Statement of the

American College of Surgeons

To the House Ways and Means Health Subcommittee

United States House of Representatives

RE: Hearing on Protecting Patients from Surprise Medical Bills

May 21, 2019

The American College of Surgeons (ACS) appreciates the U.S. House Ways and Means Committee's interest in the issue of unanticipated medical billing and thanks the Committee for holding a hearing focused on identifying ways to protect patients. ACS is also concerned about the impact that unanticipated medical bills have on both patient costs and the patient-physician relationship. However, only with a holistic approach, consisting of coordinated efforts by health insurance plans, hospitals, providers, and patients, will it be possible to remedy this complex issue. Accordingly, the ACS is hopeful that any legislative efforts focus on all of the root causes of the problem.

Legislation to address unanticipated medical billing should protect patients and keep them out of the middle, increase insurance plan transparency and accountability, and address narrow and inadequate networks. The ACS has deep concerns regarding current 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 an in-network average rate, or require providers to be in the same network as the hospital in which they are providing care.

Protecting Patients

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 requiring emergency care, who may not be in a position to make informed choices about where they are taken and treated. When seeking emergency care, patients should only be responsible for their in-network cost-sharing amounts. Additionally, to preclude patients from being burdened with negotiations between insurers and providers, physicians should be provided with direct payment/assignment of benefits from the insurer. The ACS maintains that while patients should not be responsible beyond their in-network cost-sharing amount, legislation to address this issue must provide opportunity mechanisms whereby health plans are required to work with providers to arrive at a fair rate of remuneration.

ACS believes that the out-of-network law passed in the state of New York serves as a useful and workable template for federal legislative efforts. This law holds insurers accountable for maintaining adequate networks of physicians and specialists – ensuring that patients have greater access to in-network care. The law further establishes reasonable patient benchmarks and an effective alternative dispute resolution (ADR) mechanism for those circumstances where the payment offered is in dispute due to factors such as the complexity of the patient's medical condition or the special expertise required. This law seems to have struck a careful balance among key health care stakeholders, including physicians, hospitals, and health insurers, and has been successful in protecting patients from large unanticipated medical bills. The ACS is hopeful that federal legislative solutions to address unanticipated medical billing would be modelled after the New York state law.

Insurance Plan Transparency and Accountability

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 equally unable to accurately predict who will ultimately be involved in any episode of care, nor those individuals' contract status with specific insurance plans. Legislative solutions that require physicians to provide information on another provider's in-network/out-of-network (OON) status are simply unworkable because of the current lack of reliable data that exits with regard to a provider's status.

To effectively remedy this problem, insurers must be required to accurately update their provider directories on a regular basis (at least once per month) in order to optimize the accuracy and usefulness of such to patients seeking care from in-network providers. In addition to providing greater transparency of provider networks, insurers must also be required to provide greater transparency with regards to deductibles and required cost-sharing amounts for both in-network and out-of-network care. Any legislative proposal that does not effectively address these issues would serve to simply ignore some of the major root causes of unanticipated medical billing.

Narrow and Inadequate Networks

Health insurers are taking increasingly drastic steps to lower cost plan options in order to attract consumers. Unfortunately, consumers are often completely unaware that less generous plans have an insufficient number of providers in their networks relative to both the number of covered lives and the lack of breadth in the specialties included in such networks. Insurance plans often choose to offer products with narrow and inadequate networks as a mechanism of managing costs. When consumers sign up for these plans, insurers do not adequately inform them that the provider networks are excessively restrictive, which often results in gaps in their coverage. Most physicians prefer to be in-network because it is better for both their patients and their practice. However, because of extreme health plan market dominance, unfettered by applicable and effective antitrust regulation, insurers are increasingly not acting in good faith in contract negotiations, often offering contracts of adhesion, which provide for a 'take it or leave it' payment level. Subsequently, if physicians accept this low rate, the following year's in-network payment rate is often dropped even lower. However, should a provider elect to not participate in the plan because of in-network rates, then it will become more difficult for them to attract patients and it will also be more administratively burdensome.

Insurers currently have a significant disincentive to create adequate networks as their own costs may be much lower when their covered patients actually see physicians who are out of network. This is because insurers pay these physicians less than they do in-network physicians or may

choose to outright deny claims for out-of-network care. Regardless, it is the patient who ends up with higher deductibles for out-of-network care or, in some cases, does not receive credit toward fulfilling their annual deductible obligations.

The ACS believes that legislation seeking to effectively and permanently remedy the issue of unanticipated medical billing must address network adequacy in a meaningful way. Insurance plans must be mandated to meet minimum standards of network adequacy to include contracting with an adequate numbers of surgeons, specialist and sub-specialist surgeons, emergency physicians, and hospital-based physicians. In addition, strong consideration must be given to geographic and driving distance standards and maximum wait times. Comprehensive oversight and rigorous enforcement of network adequacy will be required from both the federal and state governments.

Single Payment to Hospitals

The ACS is deeply concerned with recent proposals that would provide for a single payment for the hospital and all providers involved in an episode of care for a patient when one or more of the providers involved are out-of-network. This proposal, misleadingly referred to as "hospital bundled billing," would profoundly and adversely impact the relationship between hospitals and physicians while doing absolutely nothing to address the underlying root causes of unanticipated medical bills. Relationships between hospitals and its providers are complex, involving many types of clinicians with a variety of contractual relationships. Many private practice providers simply have privileges at a facility while others may be actual employees of the facility. The unanticipated consequences single payments to hospitals would have on the provision of complex medical care provided to patients are immense. Bundling facility and physician payments only serves to allow insurers to skirt their responsibility for establishing comprehensive provider networks and instead shifts that burden entirely to the hospitals and the providers.

Getting Benchmark Payments Right

Guidelines utilized for payment should reflect actual charge data for the same service, in the same geographic area, performed by a qualified specialist or sub-specialist, and be sourced from a statistically significant and wholly independent benchmarking database maintained by a nonprofit organization. Medicare rates are absolutely inadequate for this purpose because they establish artificial payments based on budgetary constraints and policy agendas rather than market forces. Nor should rates be based on negotiated in-network rates, which would have the effect of eliminating the need for insurers to engage in meaningful good faith contract negotiations with providers. Setting a benchmark for OON care at the in-network average or median contracted rate will ultimately result in the insurance companies intentionally lowering contracted rates. In this scenario, the insurer, who already holds a disproportionate amount of leverage in contract negotiations, will force providers to accept a rate that may be unreasonably

low or become OON, which provides an even lower default rate. To ensure fair, market-based payments for out-of-network care, any established federal benchmark should reflect actual charge data for the same service in the same geographic area from a statistically significant and wholly independent database, such as FAIR Health.

Network Matching

ACS strongly opposes any legislation that would require physicians to be in-network for all plans for 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 would shift even more power to insurers for purposes of contract negotiations with providers because insurers would know that clinicians must accept whatever payment rate offered in order to provide care in a specific facility. Such a plan is yet another ill-conceived attempt to find a quick and simple answer to a difficult and complex issue, and will have significant unintended adverse consequences, particularly on physicians in private practice.

Outdated Laws Benefit Insurers over Patients

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 very few health plans to dominate the health insurance market. In many states, there is only one dominant insurer for the 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 of adhesion. On the other hand, physicians are prohibited from jointly negotiating with insurers by the *Sherman Act.* Such represents a duplicitous standard to provide tremendous bargaining power to the insurers. The end result of the totality of the current circumstances is less choice for patients.

As the Committee continues its work to address the impact on patients of unanticipated medical billing, the ACS urges the Committee to focus its efforts on holistic solutions involving all responsible parties, including health insurance plans, hospitals, providers, and patients. Only a comprehensive joint effort, with appropriate oversight and enforcement which addresses the entirety of root causes, will remedy this complex issue.