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May 28, 2019

The Honorable Frank Pallone, Jr.
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Greg Walden
Ranking Member
Committee on Energy and Commerce
2322A Rayburn House Office Building
Washington, DC 20515

RE: ACS Comments on the *No Surprises Act*

Dear Chairman Pallone and Ranking Member Walden,

The American College of Surgeons (ACS) appreciates your interest in the issue of unanticipated medical billing and thanks you for the opportunity to provide feedback on the *No Surprises Act*. ACS is concerned about unanticipated medical bills and believes that a holistic approach is needed 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. Unfortunately, the *No Surprises Act* is missing some critical components and has significant flaws in some of the areas that are included in the draft bill. ACS would like to work with you to address these provisions to ensure that the legislation has a positive impact on the health care system.

Increasing Transparency for Consumers

Unfortunately, it is not uncommon for patients to find themselves receiving unanticipated bills from physicians who are not in their insurance plan's network despite being diligent about seeking in-network care. Many times, this is due to the fact that patients have no way of accurately determining in advance which physicians will ultimately be involved in their care. Surgeons and other physicians 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 exists with regard to a physician's status.

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The American College of Surgeons urges you to include language in the *No Surprises Act* that requires insurers 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.

Ensuring Network Adequacy

Health insurers are taking increasingly drastic steps to offer lower cost plan options in order to attract consumers. Unfortunately, consumers are often completely unaware that less generous plans have an insufficient number of physicians in their networks relative to both the number of covered lives and the lack of breadth in the specialties included in such networks. These actions by the health plans often result in gaps in coverage and lead to unanticipated medical bills.

Most physicians prefer to be in-network because it is better for both their patients and their practice. However, extreme health plan market dominance, unfettered by applicable and effective antitrust regulation, have allowed insurers to not act 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.

The ACS is concerned that that the *No Surprises Act* does not address the health plans tactic of increasingly providing inadequate networks in an effort to lower costs and thus does not address one of the key causes of surprise medical bills. 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.

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Establishing a Market-Based Benchmark to Resolve Out-of-Network Payment Disputes Between Providers and Insurers

The American College of Surgeons has extreme concerns with the use of the median contracted rate, as included in the *No Surprises Act*, 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.

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 such as FAIR Health. Additionally, an independent dispute resolution (IDR), which considers charge data from an independent database, needs to be established in order to settle payment disputes between physicians and health plans.

Model for Federal Legislative Actions

The out-of-network law 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 independent dispute

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resolution mechanism for those circumstances where the payment offered is in dispute. The IDR can take into account factors such as the complexity of the patient's medical condition or the special expertise required. It also takes into consideration the usual and customary cost of the service which is defined as the 80th percentile of charges for comparable services for that specialty in the geographic area in which the services were rendered, determined through an independent medical claims database.

While some stakeholders had concerns that considering the 80th percentile of usual and customary costs would lead to increased rates, this has not proven to be the case. The New York law is working 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 study found a 13 percent average reduction in physician payments since the law was enacted. State regulators also report that there has not yet 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 reduced those payers' costs.

The study acknowledges 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."

Encouraging the Development of State All-Payer Claims Databases

If the goal of this grant program is to aid in the elimination of surprise medical billing, several areas will need to be addressed including a federal requirement for the standardization of the data collected in order to ensure robust and accurate data. There are currently inconsistencies across states which have all-payer claims databases (APCDs), such as different criteria for the type and amount of data they collect.

The goals in establishing these databases are also different across states. Some states use these databases to collect data in order to improve population health

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or to reduce costs. For state developed and maintained all-payer claims databases to be effective to address out-of-network surprise bills, the federal government would have to enact legislation to require all health insurance providers to submit claims data, including requiring *Employee Retirement Income Security Act* (ERISA) plans to submit data to the states; and establish universal guidelines for states to collect data for their databases such as both billed and paid claims data. States with active databases would need to enact legislation and amend database systems and service contracts to accept new data. States without existing databases would need to enact legislation to establish such a database and enter into service contracts to collect data, as well as enact state legislation to establish methodology for using data to determine out-of-network rates for reimbursement. Currently, most states with APCDs are not using the databases to address out-of-network surprise bills, but rather states such as New York and Connecticut use a different third-party independent database as part of their surprise billing law.

Conclusion

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. The ACS is opposed to a solution that benchmarks against the median contracted rate as it continues to solely benefit the insurers. Only a comprehensive effort, with appropriate oversight and enforcement which addresses the entirety of root causes, will remedy this complex issue.

Sincerely,

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