar Alexander
455 Dirksen Senate Office Building
Washington, DC 20510

Honorable Patty Murray
154 Russell Senate Office Building
Washington, DC 20510

Dear Chairman Alexander and Ranking Member Murray,

On behalf of the more than 82,000 members of the American College of Surgeons (ACS), I would like to thank you for the opportunity to comment on your draft legislation, the *Lower Health Care Costs Act*. The ACS welcomes the focus on increasing transparency and improving the exchange and availability of health data in Titles III and V respectively. We are also supportive of the focus on maternal health in Title IV of the legislation. Importantly, in regards to Title I, the ACS agrees that the hardship experienced by some patients confronted with unexpected medical bills needs to be addressed. *The Lower Health Care Costs Act* is significant legislation and we look forward to continuing to work with you to strengthen the provisions highlighted below. We hope there remains further opportunity to weigh-in as the legislation continues to develop.

Title I: Ending Surprise Medical Bills

Sec. 101-102. Protecting Patients.

Legislation to address unanticipated medical billing should protect patients, increase insurance plan transparency and accountability, and address narrow and inadequate networks. The ACS has deep concerns regarding proposals that would assign a single payment to the hospital for all aspects of care, tie a benchmark payment to a percentage of Medicare or the in-network average rate, or require providers to be in all of the same networks of the hospital in which they provide care.

The ACS strongly believes that any legislation to address unanticipated medical billing should keep patients out of the middle. This is particularly important in the case of patients in need of emergency care, who may not be in a position to make informed choices about where they seek care. When seeking emergency care, patients should only be responsible for their in-network cost-sharing amounts.



AMERICAN COLLEGE OF SURGEONS

Inspiring Quality:
Highest Standards, Better Outcomes

100+ years

Sec. 103.

Subtitle A – Option 1: In-Network Guarantee.

The ACS strongly opposes any legislation that requires providers to be in-network for all plans in which the hospital is in-network. This policy proposal completely disregards the current framework hospitals have for contracting with providers for their services. Additionally, this policy shifts too much power to insurers in negotiations with providers as insurers would know that these clinicians have to accept whatever payment rate offered in order to provide care in the facility. This will have unintended adverse consequences.

Subtitle B – Option 2: Independent Dispute Resolution.

The ACS supports an Independent Dispute Resolution (IDR) process, but has highlighted some changes below that better remove patients from the middle, more fairly bring all parties to the table, and closely follow proven and existing law without fear of serious unintended consequences. To begin, the ACS has extreme concerns with the use of the median contracted rate, as currently outlined in the draft, as a benchmark for paying out-of-network physicians. Setting the payment benchmark at the median contracted rate will expand the disproportionate power that health plans have with physicians and will likely have two major negative consequences:

1. For those physicians who want to be part of the health plans network, the ability to negotiate a payment rate with the health plan will be unfairly biased towards the plan.
2. For those physicians who are currently in-network and paid above the median in-network rate, the health plan will have the unfettered power to lower the rate paid to those physicians with no realistic alternative for the physician.

If a physician is in-network and paid in the 80th percentile, above the median rate, during the next contract negotiation the health plan could offer the physician the 65th percentile rate with no alternative. The physician is now forced to accept the insurer's lower offer or go out-of-network and receive the median in-network rate. Insurers have no incentive to negotiate higher rates with the physician and could intentionally lower the median rate with each new contract. A viable solution must strike a careful balance, allowing physicians and insurer to negotiate a final payment while completely protecting patients from unanticipated medical bills.

Additionally, while arbitration is the most effective tool for addressing unanticipated bills, the arbiter should be allowed to review a variety of factors when making their determination and not just the median in-network rate.

Chicago Headquarters

633 N. Saint Clair Street
Chicago, IL 60611-3211

Voice: 312-202-5000

Fax: 312-202-5001

E-mail: postmaster@facs.org

Washington Office

20 F Street, NW Suite 1000
Washington, DC 20001

Voice: 202-337-2701

Fax: 202-337-4271

E-mail: ahp@facs.org

facs.org



Within a successful IDR the arbiter should consider:

- The usual and customary cost of the service (as defined by the 80th percentile of charges for that service in that region);
- Whether there is a “gross disparity” between the fee charged by the physician as compared to other fees paid to similarly qualified non-participating physicians in the same region;
- Non-participating physicians usual charge for comparable services;
- Individual patient characteristics; and
- Level of training, education, and experience of the physician and the circumstances and complexity of the case.

Concerns that considering the 80th percentile of usual and customary costs would lead to increased rates, has not proven to be the case. According to a recent study from Georgetown titled “*New York’s 2014 Law to Protect Consumers from Surprise Out-of-Network Bills Mostly Working as Intended: Results of a Case Study*,” the New York law, which uses a fair arbitration model, is working well. The study found a 13 percent average reduction in physician payments since the law was enacted. State regulators also report that there has not been an indication of an inflationary effect in insurers’ annual premium rate filings. Observers further noted that, prior to the law, New York HMOs were required to pay out-of-network doctors’ full billed charges for emergency services if the provider would not agree to a negotiated rate; the IDR process has served to likely reduce those payers’ costs.

The study acknowledged that the IDR is not perceived as “a slam dunk for either side.” As of October 2018, IDR decisions have been roughly evenly split between providers and payers, with 618 disputes decided in favor of the health plan and 561 decided in favor of the provider. However, insurers have tended to win the majority of out-of-network emergency services disputes (534-289), while providers have won the majority of surprise bill disputes (272-84). The study highlights that observers do believe the legislation has sent a signal to insurers and providers alike to “just be reasonable and work it out amongst yourselves if you can.”

Subtitle B – Options 3: Benchmark for Payment.

For all of the reasons mentioned above, the ACS strongly opposes benchmarking payment to the median in-network rate. The long-term consequences of allowing insurers to dictate physician payment should not be under-estimated. Physicians already have less power in the negotiation of payment process and such a benchmark would impact both in-network and out-of-network providers.

Chicago Headquarters

633 N. Saint Clair Street
Chicago, IL 60611-3211

Voice: 312-202-5000

Fax: 312-202-5001

E-mail: postmaster@facs.org

Washington Office

20 F Street, NW Suite 1000
Washington, DC 20001

Voice: 202-337-2701

Fax: 202-337-4271

E-mail: ahp@facs.org

facs.org



AMERICAN COLLEGE OF SURGEONS

Inspiring Quality:
Highest Standards, Better Outcomes

100+ years

Over the past several decades, the health insurance market has become extremely concentrated. Antitrust exemptions and consolidation within the health insurance industry have facilitated the opportunity for fewer and fewer health plans to dominate the health insurance market. In many states, there may only be one dominant insurer for the entire private health insurance market. While health insurers are still subject to antitrust enforcement involving mergers and acquisitions under the *Clayton Act*, a separate federal antitrust exemption, created by the *McCarran-Ferguson Act*, allows insurers to share information on pricing. As a result, physicians are frequently placed in positions of diminished negotiating strength, and health plans are able to impose unilateral, essentially non-negotiable contracts. Additionally, the *Sherman Act* currently places restrictions on providers to jointly negotiate contracts. This leads to less choice for patients.

The ACS is committed to addressing surprise medical billing, and as the Committee continues its work, we urge the Committee to consider proven solutions consisting of coordinated efforts by health insurance plans, hospitals, providers, and patients.

TITLE III—IMPROVING TRANSPARENCY IN HEALTH CARE

Sec. 301 - 302. Increasing transparency and banning anticompetitive contracts.

Increasing transparency in cost and quality is important and necessary to develop an accurate assessment of value in health care. However, existing information available can sometimes be misleading. Care should be taken to ensure that quality information provided through these sections and potentially used to steer or incentivize patients to certain providers, is accurate and that sample sizes are large enough to make a valid assessment.

ACS has proposed to CMS a novel quality measurement framework which incorporates verification programs, patient reported outcomes and experience measures as well as more traditional measures to create a more useful and valid picture of surgical quality. We would be happy to discuss this quality framework with you in greater detail at your convenience.

Sec. 303. Designation of a nongovernmental, nonprofit transparency organization to lower Americans' health care costs.

As noted in our March 1st letter, ACS sees an opportunity for increased transparency and the insights into cost drivers that this can provide. In order to address the growing costs of medical care meaningfully, we must have a clear

Chicago Headquarters

633 N. Saint Clair Street
Chicago, IL 60611-3211

Voice: 312-202-5000

Fax: 312-202-5001

E-mail: postmaster@facs.org

Washington Office

20 F Street, NW Suite 1000
Washington, DC 20001

Voice: 202-337-2701

Fax: 202-337-4271

E-mail: ahp@facs.org

facs.org



AMERICAN COLLEGE OF SURGEONS

Inspiring Quality:
Highest Standards, Better Outcomes

100+years

picture of where money is being spent, in what clinical context, and what impact this spending is having on the health of patients. To accomplish this level of transparency requires standardized definitions of episodes of care, to clarify the clinical context, so that apples-to-apples comparisons can be made of the resources, personnel and other inputs required for that care. ACS agrees that defining such a standard is accomplished most readily through an impartial, nongovernmental, not-for-profit organization with the support and input of the medical community to verify the clinical content of the episodes. For that reason, we welcome the inclusion of this section in the draft legislation.

ACS has been involved in a coalition of stakeholders working to form such an entity, now called the PACES Center, which is very much in line with that described in this section. By way of an update to our previous letter, as of this week, the PACES Center has officially launched as a not-for-profit organization. The stated mission of this organization is to serve the public interest by educating consumers about value in healthcare, including the services and costs that can occur by type of episode. This will be achieved through refinement of a voluntary single standard for the analysis of value in healthcare by payers and providers, building on work paid for by taxpayers and reflecting the state of the art in medicine. While much work remains to achieve the PACES Center's goal, this work is moving forward and we believe it could complement and help bring to fruition the goals of this section. To that end, the ACS would welcome the opportunity to facilitate a meeting with representatives of the PACES Center to discuss how our shared goals can be accomplished.

Sec. 304. Protecting patients and improving the accuracy of provider directory information.

ACS is supportive of the concept of maintaining an up-to-date provider directory to help patients better understand what their out-of-pocket costs will be.

Too often, despite being diligent about seeking care from in-network providers, patients may find themselves receiving unanticipated bills from those who are not in their insurance plan's network. Much of the time this is simply because patients have no way of accurately determining in advance which physicians will ultimately be involved in their care. Surgeons and other providers are also limited in their ability to help patients avoid these unanticipated costs because they are unable to accurately predict who will ultimately be involved in an episode of care, nor those individuals' contract status with specific insurance plans.

Chicago Headquarters

633 N. Saint Clair Street
Chicago, IL 60611-3211

Voice: 312-202-5000

Fax: 312-202-5001

E-mail: postmaster@facs.org

Washington Office

20 F Street, NW Suite 1000
Washington, DC 20001

Voice: 202-337-2701

Fax: 202-337-4271

E-mail: ahp@facs.org

facs.org



AMERICAN COLLEGE OF SURGEONS

Inspiring Quality:
Highest Standards, Better Outcomes

100+years

We are concerned that while the requirements in (a)(1) and (a)(2) of this section are placed on “a group health plan or a health insurance issuer offering coverage in the individual or group market”, the penalties and enforcement provisions in (b) and (c) are inappropriately targeted against health care providers. Legislative solutions that require physicians to provide information on another provider’s in-network/out-of-network status are currently unworkable with the lack of data that exists on providers’ status.

Because of this, insurers should be required to accurately update their provider directories on a regular basis in order to optimize their usefulness to patients seeking care from in-network providers. In addition to providing greater transparency of their provider networks, insurers should be providing greater transparency regarding deductibles and required cost-sharing for in-network and out-of-network care. Any legislative proposal that does not touch upon these issues simply avoids addressing one of the major reasons for unanticipated medical billing.

The ACS agrees that if a patient, after performing due diligence to determine a provider where he or she plans to receive care is in-network, receives an unexpected bill due to inaccurate information, that patient should not be required to pay out-of-pocket costs greater than they would have for in-network care. However, in many cases these unexpected charges result from inaccurate provider directories maintained by the health plan, and are not the fault or responsibility of the providers involved. In many cases providers can be dropped from network by plan issuers in the middle of a plan year as issuers seek to further narrow networks. If such is the case, not only should the patient not be required to pay more than for in-network care, the plan should be required to pay the provider the difference, since the confusion is due to their failure to meet the requirements outlined in (a)(1) and (a)(2).

Sec. 305. Timely bills for patients.

While at first glance, Section 305 seems completely reasonable, the current reality is that there are several logistical steps following a clinical service or procedure that may impact a provider’s ability to provide a complete list at discharge and a bill within 30 days of providing the service. This is especially true for patients with lengthier hospital stays and more involved admissions. In certain situations, the bill may also be bundled with the hospital and/or outpatient facility charges. When multiple specialties are involved or a patient’s hospital stay is longer than 30 days, this becomes infinitely more complex.

Chicago Headquarters

633 N. Saint Clair Street
Chicago, IL 60611-3211

Voice: 312-202-5000

Fax: 312-202-5001

E-mail: postmaster@facs.org

Washington Office

20 F Street, NW Suite 1000
Washington, DC 20001

Voice: 202-337-2701

Fax: 202-337-4271

E-mail: ahp@facs.org

facs.org



AMERICAN COLLEGE OF SURGEONS

Inspiring Quality:
Highest Standards, Better Outcomes

100+years

Surgical services require a signed operative note accomplished through a variety of means. The note results in coding for the service which then often goes through a secondary process of examination for correctness prior to being issued to insurers (Medicare, Medicaid and Private). During this time, at which the bill is out of the provider's hands, the payer is also making decisions on co-pay and coverage for support services. The bill is not accurate until the review is complete. The legislation as drafted does not currently limit the amount of time the payer may take examining the bill, even though the review impacts the 30-day window. Forcing providers to send a bill within 30 days at risk of penalty may lead to inaccurate bills, putting the patient in the middle between their provider and insurer. These issues which reside outside of the providers' control should be resolved prior to moving this provision forward.

Sec. 309. Ensuring enrollee access to cost-sharing information.

The ACS appreciates the recognition that providing expected cost for a given service is not enough to inform patients or providers, and does not align with how patients experience care, as noted in our March 1 response to the Committee. In that letter we state that a price transparency tool which provides patients and their physicians with a range of expected costs for an entire episode of care based on historical data from similar patients creates a much more realistic expectation of the true cost to treat a given condition. With such a tool, the patient or their physician can see the mean price or an entire array of prices broken into deciles. As noted above, we remain committed to working with partners who hope to develop these resources and Title III of this legislation could greatly help accelerate this or other efforts toward cost transparency and awareness.

However, we are concerned that it may not be feasible for a surgeon to provide cost sharing information for a service and all reasonably related services at the time of making an appointment. While a surgeon or other provider may have a reasonable idea of what services are likely to be provided in conjunction with a given surgical procedure, he or she may not know at the time of scheduling an appointment who will be providing those ancillary services or whether or not that provider will be in-network for the patient. Furthermore, unless both the surgeon and the patient are in an HMO or similarly closed system, the surgeon may have no influence over who will be providing these services. Therefore, they can't be expected to provide accurate information to the patient.

Providing patients with cost information for the specific service coupled with an expected range of what a patient with similar characteristics could expect based on the outputs of a price transparency tool such as the one discussed above could be an alternative. However, it is unlikely that such a tool will be

Chicago Headquarters

633 N. Saint Clair Street
Chicago, IL 60611-3211

Voice: 312-202-5000

Fax: 312-202-5001

E-mail: postmaster@facs.org

Washington Office

20 F Street, NW Suite 1000
Washington, DC 20001

Voice: 202-337-2701

Fax: 202-337-4271

E-mail: ahp@facs.org

facs.org



AMERICAN COLLEGE OF SURGEONS

Inspiring Quality:
Highest Standards, Better Outcomes

100+years

widely available by the January 1, 2020 effective date of this provision as drafted.

TITLE IV—IMPROVING PUBLIC HEALTH

Sec. 406 – 410 Innovating for maternal health.

The ACS commends the Committee for including provisions that seek to improve maternal health care quality and prevent maternal mortality. The U.S. is the only industrialized nation with a rising maternal mortality rate. The U.S. saw a 26% increase in the maternal mortality rate from 18.8 deaths per 100,000 live births in 2000 to 23.8 in 2014¹. Considerable racial disparities in pregnancy-related mortality exist. According to the Centers for Disease Control and Prevention’s (CDC) Pregnancy Mortality Surveillance System, during 2011–2013, the pregnancy-related mortality ratios were 12.7 deaths per 100,000 live births for white women compared to 43.5 deaths per 100,000 live births for black women.

According to the CDC Foundation, the leading causes of pregnancy-related death include seven causes accounting for 72.2% of all pregnancy-related deaths. The leading underlying causes of pregnancy-related death are hemorrhage, cardiovascular and coronary conditions, cardiomyopathy, infection, embolism, mental health conditions, and preeclampsia. Variations amongst the leading causes exist among states, race-ethnicity, and age. Determining methods to address disparities amongst different populations by providing high quality care will help to improve health outcomes. The ACS applauds the Committee’s effort to harness data to address these issues.

TITLE V—IMPROVING THE EXCHANGE OF HEALTH INFORMATION

Sec. 501. Requirement to provide health claims, network, and cost information.

The information made available to patients and authorized third parties in this section will provide valuable insights. This is especially true when coupled with the designation of the non-profit transparency organization outlined in section 303 (such as the new PACES Center). Granting patients the right to

¹ [1] MacDorman, M., Declercq, E., Cabral, H., Morton, C., “Is the United States Maternal Mortality Rate Increasing? Disentangling trends from measurement issues: Short title: U.S. Maternal Mortality Trends.” *Journal of Obstetrics and Gynecology*. September, 2016

Chicago Headquarters

633 N. Saint Clair Street
Chicago, IL 60611-3211

Voice: 312-202-5000

Fax: 312-202-5001

E-mail: postmaster@facs.org

Washington Office

20 F Street, NW Suite 1000
Washington, DC 20001

Voice: 202-337-2701

Fax: 202-337-4271

E-mail: ahp@facs.org

facs.org



AMERICAN COLLEGE OF SURGEONS

Inspiring Quality:
Highest Standards, Better Outcomes

100+ years

easy access of claims data through an Application Programming Interface (API) will allow for information to be made available at the patient's request, and in order to inform decisions about their care. This can help to facilitate shared decision making with a patient's physician.

The Directory information on participating facilities and physicians, along with the expected out-of-pocket cost information on a common set of services and episodes will likewise remove barriers for patients trying to make informed decisions about their care. To the extent that the provisions of section 501 can be closely aligned with the work of the nongovernmental nonprofit organization described in section 303, this would make both provisions more effective and meaningful. Allowing a patient or designee to access their personal claims history, organized understandably by episode of care, and compare that with the insights available through use of the deidentified data in the nongovernmental database, would provide a much clearer picture of what they can expect. Beyond out-of-pocket pricing, this could provide information on the potential for complications, the need for rehabilitation or other follow-up care based on the experience of prior patients with similar characteristics taking much of the mystery out of healthcare decisions.

Sec. 502. Recognition of security practices.

With threats to cybersecurity evolving at a rapid pace, the ACS welcomes this recognition that a business can fall prey to such attacks even if they are using best practices in securing data. When an attack is successful despite the best efforts of a data holding organization fully in compliance with current standards, this flexibility provides clarity and will help to ensure that penalties are not overly punitive.

On behalf of the ACS, I again thank you for your efforts to make health care more affordable for patients. We agree that many of the provisions in this legislation represent important steps toward that goal. As noted above, we would like to facilitate a meeting between you or your staff and representatives of the recently launched PACES Center to discuss how best to move forward on our shared goals of improving transparency and value in healthcare. We would also welcome the opportunity to further discuss our concerns with other provisions which we believe could be improved to achieve the stated goal of the legislation while addressing longstanding barriers to achieving value in health care.

Chicago Headquarters

633 N. Saint Clair Street
Chicago, IL 60611-3211

Voice: 312-202-5000

Fax: 312-202-5001

E-mail: postmaster@facs.org

Washington Office

20 F Street, NW Suite 1000
Washington, DC 20001

Voice: 202-337-2701

Fax: 202-337-4271

E-mail: ahp@facs.org

facs.org



AMERICAN COLLEGE OF SURGEONS

Inspiring Quality:

Highest Standards, Better Outcomes

100+years

Please contact Kristin McDonald, Manager of Legislative and Political Affairs, in the ACS Washington D.C. office at 202 672-1512 or at kmcdonald@facs.org if you have questions or if we can provide additional information or clarification on any of our comments.

Sincerely,

David B. Hoyt, MD, FACS
Executive Director

Chicago Headquarters

633 N. Saint Clair Street
Chicago, IL 60611-3211

Voice: 312-202-5000

Fax: 312-202-5001

E-mail: postmaster@facs.org

Washington Office

20 F Street, NW Suite 1000
Washington, DC 20001

Voice: 202-337-2701

Fax: 202-337-4271

E-mail: ahp@facs.org

facs.org