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American
Association of
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Congress of
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CONGRESS OF
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October 10, 2018

The Honorable Bill Cassidy
United States Senate
520 Hart Senate Office Building
Washington, DC 20510

Submitted electronically via transparency@cassidy.senate.gov

SUBJECT: Protecting Patients from Surprise Medical Bills Act

Dear Dr. Cassidy,

The American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS), representing more than 4,000 practicing neurosurgeons in the United States, thank you for the opportunity to provide feedback on your draft legislation the "Protecting Patients from Surprise Medical Bills Act." Americans continue to struggle with rising health care costs, including high deductibles and other out-of-pocket expenses. As such, a balanced solution for cost-sharing between patients, physicians and health plans is a priority for organized neurosurgery. In formulating legislation to prevent such a practice, it is essential to understand the origin of these "surprise" bills the interpretation of current legislation or absence of legislation that has created an environment for this billing practice to occur.

Patients deserve access to the physicians of their choice which at times may require seeking care from out-of-network physicians. Unfortunately, the current health care delivery system, with its arcane rules, narrow networks, and lack of transparency, often leaves patients vulnerable. As physicians, we can, and must do better, to assure that our patients are not left with medical bills that can soar into the thousands of dollars, leaving them financially vulnerable. The AANS and CNS, thus, applaud your effort to tackle this issue, and your draft bill, the Protecting Patients from Surprise Medical Bills Act, is a good starting point for these discussions. We appreciate your willingness to work with the medical community to refine your bill, as we have some concerns about the draft, and urge you to make changes to reflect our comments.

Neurosurgery's Position on Out-of-Network Care

The AANS and CNS have joined with our colleagues in hospital-based specialties to develop consensus principles on insurance coverage for out-of-network care. When insured patients are treated in the hospital, they should be confident in the knowledge that their health insurance will cover them. Unfortunately, a growing number of these patients are finding out too late that their coverage is far less comprehensive than they thought. Increasingly, insurers are making unsuspecting patients responsible for additional payments of covered services provided by hospital-based physicians who are not in their insurer's network. Insurers further exacerbated this problem by enticing consumers to enroll in plans with ever-growing deductibles and ever-narrowing networks of providers. It should be recognized that these are intentional business decisions by the insurers that allow them to reduce costs by shifting

significantly more of the cost-sharing burden onto patients and by limiting the pool of physicians in their networks to those who agree to contract at greatly reduced rates that may be well below market value. Since the insurance industry is intensifying its efforts to narrow networks further and force more physicians out-of-network, we believe a fair and equitable solution to the out-of-network balance billing issue should be developed that protects unsuspecting patients from facing significant financial hardships simply because the hospital services they needed at that moment were provided by an out-of-network physician. Legislation should foster an environment where commercial payers have an incentive to broaden the network of physicians within their plans, instead of narrowing their networks. Legislation that establishes fair and equitable payment from commercial payers to physicians for out-of-network care creates that incentive. A broader network diminishes the need for out-of-network care and thereby "surprise" billing.

The AANS and CNS believe that the following shared principles of consensus should apply in all situations, whether the health plans are regulated by the states or federal government.

1. Insurers must meet appropriate network adequacy standards that include adequate patient access to specialty care, including access to hospital-based physician specialties. State regulators should uphold such standards in approving health insurance company plans.
2. Patients who unknowingly receive treatment from an out-of-network hospital-based physician should not be financially penalized by an unanticipated gap in their insurance coverage. The need for (and practice of) balance billing these patients can be eliminated if replaced with a fair and effective minimum benefit standard based on reasonable physician charges for the same service in the same geographic area.
3. Medicare is not an appropriate benchmark for determining out-of-network payment. Medicare amounts are politically derived for the purpose of reimbursing medical services for a specific population based on federal budgetary and regulatory constraints. Such a methodology does not determine appropriate payment in other contexts, such as payment for commercially insured services. In addition, for some specialties, billing practices and amounts are not tied to Medicare.
4. Participating provider contractual rates are not an appropriate benchmark for determining out-of-network payment. Contracted rates are negotiated rates for which the insurer promises consideration in exchange for access to a discounted price. If insurers can pay contractual rates for out-of-network services, there is no incentive for them to negotiate in good faith for fair reimbursement and in fact, this would serve only as motivation for insurers to drive down contractual rates even further.
5. Basing out-of-network payments on provably reasonable physician charges for the same service in the same geographic area is vastly superior to any methodology based on a contrived Medicare rate or a rate completely under the control of the insurance company. The FAIR Health database is an example of a database of physician charges that is geographically specific, completely transparent, and independent of the control of either payers or providers. Utilizing the 80th percentile of the FAIR Health database to determine the minimum benefit standard would exclude the highest outlier physician charges from consideration and ensure that out-of-network payment is reflective of truly reasonable charges. Implementation of such a system would substantially decrease, if not eliminate the balance billing while simultaneously creating an incentive for commercial payers to increase their network.
6. The vast majority of physicians want to participate in-network with insurance companies, but can only do so when insurers negotiate in good faith for fair reimbursement.

7. All persons and entities involved in providing and financing health care have an obligation of transparency to patients and health care consumers. However, any discussion of transparency in the emergency setting must recognize that federal requirements under the Emergency Medical Treatment and Labor Act (EMTALA) statute provide that patients seeking emergency care have unfettered access to a diagnostic evaluation and stabilizing treatment without regard to their ability to pay, thus appropriately restricting any discussion of costs and insurance status until a patient is stabilized.
8. Insurers' high-deductible plans transfer more unexpected costs to patients who often choose options based on monthly premium costs without fully realizing the magnitude of their out-of-pocket expenses. The influx of large gaps in insurance coverage or "surprise bills" in this environment is as much the result of "surprise coverage gaps," as it is balance billing. Insurers must clearly inform their enrollees of the limits of their coverage and, prior to scheduled procedures, provide enrollees with reasonable and timely access to in-network physicians.
9. Physician triggered mediation should be permitted in those instances where their unique background or skills are not accounted for within a minimum benefit standard.
10. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.

Specific Recommendations and Observations

With these principles in mind, we turn to some specific observations and recommendations regarding your draft legislation.

- **Ensure network adequacy.** While your legislation is geared towards regulating surprise billing, the bill should also address the issue of narrow networks. The practice of narrowing networks by commercial payers is a central reason physicians practice out-of-network and the root cause of many of these "surprise" bills brought to our attention by the media. Patients increasingly face access to care barriers due to narrow health plan networks. Many times, unknown to patients, entire specialties are excluded from health plans or the number and mix of specialists and subspecialists are not adequate to meet the needs of the insured population. Networks should, therefore, be sufficiently robust to ensure that an appropriate number of specialists and subspecialists per enrollee are available. Additionally, network directories, which currently are notoriously inaccurate, should be updated in real-time and provide patients with clear, concise, and accurate information. Finally, decisions to remove a physician or physician group from the network without cause should not be made in the middle of a contract year.

Since the incidence of surprise medical billing is directly related to a lack of contractual agreements between insurance companies and providers, your draft legislation should be amended to ensure that insurers meet appropriate network adequacy standards — including specialists and subspecialists — that provide timely access to the right care, in the right setting, by the most appropriate health care provider. The first priority of legislation conceived to eliminate "surprise" bills and protect patients should be to provide the requisite environment and support to foster contractual arrangements between providers and payers, tempering the monopsony function of insurance. Monopsony is particularly problematic in rural counties where there may be only one insurance carrier. In such a circumstance, that insurer has monopsony power in the purchasing of physician services. If both in-network and out-of-network providers

receive similarly inadequate reimbursement, determined exclusively by that insurer, that provider will be unable to continue caring for that community. This will exacerbate the pre-existing disparity in access to care for rural versus non-rural patients. Conversely, if providers in these sole insurer markets are allowed a stronger negotiating position, that will promote network participation, particularly since a contractual agreement with an insurer decreases provider collection risk and stabilizes cash flow. This not only improves network adequacy in rural markets, but also the supply of providers for patients there. Given that prevention is more powerful than cure, and the first goal of government in this arena should be to promote contractual arrangements, policies should be judged by their ability to level the negotiating playing field between insurers and providers.

- **Hold patients harmless and ensure that health plans provide the promised benefits.** We agree with you that patients must not be financially penalized for receiving unanticipated care from an out-of-network provider. We cannot impose a burden on patients who are facing an emergency or are sick, or caregivers who may not even know/have access to the patient's insurance policy to determine whether a particular facility or provider is within their plan's network. Thus, another priority should be to ensure that health plans provide their contracted benefits to patients, eliminate surprise bills and help patients guard against financial ruin. And it is quite challenging — by some estimates, nearly 50 percent of Americans would be unable to financially withstand a \$400 surprise bill without selling assets or taking on new debt. That an insured patient receives a bill despite having insurance and meeting their cost-sharing obligation is more indicative of inadequate insurance coverage than price gouging by the provider. Services like neurosurgery are inherently expensive, and the vast majority of patients depend upon the financial protection of insurance and rightfully expect it to be there when they need it.
- **Payment rates should be fair and transparent.** The draft bill would require insurers to pay providers the greater of the median in-network rate negotiated by health plans participating providers, or 125 percent of the **average allowed amount** for all private health plans for the services provided by a provider in the same or similar specialty and provided in the same geographical area, using a benchmarking database that is transparent and maintained by a nonprofit organization unaffiliated with any health plan. While on its face, this provision may seem reasonable, the AANS and CNS have significant concerns that this approach will systematically undervalue physician services (for example, it is our understanding that 125 percent of allowed amounts is far less than the median out-of-network rate or the 80th percentile of out-of-network charges).

First and foremost, as stated in our principles, and for numerous reasons, out-of-network payments must not be based on some percentage of Medicare rates. Nor should they be based on rates determined by the insurance company. As written, we believe the draft falls short because it would force physicians to accept either an already discounted in-network rate or rates that could be controlled by insurers. Such an environment creates no incentive for commercial payers to broaden their networks, which exacerbates the problem. Rather, minimum coverage standards, such as those in place in the state of New York, should pay out-of-network providers at a usual and customary rate based on the **80th percentile of all out-of-network charges** for the particular health care service performed by a provider in the same or similar specialty in the same geographical area as reported by an independent benchmarking database, such as FAIR Health, Inc. Any such minimum coverage standard should serve as a payment floor. The insurance plan will then pay the physician the usual and customary rate after which the physician would no longer balance bill the patient. In addition to the formula for setting rates, the New York law also sets forth an independent dispute resolution process to ensure a fair process for physicians and insurers alike.

Alternatively, you may consider **modifying** existing out-of-network coverage requirements that were implemented by the Affordable Care Act (ACA). On this point, consider the following.

The ACA tried to protect patients from high medical bills for emergency medical care provided by out-of-network physicians. Included in the ACA is a provision stating that insurance plans that cover emergency services must cover such services “in a manner so that, if such services are provided to a participant, beneficiary, or enrollee... out-of-network, the cost sharing requirement (expressed as co-payment amount or co-insurance rate) is the same requirement that would apply if such services were provided in network...” The law also provides that while the physician could balance bill the patient, the insurer had to pay a “reasonable” amount based on “objective” criteria. Unfortunately, the federal agencies charged with implementing this provision — the Departments of Health and Human Services, Treasury and Labor (the “Departments”) — have adopted an unworkable approach.

The Departments’ interpreted this objective standard with a regulation that said that in these cases the insurer need only pay the Greater Of Three (GOT) amount: (1) Medicare; (2) the insurer’s in-network rate; or (3) the insurer’s determination of the out-of-network rate. Unfortunately, this approach has led to a cascade of deleterious consequences. First, insurance plans have dramatically lowered their usual out-of-network benefits from usual and customary fees (which will cover most of the cost) to the Medicare physician fee schedule (which covers only a small part of most medical bills). Because health plan emergency fees are tied to the out-of-network schedule they select, they have been encouraged to offer the poorest coverage possible for elective out-of-network services. Second, as mentioned above, insurance plans have dramatically decreased their networks. With no concern that they would have to pay higher fees for patients who need non-network doctors, there became little incentive to have any but the smallest number of doctors in their networks being offered very low contracted rates. The interpretation of the Departments’ provision created an incentive for commercial payers to narrow their networks further, not broaden them, further compounding the “surprise” billing problem. Third, insurers have had much less incentive to authorize and promote needed elective care. With little concern that there would be higher fees if a patient’s health deteriorated and they needed to go to the emergency room, there was much less reason to facilitate preventive and elective care. Fourth, as evidenced by the need for your legislation, while the GOT methodology — which is applied to every single professional service — may be adequate for certain services such as evaluation and management services and minor procedures, it is wholly inadequate for major procedures or other expensive health care services, particularly in certain metropolitan regions. In these situations, the GOT formula will cover only a small part of the anticipated charges, leaving the patient responsible for most of the bill, which is likely the greatest source of surprise medical bills. Most people would agree, that if health insurance should cover anything, it should cover major catastrophic emergency care. When emergency payments now often pay only a small portion of the physician’s bill, the problem of large surprise medical bills became much worse.

An improved federal standard should be considered, as state laws and regulations are often not adequate to offset cases where the GOT method is inadequate. States have been increasing their protections for emergency medical care. New York’s law, adopted in 2014, is a model for such legislation. However, many states, have no such laws, and some state laws are not nearly as protective as those of New York. Also, state laws, at best, only govern certain plans. ERISA-regulated plans, which are a large part of the private insurance market, are completely regulated at the federal level. Patients with self-funded health insurance plans have no recourse in state law if the GOT method proves inadequate for the services they required.

As an alternative to the standard outlined in your draft bill, you might consider amending the GOT method, to ensure that it leads to "reasonable" payment for out-of-network services, as follows:

If the GOT method leads to a payment that, after patient responsibilities, is less than 70 percent of the regional usual and customary rate (as determined by the 80th percentile of similar charges for that procedure and that region based on the FAIR Health database), then insurer payment would instead be the lesser of three figures: (1) the physician's fee; (2) the FAIR Health 80th percentile figure; or (3) a mutually agreed upon amount between the physician and the insurer.

With regards to a database that establishes the usual, customary and reasonable rate, it is essential that the database remain completely independent from commercial payers and non-for-profit. FAIR Health, a database created in the aftermath of a fraudulently manipulated database owned by a commercial payer, meets that criteria at this time.

Either of the options enumerated above would ensure that patients no longer see large surprise medical bills, while at the same time providing physicians with fair reimbursement. Since New York passed its surprise medical bill law, it has been viewed as a win-win-win situation. The incidence of surprise bills decreased substantially, as did patient complaints. Additionally, physicians and insurance plans have a system that is fair, workable and transparent.

- **Balance billing should be allowed in certain limited circumstances.** The AANS and CNS are concerned about your blanket prohibition on balance billing without also implementing a corresponding federal minimum payment standard such as the one in place in New York or as outlined above. Thus, if you intend to prohibit balance billing, you should also amend your bill to include a minimum federal floor for payments to out-of-network providers, particularly as it pertains to emergencies. In nonemergent situations, however, balance billing should be permitted provided certain safeguards are in place, as patients should be able to see the physician of their choice, whether the physician is in- or out-of-network.

Health insurance companies should be required to standardize the way in which they market and describe their out-of-network coverage in such a manner that patients have a clear idea of how much of the physician's bill the health insurer will pay and how much of that bill will remain the patient's financial responsibility. Furthermore, physicians should discuss their charges with patients whenever possible, and they should have a fee schedule that they can provide to patients. This helps patients determine their financial responsibilities, depending on the out-of-network coverage their health insurance plan provides, and will allow the patient and provider to determine a negotiated rate for the excess amount not covered by the patient's insurance plan. If the treatment by an out-of-network physician is planned, and the patient with full knowledge knowingly seeks care from an out-of-network physician, the government should not mandate what the physician may charge and balance billing should not be prohibited.

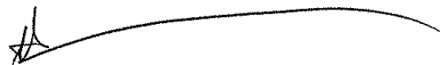
Once again, the AANS and CNS want to thank you for providing us with an opportunity to comment on your draft legislation. Our central goal remains protecting the patient from "surprise" bills while ensuring that all Americans have access to the care that they need. Legislation that creates an incentive for commercial payers to broaden networks and ensure fair and equitable payments to physicians for out-of-network emergency care will accomplish that goal. Given the complexity and importance of this topic, we hope you will continue the ongoing dialogue with stakeholders and undertake an iterative process for finalizing this bill before introduction.

If you have any questions or need additional information, please feel free to contact us.

Sincerely,



Shelly D. Timmons, MD, PhD, President
American Association of Neurological Surgeons



Ganesh Rao, MD, President
Congress of Neurological Surgeons

cc: Hon. Michael Bennet, United States Senator
Hon. Charles Grassley, United States Senator
Hon. Tom Carper, United States Senator
Hon. Todd Young, United States Senator
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