

AMERICAN ASSOCIATION OF
NEUROLOGICAL SURGEONS

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May 22, 2017

The Honorable Orrin Hatch
Chairman, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

Via: HealthReform@finance.senate.gov

SUBJECT: Health Care Reform

Dear Chairman Hatch:

On behalf of the American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS), we are writing to offer our thoughts on health care reform, including H.R. 1628, the American Health Care Act (AHCA) as passed by the House of Representatives.

America's neurosurgeons strongly support improving our nation's health care system, including expanding access to affordable health insurance coverage for every American, enhancing patients' choice of insurance plans and providers, and maintaining reforms that redress a number of inexcusable insurance practices. While the Affordable Care Act's (ACA) insurance market reforms — such as coverage for pre-existing conditions and guaranteed issue — provide critical consumer protections, rather than lowering costs and expanding choice, premiums have skyrocketed, high deductibles leave patients financially on the hook for their medical bills and narrow networks restrict patient access to the physician of their choice. Thus, by many objective measures, the promises of the ACA have fallen short. Consider the following:

- 20 million more Americans have health insurance today, yet nearly 30 million continue to lack coverage.
- Insurance market reforms — such as coverage for pre-existing conditions and guaranteed issue — provide critical consumer protections. However, because not enough young or healthy people have purchased insurance, the individual and small group market is in a so-called “death spiral.”
- Health insurance premiums remain very expensive for most, and annual double-digit increases are not uncommon. Additionally, consumers face significant out-of-pocket costs with annual deductibles of \$5,000 to \$10,000 in some cases.
- Keeping your preferred physician or insurance plan is not always possible, and insurance practices such as “narrow networks” further restrict choice and access.
- Insurance markets have become less competitive and 32 percent of counties now only have one insurer.

Of course, for individuals with preexisting conditions and health problems requiring ongoing care, the ACA has been a significant benefit. The same goes for Americans that have received financial assistance for insurance premiums and other cost-sharing subsidies.

It is with this in mind that we offer some comments on the health care reform efforts currently underway.

We understand that because the initial reform efforts are proceeding under the budget reconciliation process, many issues related to improving the ACA will not be included in this bill and will be addressed by the Trump Administration and additional legislation later in the year. We offer our comments in the spirit of working collaboratively with Congress and the Administration to find solutions that improve the nation's health care system.

Budget Reconciliation/American Health Care Act Reforms

Unfortunately, as passed by the House, we have some serious concerns that under the AHCA many Americans may lose insurance coverage or they will be unable to afford coverage. And while we recognize that this is the first step in a more comprehensive approach to improving the nation's health care system, Congress will have to take additional measures to ensure that affordable health insurance coverage is available to all our nation's citizens.

Regarding topics included in the AHCA, we offer our observations on the following:

Health Insurance Market Reforms. The AANS and CNS support maintaining the health insurance market reforms that were included in the ACA. We are pleased that the AHCA:

- Bans coverage exclusions of pre-existing health condition;
- Eliminates lifetime limits on benefits and places restrictions on annual limits on benefits;
- Allows children to be covered on their parents' insurance policy up to age 26; and
- Requires guaranteed issue and guaranteed renewability of coverage.

We are concerned, however, that the "continuous coverage" provision of the AHCA may leave individuals vulnerable to hefty fines if they drop coverage and reenter the insurance market — although we do appreciate that there needs to be a mechanism to encourage individuals to obtain and maintain health insurance coverage to prevent adverse selection and the insurance death spiral.

We are also concerned that despite its pledge to maintain the ACA's consumer protections, the provisions of the AHCA that allow states to apply for waivers from these protections, including the age rating ratio and the ban on health status underwriting, undermine these safeguards. While the bill would require states to show that the purpose of their waiver requests is to reduce premiums, increase the number of people with health care coverage, or advance a benefit to the public interest in another way, allowing states to waive these protections may, in fact, lead patients to lose coverage and may return us to the days when consumers with preexisting conditions could not find affordable insurance. Additionally, the requirement that states have some reinsurance or high-risk pool mechanism to help such individuals will not likely be sufficient to provide for affordable health insurance or prevent discrimination against individuals with certain high-cost medical conditions. While the Patient and State Stability Fund is a step in the right direction, the funds included are likely insufficient to cover these costs adequately.

Enhancing Choice and Flexibility. An important health care reform principle advocated by the AANS and CNS is the notion that patients should have enhanced choice and the flexibility to select the health plan that best meets their needs. As such, we have repeatedly expressed our concerns that, as implemented, the ACA hinders this flexibility. The AHCA takes a step in the right direction by allowing individuals to spend their health care dollars the way they want and need by enhancing and expanding Health Savings Accounts (HSAs) — nearly doubling the amount of money people can contribute and broadening how people can use it. To ensure that patients are educated consumers, it is essential that Congress and the Administration support efforts to improve cost transparency for medical services.

Refundable Tax Credits. The AANS and CNS support advanceable, refundable tax credits to help individuals obtain health insurance coverage. Rather than allocate these credits based on an individual's age, however, we believe it makes more sense to distribute the tax credits based on income and financial need. It is also important that the amount of the credits are sufficient for individuals to purchase health insurance. We are, therefore, concerned that the AHCA's tax credit structure will lead to serious

gaps in affordable coverage for many Americans. If appropriately structured, however, the AANS and CNS believe that advanceable tax credits will help incentivize more individuals to purchase health insurance and provide them with the flexibility to obtain coverage that best meets their needs.

Health Insurance Coverage through Medicaid Expansion. Over the years, the AANS and CNS have expressed concerns about the shortcomings of the Medicaid program. In many instances, individuals covered by Medicaid may have an insurance card, but find it difficult to get access to care because many providers are not able to accept Medicaid due to reimbursement rates that are far below medical practice costs. For these and other reasons, we did not support the ACA's Medicaid expansion as an effective mechanism for increasing American's access to health care. Nevertheless, Medicaid is an important safety net program for patients with low incomes, and we do not want to see these individuals lose coverage as a result of the proposed changes to the Medicaid expansion program. Additionally, while we firmly support providing the states with more flexibility to develop health care programs that best meet the needs of their citizens, we urge Congress to ensure that any changes to Medicaid financing do not undermine these state-based efforts.

Medical Device Excise Tax. America has a long tradition of excellence and innovation in patient care, and neurosurgeons have been on the cutting edge of these advancements. However, American medical innovation is at serious risk. While temporarily suspended for two years from 2016-17, the ACA's medical device excise tax is adversely affecting medical innovation and patient care. The AANS and CNS, therefore, support the inclusion of a provision to repeal this tax permanently.

Additional Health Care Reforms

Again, the AANS and CNS understand that the procedural rules for budget reconciliation do not allow all health reform issues to be addressed. However, the task of health reform will not be complete unless Congress and the Administration also tackle some additional critical elements. These include:

Children's Health Insurance. To ensure that our nation's children have uninterrupted health insurance coverage, Congress should reauthorize the Children's Health Insurance Program (CHIP) — for two to five years — before it expires later this year.

Ensuring Network Adequacy. Patients 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 be sufficiently robust to ensure that an appropriate number of specialists and subspecialists per enrollee are available. Additionally, network directories should be updated in real-time and provide patients with clear, concise and accurate information. Finally, decisions to remove a physician from the network without cause should not be made in the middle of a contract year. Congress and the Administration should ensure appropriate oversight to hold insurers accountable and to ensure that patients have timely access to the right care, in the right setting, by the most appropriate health care provider.

Timely Access to Care. Health insurers are increasingly using prior authorization as a cost-control process that requires providers to obtain approval before rendering medical services. According to a recent survey, every week a medical practice completes an average of 37 prior authorization requirements per physician, which takes a physician and their staff an average of 16 hours, or the equivalent of two business days, to process. While the AANS and CNS understand the need to hold down health care expenditures, the inefficiency and lack of transparency associated with prior authorization costs physician practices both time and money. More importantly, however, are the delays in patient care that result from prior authorization programs, which can lead to poor health care outcomes. We believe that prior authorization is overused and should be reassessed. One of the goals of health care reform is to ensure that patients have timely access to the care they need when they need it, and Congress and the Administration should take the necessary steps to eliminate inappropriate prior authorization requirements.

Medical Liability Reform. The AANS and CNS support legislation to provide common sense, proven comprehensive medical liability reform. Federal legislation modeled after the laws in California or Texas, which includes reasonable limits on non-economic damages, represents the “gold standard,” and the CBO has determined that comprehensive medical liability reform would save the federal government approximately \$65 billion over 10 years. To this end, we support both H.R. 1215, the Protecting Access to Care Act — which was reported out of the House Judiciary Committee on Feb. 28, 2017 — and H.R. 1704, the Accessible Care by Curbing Excessive lawSuitS “ACCESS” Act. Other solutions should be adopted including: (1) applying the Federal Tort Claims Act to services mandated by the Emergency Medical Treatment and Labor Act (EMTALA); (2) liability protections for physicians who volunteer their services; and (3) liability protections for practitioners who follow practice guidelines established by their specialties, such as those included in H.R. 1565, the Saving Lives, Saving Costs Act.

Independent Payment Advisory Board (IPAB). Created by the ACA, the IPAB is a 15-member government board — whose members are appointed by the president — with little or no clinical expertise or the oversight required to protect access to care for our country’s seniors. It has only one job: to cut billions of dollars from Medicare. Even worse, if no board is appointed, which is the situation right now, the Secretary of Health and Human Services has the sole authority to make these decisions. Proposed spending cuts automatically go into effect if Congress does not replace the recommendations with cuts of equal magnitude. Congress only has a very short time in which to pass its substitute proposal — making it a virtual certainty that the board’s recommendations would be adopted. The AANS and CNS strongly urge repeal of the IPAB because leaving Medicare payment decisions in the hands of an unelected, unaccountable governmental body with minimal congressional oversight will negatively affect timely access to quality neurosurgical care for our nation’s senior citizens and those with disabilities.

Graduate Medical Education. An adequate supply of well-educated and trained physicians — both in specialty and primary care — is essential to ensure access to quality health care services for all Americans. Unfortunately, the nation is facing an acute shortage of physicians, due to an aging population and the expansion of health insurance coverage through the ACA. And while medical schools in the U.S. have increased their enrollments, and additional medical and osteopathic schools have been established, the number of Medicare-funded resident positions has been capped by law at 1996 levels. To ensure an adequate supply of physicians and allow the graduate medical education system to operate optimally, policymakers should, among other things:

- (1) Eliminate the current graduate medical education (GME) funding caps and increase the number of funded residency positions;
- (2) Expand funding to fully cover the entire length of training required for initial board certification;
- (3) channel a larger percentage of GME funds directly to the academic departments responsible for resident education;
- (4) Maintain current financial support for children’s hospital GME;
- (5) Encourage all other payers to contribute to GME programs;
- (6) allow residents to bill for the services they render after achieving verified competence in particular skills;
- (7) Provide additional funding to investigate innovative approaches to modernized GME;
- (8) Supply the profession with the tools, including antitrust relief, to ensure a well-trained physician workforce;
- (9) Preserve the ability of surgeons to maximize education and training opportunities by performing overlapping surgical procedures and allowing for more flexible resident duty hours; and
- (10) Reject additional unnecessary layers of regulations and ensure that the Accreditation Council for Graduate Medical Education (ACGME), American Board of Medical Specialties (ABMS) and Association of American Medical Colleges (AAMC) retain their preeminent roles in overseeing resident training and education.

Health Care Reform Survey of Neurosurgical Leaders

Included with this letter is a report of an AANS/CNS survey of a cross-section of approximately 300 leaders in organized neurosurgery. The report contains information on such topics as:

- Percent of neurosurgeons treating Medicaid and ACA exchange patients;
- Health insurance deductibles;
- Narrow health plan provider networks; and
- Administrative burdens such as prior authorization.

We hope you will find this information useful as you develop health care reform legislation — whether through the budget reconciliation process or otherwise.

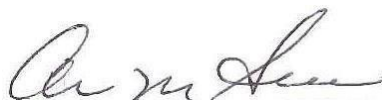
Conclusion

Thank you for considering our views. We look forward to continuing to work with you to improve our country's health care system for the benefit of our patients and appreciate your willingness to make improvements in the bill as it goes through the legislative process. If you have any questions or need additional information, please don't hesitate to contact us.

Sincerely,



Alex B. Valadka, MD, President
American Association of Neurological Surgeons



Alan M. Scarrow, MD, President
Congress of Neurological Surgeons

cc: United States Senate

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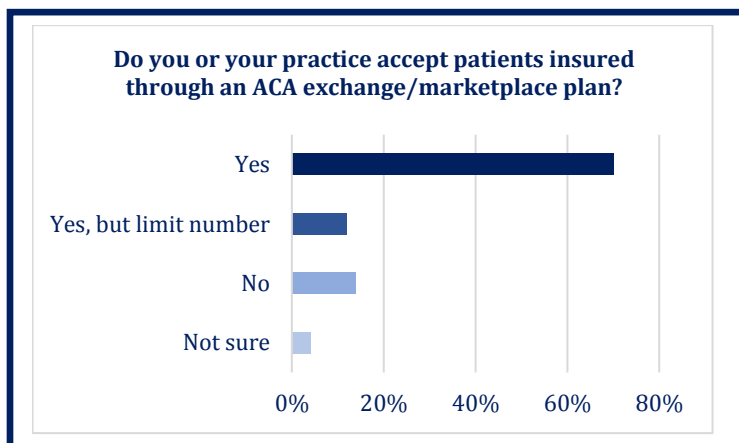
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Health Care Reform Survey of Neurosurgical Leaders

On March 19, 2017, the American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS) surveyed a cross-section of approximately 300 leaders in organized neurosurgery. The survey asked a series of questions related to their experience since the Affordable Care Act (ACA) was enacted in 2010. As of March 21, nearly one-third (100) of those surveyed had responded. The following report summarizes the findings.

Most Neurosurgeons Accept ACA Exchange and Medicaid Plans, but Cracks in the System Exist

Eighty-two percent of respondents accept patients insured through an ACA exchange plan. However, 12 percent limit the number of ACA-exchange covered patients that they see in their practices. Slightly fewer (66%) accept patients who are insured through Medicaid, and a higher percentage (21%) restrict the number of Medicaid patients that their practice sees. Nevertheless, less than half (46%) of neurosurgeons participate as a preferred provider in an exchange or Medicaid plan.



This relatively robust participation rate generally correlates with the number of neurosurgeons that are now employed by hospitals. For these individuals, they take care of patients based on their hospital agreements and policies. However, there are cracks in the system, as neurosurgeons in private practice cease participating in exchange health insurance plans.

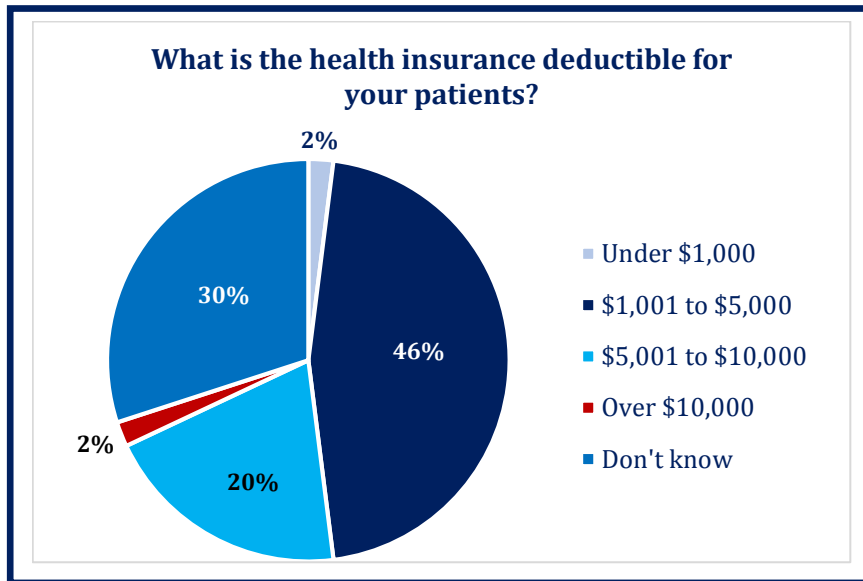
For example, a neurosurgeon in Texas writes, “We accepted PPO marketplace plans until the insurance carriers moved the PPO plans out of the marketplace. HMO plans are labor intensive anyway, but the marketplace plans were particularly burdensome because of the subsidy and gathering information whether premium payments were up to date.” Another neurosurgeon in private practice from Mississippi pointed out, “We have accepted United and Humana exchange patients as they both paid commercial rates for services provided. Once both of these carriers pull out of the exchanges (United already has), we will quit seeing any exchange patients as the only carrier left (with whom we’ve never participated) reimburses at 125% of Medicare.”

When it comes to Medicaid, many neurosurgeons only treat patients who have emergency medical conditions. For example, a neurosurgeon in California notes, “We only accept Medicaid patients through the emergency department. We don’t accept new Medicaid patients in the clinic.” A neurosurgeon in North Carolina likewise informed us that, “I only see emergencies from trauma call or patients that were established some time ago. The payments from my state are prohibitively low.”

Skyrocketing Deductibles Leave Patients Financially on the Hook for Large Medical Bills

Unfortunately, more and more patients in need of neurosurgical care are experiencing high deductibles and other out-of-pocket expenses. Eighty percent of respondents verified that an increased number of their patients have high-deductible health plans. Slightly less than half (46%) are treating patients whose health plan

deductibles range from \$1,001 to \$5,000 and an addition 20 percent have plans with deductibles from \$5,001 to \$10,000. Although rare (2%), some neurosurgical patients have deductibles in excess of \$10,000.



Despite improved health care coverage, these skyrocketing deductibles are nevertheless leaving patients financially on the hook for large medical bills. To keep their practices open and functioning, forty-five percent of neurosurgeons require their patients to pay all or part of any deductible or other cost-sharing fees at the point of service or before performing any test or procedure. As a neurosurgeon from Georgia noted, their practice must collect these fees in advance “because if we don't, we won't get paid after the fact.” However, this neurosurgeon goes on to tell us, “If it's a brain tumor or life threatening issue we don't [collect the fees in advance].”

Fortunately for patients, as a neurosurgeon from Tennessee points out, they will “work out a payment schedule and have their patients meet with our financial counselors before seeing us.” A little more than a third (38%) do not require their patients to pay these costs up front.

To cope with these high deductibles, nearly one-third (29%) of neurosurgical practices have adopted new administrative or other accounts payable strategies. For example, many will hold their claims until after the hospital first files, so the hospital is responsible for managing health plan deductibles.

Administrative Burdens

Health insurers and Medicaid programs are increasingly using prior authorization as a cost-control process that requires providers to obtain approval before rendering medical services. Three-quarters (77%) of neurosurgeons now regularly must comply with onerous prior authorization procedures. More important than the administrative burdens these processes impose, prior authorization is resulting in unnecessary delays in patient care. Prior authorization is a source of extreme frustration among neurosurgeons. Consider the following comments:

The insurance company will authorize the surgery up front after we provide needed medical records to support the need for the surgery, then they will deny the claim after the surgery is performed saying it was not needed. Their disclaimer "authorization is not a guarantee of payment." They drive up the cost of health care delivery with all the burdens put in place to obtain an authorization only to deny it after.

Neurosurgeon from Florida

Medicaid has 14 days to approve; they look at the authorization request on the 13th day then want additional information. This means we have to cancel the surgery because of no authorization and reschedule. This makes the patient have to reschedule their plans for child care, work schedule, who is going to get off work to take them and pick them up and taking that surgical slot means someone else will have to wait, we can't fill it at the last minute. Even after the medical records are sent, they request a peer to peer review. It's hard to get our doctors on the phone when they are in surgery 4 out of 5 days a week.

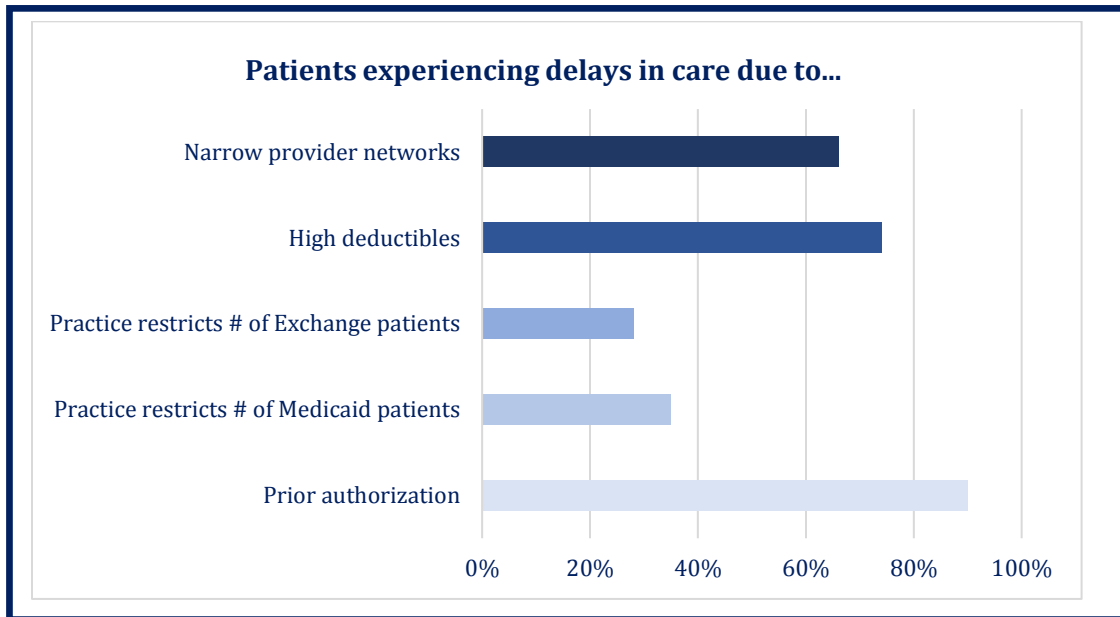
Neurosurgical Practice Administrator from Georgia

We have had to jump through many hoops for patients who are on ACA plans, the worst being that after-the-fact, insurance companies refuse to abide by the authorizations they required us to get upfront.

Neurosurgical Practice Administrator from North Carolina

Delays in Access to Care

There is no question that millions of Americans have health insurance as a result of the Affordable Care Act and as a neurosurgeon in Maryland wrote, “A lot more patients have access to care because they now have insurance. Before the ACA they had none.” Nevertheless, having a medical insurance card does not always translate into timely access to quality neurosurgical care at an affordable price. Indeed, our findings demonstrate that barriers to access remain. Narrow provider networks, high deductibles and prior authorization processes are all contributing to access to care problems for neurosurgical patients. To wit:



Prior authorization or other administrative barriers to care	90%
Physician practice restrictions on the number of Medicaid patients treated	35%
Physician practice restrictions on the number of ACA-exchange plan patients treated	28%
High deductibles or other out-of-pocket costs	74%
Narrow provider networks	66%

Many survey respondents added a variety of comments related to their ACA-related experience. Some examples include:

We are having to limit the number of Medicaid slots in clinic, as no one in the state will see the spine Medicaid patients, and they are filling our group's clinic as a result. There is now a long wait list for Medicaid patients.

Neurosurgeon from Indiana

Now patients being followed for tumors with repeat imaging have to see us before the imaging can be approved. This results in patients having to make two trips to see us and get yearly imaging, instead of one trip. Given the long distances and limited means of many of our patients, this is a huge burden.

Neurosurgeon from West Virginia

We have a brain tumor patient for whom we have been caring. Now that he had to switch plans to Blue Cross-Blue Shield, we can no longer see him, and he has to travel 2 hours away to get care.

Neurosurgeon from Georgia

Because patients' insurance plans now change so frequently, and the networks also change often, we have had many patients whom we have taken care of for many years, but now we have to jettison. This is especially difficult on the more disabled patients on Medicaid who have such issues as intrathecal pumps that need surgical care and intractable epilepsy or pain that need chronic specialist management.

Neurosurgeon from Illinois

Patient signed up for Covered California and then discover there are virtually no specialists in the networks.

Neurosurgeon from California

I had a cancer survivor patient who waited one year for surgical approval to get her active spondylolisthesis treated. Approval waiting times are getting longer. Narrow networks have markedly increased the complexity to finding services our patients need.

Neurosurgeon from Illinois

Since the ACA and Medicaid expansion, we have seen a dramatic increase in the number of patients coming to the emergency department for care. The promise that the increased number of patients with insurance would allow them to substitute low-cost primary care for high-cost emergency department care has not occurred.

Neurosurgeon from Pennsylvania

Concluding Thoughts

America's neurosurgeons strongly support improving our nation's health care system, including expanding access to affordable health insurance coverage for every American, as well as reforms to redress a number of inexcusable insurance practices. While the Affordable Care Act's (ACA) insurance market reforms — such as coverage for pre-existing conditions and guaranteed issue — provide critical consumer protections, rather than lowering costs and expanding choice, premiums have skyrocketed, high deductibles leave patients financially on the hook for their medical bills and narrow networks restrict patient access to the physician of their choice. To address these ongoing shortcomings, policymakers must take additional steps to require plans to offer a sufficient number and type of specialists and subspecialists in their provider networks; maintain patient choice through out-of-network options; improve access to trauma and emergency care; reduce preauthorization requirements; and expand competition and the choice of health plans — including health savings accounts. Additionally, to ensure that our nation's children have uninterrupted health insurance coverage, Congress should reauthorize the Children's Health Insurance Program (CHIP) — for two to five years — before it expires later this year.

For More Information Contact:

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