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February 19, 2019

The Honorable Bill Cassidy, MD
United States Senate
520 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Cassidy:

On behalf of the more than 80,000 members of the American College of Surgeons (ACS), I am pleased to respond to your recent letter. The ACS recognizes the need to protect patients and their families from unanticipated medical bills. At the same time, the ACS also believes that all providers should be fairly compensated for the provision of care rendered, regardless of whether or not they choose to contract with insurance plans.

The problem of unanticipated bills for patients can only be remedied via a holistic approach, which appropriately focuses on the multiple reasons of this problem. One of these root causes is network adequacy. Surgeons may be excluded from health insurance networks for a variety reasons. Plans often do not contract with the full battery of surgeons necessary to provide coverage to their beneficiaries. On the other hand, surgeons may make the deliberate choice to remain out-of-network due to poor contract rates that are inherently not negotiable and often represent significant cuts to reimbursement. The surgeon's motivation for refusing these rates rests in the inadequacy they represent in the face of increasing costs of practice.

Insurance plans have chosen in many cases to offer products with narrow, inadequate networks. These products are often deficient in specialists and other key health care providers. Thus, patients may unknowingly receive out-of-network care and incur unanticipated charges for services rendered by an out-of-network provider even if they receive that care at an in-network facility. Any attempt to address the problem posed by these unanticipated medical bills, without including provisions that also require third party payers to simultaneously address network adequacy, would not only be short-sighted, but also unjust and likely to ultimately fail to protect patients.

ACS has no comments relative to the questions in the letter posed for the "Plans." Upon review of the questions posed for "Providers," ACS had discussion with outside counsel, and has been advised that several of the questions could potentially violate anti-trust law. Accordingly, ACS will not be

providing responses to all of the questions directed at provider groups.

Question -- According to an article published by the Health Care Cost Institute, emergency room spending per person has increased by 98% while overall emergency room utilization remained the same between 2009 and 2016.[1] How do you explain this trend?

We are unsure what goes into the total definition of spending relative to emergency care. For example, does such include expenditures for trauma care and acute surgical care or only acute surgical care. Without a more complete understanding of what is included in definition of emergency room spending, it is not possible for us to provide any meaningful comment.

Question -- In situations where the ED or ancillary physician is out-of-network but the facility is in-network, can you provide data to show how often a balance bill is sent to the patient?

Unfortunately, the ACS cannot answer this question as we do not collect or otherwise have access to this data.

Question -- What percentage of care provided in the emergency department results in bad debt from patients not paying their part of what is owed from care they received, from missed copayments, denied claims, or other means?

The ACS cannot answer this question as we do not collect or otherwise have access to this data

Question -- What specific recommendations do you have to facilitate in-network contracting between providers and plans in the context of federal legislation to address surprise medical billing?

As mentioned above, many areas in the United States have narrow, inadequate networks—deficient in specialists and other key health care providers. The ACS strongly believes that in order to address the problem of unanticipated medical bills sent to patients, the insurance plans must be mandated to meet minimum standards of network adequacy.

Over the past several decades, the health insurance market has become extremely concentrated. Antitrust exemptions and consolidation within the health insurance industry have enabled fewer and fewer health plans to dominate the health insurance market. In many states, there may only be one

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dominant insurer for the entire private health insurance market.

While these insurers are still subject to antitrust enforcement involving mergers and acquisitions under the Clayton Act, the McCarran-Ferguson Act created a federal antitrust exemption which allows insurers to share information on pricing for premiums. 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. In order to establish more equity in negotiating power, Congress should remove restrictions currently in place on providers to jointly negotiate contracts.

Question -- What role do you think that hospitals should play in combatting surprise medical billing?

Hospitals should be responsible for maintaining up to date information relative to which plans the providers on their medical staff are contracted as in-network. This information should be made available to patients upon their registration for the emergency department, inpatient admission, or outpatient department. Obviously, such information can only be acquired and be accurate with cooperation of both health care providers and the insurance providers. ACS believes that such a collective effort is warranted in the attempt to remedy this problem. That said, the ACS believes that hospitals should be prohibited from mandating that the extension of staff privileges to providers be based on their being in-network for all plans in which the hospital is in-network.

Question --- In your view, is there a state model that has worked particularly well at protecting patients from surprise medical billing? If so, why has it worked well? Please provide the details of this model, including its impact on contracting rates and out-of-network payment rates, and describe the data and policy rationale underlying this state legislation.

The ACS would point to the success of New York in addressing unanticipated medical bills. The law adopted by New York State in 2014 has been touted as a model for the rest of the country. This law strikes a careful balance among key health care stakeholders, including physicians, hospitals, and health insurers, and has had success in protecting patients from large unanticipated medical bills. Most importantly, this policy was constructed in a way that it did not adversely affect the ability of hospital emergency departments to have an

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adequate on-call battery of specialty physicians.

The New York law also took the holistic approach and addressed both narrow and inadequate health insurance provider networks and inadequate insurance coverage for out of network (OON) physician care. The law contains provisions that attempt to ensure that patients have a better understanding of the scope of a health insurer's OON coverage, expands the availability of a patient to have coverage for an OON physician if the insurer's existing participating physician network is inadequate for such, assures that OON benefits offered by insurers are more comprehensive, and establishes a process to define the extent of insurer coverage for emergency and unanticipated OON medical bills.

The New York law also establishes essential patient marketplace protections for voluntary OON care. One way the New York law addresses the issue of unanticipated billing is by requiring that all health insurance products regulated by the State of New York meet physician network adequacy requirements. Additionally, patients also have the right to receive treatment from a specialist appropriately qualified to treat that patient's particular condition at no additional cost if the network of the insurer fails to include a qualified physician specialist. If the insurer network is insufficient to meet their health care needs, a patient has the right to have an independent external appeal to be treated by an OON physician.

The New York law requires health insurers must provide OON coverage in a manner based upon the percentage of the "usual and customary cost" of OON health care services. Health insurers are required to offer coverage to consumers of policies that cover at least 80% of usual and customary cost of any OON health care services. The New York law defines "usual and customary cost" as the 80th percentile of "all charges for the particular health care services performed by a provider in the same or similar specialty and provided in the same geographical areas as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent." The "usual and customary" data from the publicly available benchmarking service FAIR Health, not Medicare, has become the benchmark for different state programs across the country, including New York. Using a percentage of Medicare as a benchmark will not work and is evidenced by the experience in California following the passage of legislation in 2016.

The New York law provides protection to patients for unanticipated medical bills by holding them "harmless" for amounts above the patient's otherwise

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required cost-sharing. To ensure fair payment to the physician from the health insurer, the following process is employed:

- The physician submits the OON claim to the insurer
- The insurer pays what it deems to be reasonable
- If efforts to informally settle the payment dispute are unsuccessful, either the physician or the insurer can bring the claim to an Independent Dispute Resolution (IDR) process.

The IDR must choose between the plan's payment or the non-participating physician's fee (otherwise known as "baseball arbitration") and may not set their own amount. The IDR entity is required to 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 physician's usual charge for comparable services
- individual patient characteristics
- level of training, education, and experience of the physician, and the circumstances and complexity of the case.

Using the IDR or "baseball arbitration" disadvantages providers that bill for unreasonably high charges and as well as insurers that offer unreasonably low initial payments. The law also encourages physicians and payers to negotiate independently and avoid arbitration as the IDR is defined as a "loser pays" process. The New York law also contains provisions to ensure both health care provider and health insurer transparency. Because the major goal of New York's law was to reduce the incidence of unanticipated medical bills, the law imposes significant disclosure requirements on physicians, requiring that they disclose the plans in which they participate and the hospitals where the physician is privileged. This was done to better inform patients of situations where they may end up receiving treatment by and OON provider.

The ACS appreciates the opportunity to respond to the questions provided to stakeholders and encourages the working group to consider the responses as

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they craft legislation to address the issue of unanticipated medical billing. If you would like to further discuss any of the concepts included in this letter, please contact Mark Lukaszewski, at (202) 672-1509 or at mlukaszewski@facs.org.

Sincerely,

David B. Hoyt, MD, FACS
Executive Director, American College of Surgeons

cc: Hon. Michael Bennet, United States Senator
Hon. Todd Young, United States Senator
Hon. Tom Carper, United States Senator
Hon. Lisa Murkowski, United States Senator
Hon. Margaret Wood Hassan, United States Senator

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