

AMERICAN ASSOCIATION OF
NEUROLOGICAL SURGEONS

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American
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Congress of
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CONGRESS OF
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May 28, 2019

The Honorable Frank Pallone, Chairman
Energy and Commerce Committee
United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Greg Walden, Ranking Member
Energy and Commerce Committee
United States House of Representatives
2322-A Rayburn House Office Building
Washington, DC 20515

SUBJECT: The No Surprises Act Discussion Draft Comments

Dear Chairman Pallone and Ranking Member Walden,

The American Association of Neurological Surgeons (AANS) and the 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 No Surprises 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.

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 devastated. The AANS and CNS, therefore, applaud your effort to tackle the issue of unanticipated medical bills. We also 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

In formulating legislation to prevent the practice of so-called "surprise billing," it is essential to understand the origin of these unanticipated medical bills. 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 exacerbate 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 an out-of-network physician provided the medical services they needed at that moment. 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 unanticipated medical bills.

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. **Adopt network adequacy standards.** Insurers must meet appropriate network adequacy standards including, but not limited to, an adequate ratio of emergency physicians, hospital-based physicians, and on-call specialists and subspecialists to patients, as well as geographic and driving distance standards and maximum wait times. Provider directories must be accurate and updated regularly to be useful to patients seeking care from in-network providers.
2. **Physicians want to participate in health plan networks.** The vast majority of physicians, including neurosurgeons, want to participate in-network with insurance companies, but can only do so when insurers negotiate in good faith for fair reimbursement.
3. **Limit patient responsibility and keep patients out of the middle.** Patients who unknowingly receive treatment from an out-of-network hospital-based physician should be held harmless and not be financially penalized by an unanticipated gap in their insurance coverage. Rather they should only be responsible for in-network cost-sharing rates. So patients are not burdened with payment rate negotiations between insurers and providers, physicians should be provided with direct payment/assignment of benefits from the insurer.
4. **Increase transparency for patients.** 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, before scheduled procedures, provide enrollees with reasonable and timely access to in-network physicians. In addition, all patients who choose in advance to obtain scheduled care from out-of-network physicians, hospitals or other providers should be informed before receiving care about their anticipated out-of-pocket costs. When scheduling services for patients, providers should be transparent about their own anticipated charges, and insurers should be transparent about the amount of those charges they will cover.
5. **Medicare is not an appropriate payment benchmark.** Medicare is not an appropriate benchmark for determining out-of-network payment. Medicare amounts are politically driven to reimburse 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. Furthermore, Medicare payment rates have become increasingly inadequate in covering overhead costs and are not market rates.
6. **In-network rates are not an appropriate payment benchmark.** 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.

7. **Out-of-network payments should include physician charges.** Basing out-of-network payments on 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 balance billing, while simultaneously creating an incentive for commercial payers to increase their network.
8. **Arbitration should be permitted to resolve out-of-network billing disputes.** Health plans should be required to pay physicians a commercially reasonable rate within 30 days. If either the physician or health plan is dissatisfied with that amount, they should privately settle on a payment amount or resolve the dispute using a “baseball-style” arbitration process that bases payment on the usual and customary cost of the service referenced from an independent medical claims database.
9. **EMTALA limits any discussions of costs and insurance status.** 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.
10. **A prudent layperson standard should be recognized.** 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.

Points of Agreement

We are encouraged that the draft legislation reflects our principles related to patient responsibility and increased transparency.

Hold the Patient Harmless

The AANS and the CNS agree with you that patients must not be financially penalized for receiving unanticipated care from an out-of-network provider — whether the unanticipated medical bill stems from emergencies or scheduled care from providers that the patients cannot reasonably choose. In these situations, patients should be held harmless and only be responsible for the amount they would have paid in-network, including any deductibles and other cost-sharing amounts. We cannot impose a burden on patients who are facing an emergency or are sick to determine whether a particular facility or provider is within their plan’s network.

The AANS and the CNS would also point out that another priority should be to ensure that health plans provide their contracted benefits to patients, which would minimize surprise bills and help patients guard against financial ruin. 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.

Increase Transparency

We also agree that increasing transparency is critical. To the extent that it is feasible, patients receiving scheduled care should be given written and oral notice about their physician's network status and any potential charges they could be liable for if treated by an out-of-network provider at the time of scheduling. We note, however, that the primary treating physician may not always have access to this information. For example, while a neurosurgeon would know his/her network status, and can easily determine the status of the hospital in which the surgical procedure will take place, the neurosurgeon may not know in advance who will be providing all ancillary services (e.g., pathology or radiology services). In this case, it is important that any legislation holds the *treating physician* harmless if he/she is not able to ascertain for the patient the network status of every provider that may contribute to the care of that patient.

Reject Single Hospital Bill and Network Matching

Additionally, we are particularly pleased that the legislation does ***not*** embrace either the single medical bill/payment or network matching approaches that have been promoted by certain stakeholders, think tanks, commentators and policymakers.

Hospital bundled billing is an untested and unworkable solution. This approach would be administratively complex and ignores the fundamental relationships between hospitals and physicians, which involve different contractual arrangements. Some physicians are employees, others are independent groups that contract directly with the hospital to provide certain services (e.g., emergency care), and others (e.g., neurosurgeons) merely have privileges to provide health care services at a given hospital. A single bundled payment to the hospital for all providers would be completely unworkable.

Network matching or forced contracting are likewise unproven models that would have massive unintended consequences. Hospitals and providers separately contract with health plans for one or more insurance products, and each contract reflects its own terms and conditions, including network participation. To try and align each of these products across each hospital and any physician involved will introduce even further additional administrative complexities and have a significant negative impact on private practice physicians.

We urge you to reject calls to include either of these purported solutions in any final legislation.

Areas in Need of Improvement

Our principal concerns about the bill as drafted include:

- Absence of network adequacy standards;
- Use of the median in-network rate as a federal benchmark for resolving payment disputes between health plans and providers and lack of reference to the use of a wholly independent database (e.g., FAIR Health) to determine market-based payments for out-of-network care; and

- Failure to incorporate the use of “baseball-style” arbitration through an independent dispute resolution (IDR) process as a means of settling out-of-network payment disputes between health plans and providers.

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 unanticipated medical bills. 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 — so patients have timely access to the right care, in the right setting, by the most appropriate health care provider.

Payment Rates Should be Fair, Market-Based and Transparent

A priority of legislation developed 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. Under your draft bill, insurers would be required to pay the median in-network rate negotiated by health plans for the same or similar service that is provided by a physician in the same or similar specialty and provided in the geographical area region in which the medical service is furnished.

This federal payment benchmark is ***unacceptable***, and contrary to the discussion draft’s summary, this is ***not a market-based benchmark***. The AANS and the CNS have significant concerns that using any in-network rates as a federal benchmark, median or otherwise, will systematically undervalue physician services, disincentivize plans from negotiating in good faith with physicians and will likely increase the number of out-of-network providers. Consider the following points:

- Many physicians are in a weak bargaining position relative to commercial health insurers. According to a recent study, the majority of health insurance markets are highly concentrated and characterized by insurers with high market shares of patients.¹ This increases the risk of those insurers exercising monopsony power and paying physicians below competitive levels.

Furthermore, more than half of practicing physicians are in practices with 10 or fewer physicians and, therefore, are in a weak bargaining position relative to health insurers. This subjects physicians to “take it or leave it” contracts, with lower in-network reimbursement, which does not necessarily reflect the true market rate for provider services. Setting out-of-network payments at those discounted rates would place physicians at a competitive disadvantage when they attempt to negotiate a fair contract.

¹ Guardado J., Kane C. Competition in Health Insurance, A Comprehensive Study of U.S. Markets, 2018. Chicago, IL: American Medical Association, Division of Economic and Health Policy Research, May 2018, https://www.ama-assn.org/system/files/2018-11/competition-health-insurance-us-markets_1.pdf (accessed May 2019).

Monopsony is particularly problematic in rural counties where there may be only one insurance carrier. 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 improves network adequacy in not only rural markets but also the supply of providers for patients there.

- Setting a federal benchmark at median in-network rates would also disadvantage physicians who have negotiated contracts at the higher end of the in-network payment range. In such situations, health plans would be incentivized to drop these physicians from their network knowing that the health plan would need not pay more than the median in-network rate for any resulting out-of-network care that physician may provide in the future. This would ultimately lower all in-network rates over time. Also, rather than encouraging broader provider networks, which would minimize out-of-network care/surprise bills in the first place, setting a federal benchmark rate could actually lead to more physicians being dropped from their networks.
- The median in-network rate may not adequately represent physician costs, depending on the geographic location and specialty. For example, in New York, some neurosurgeons are paying upwards of \$200,000 for medical malpractice insurance. At the same time, fewer insurance companies give health plans enhanced market power. The contracted rates are not always adequate to meet basic expenses, let alone pay for a reasonable “salary” for the physicians, so some New York neurosurgeons have no choice but to practice out-of-network to pay the bills.

Rather than creating a federal benchmark payment — whether at median in-network rates or otherwise — the AANS and the CNS urge the committee to adopt the approach that New York has taken. According to New York’s law, which was adopted in 2015, health insurers are required to offer policies that cover at least 80% of the usual and customary cost of any out-of-network service. The law defines “usual and customary” as 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. Because of its comprehensiveness, FAIR Health’s “usual and customary” data has become the benchmark for many different state programs across the country. Furthermore, FAIR Health’s methodology employs mechanisms to ensure that outliers in charges are eliminated from its data. It is, therefore, a more predictive indicator of actual out-of-network costs than the median in-network rates described in your draft legislation.

While your bill provides grants to states to develop all-payer claims databases, this provision is flawed as it would interject payment systems (e.g., Medicaid and Medicare), as well as negotiated in-network rates, into the database further diluting payment rates. Rather than create a fair market-based solution, this approach would facilitate a race to the bottom.

Establish an Independent Billing Resolution Process

The discussion draft also falls short because it fails to incorporate a fair process for resolving billing disputes between health plans and physicians. The AANS and the CNS believe that it is essential that legislation addressing unanticipated medical bills includes a framework for facilitating a process to quickly, efficiently and fairly resolve physician and health plan billing disputes. Once again, we have a proven solution readily at hand from the State of New York — arguably the most comprehensive law in the country that addresses out-of-network care. In addition to the formula for setting out-of-network

payment rates, the New York law also sets forth an independent dispute resolution (IDR) system to ensure a fair process for physicians and insurers alike. This process is very straightforward and works as follows:

1. The out-of-network physician submits a claim to the health insurer.
2. The health insurer pays what it deems to be reasonable.
3. The physician can accept this amount as payment-in-full or continue to work with the insurer to privately negotiate a mutually acceptable amount.
4. If efforts to reach a privately negotiated rate are unsuccessful, either party may trigger the IDR process.
5. The IDR process utilizes “baseball-style” arbitration, whereby each party submits their suggested payment rate and the IDR entity chooses between one or the other.

The IDR process encourages reasonableness, and as part of the process, the IDR entity is required to consider the following:

- The usual and customary cost of the service, i.e., 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 out-of-network physicians in the same region;
- The out-of-network physician’s usual charge for comparable services;
- Individual patient characteristics;
- The level of training, education and experience of the physician; and
- The circumstances and complexity of the case.

Generally, speaking, in New York the IDR entity bases its decision on which offer is closest to the usual and customary rate — underscoring the importance of the independent medical claims database as part of this process. Claims also must be resolved within 30 days of claim submission, so the process is fairly expeditious. Finally, the New York process also works well because it discourages physicians and health plans from bringing frivolous claims to the IDR entity since, by law, the “loser” pays the costs associated with the IDR.²

Since New York passed its surprise medical bill law, it has been viewed as a win-win-win situation according to a recent review of the New York law.³ 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. For example:

- Virtually all stakeholders agree that the law has successfully helped protect consumers from surprise bills.
- State officials report a “dramatic” decline in consumer complaints about balance billing: “It’s downgraded the issue from one of the biggest [consumer concerns our call center receives] to barely an issue,” said one regulator.
- Stakeholders viewed the IDR process as fair, and 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

² Note that contrary to some reported assertions, the cost of New York’s IDR process is relatively reasonable, ranging from \$250 to \$395.

³ Corlett S, Hoppe O. New York’s 2014 Law to Protect Consumers from Surprise Out-of-Network Bills Mostly Working as Intended: Results of a Case Study. Washington, DC: Georgetown University Health Policy Center, Center on Health Insurance Reforms, May 2019, <https://georgetown.app.box.com/s/6onkj1jaiy3f1618iy7j0gpzdoew2zu9> (accessed May 2019).

majority of out-of-network emergency services disputes (534-289), while providers have won the majority of surprise bill disputes (272-84).

- A 13 percent average *reduction* in physician payments has occurred since the law was enacted, and state regulators report that there has not been any indication of an inflationary effect in insurers' annual premium rate filings.
- In short, while the IDR is not perceived as "a slam dunk for either side," 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."

Moving forward, we hope the legislation can evolve to more closely align with New York's law — the legislative gold standard to address out-of-network/surprise medical bills — which is working very well since it went into effect in 2015.

CONCLUSION

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 to protect the patient from unanticipated medical bills while ensuring that all Americans have access to the care that they need. To that end, while the AANS and the CNS support the patient protections that are included in your legislation, 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. We, therefore, urge you to amend your bill and model it more closely to New York's law, which has proven to protect patients, lower costs and create an incentive for commercial payers to broaden networks and ensure fair and equitable payments to physicians for out-of-network care.

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. In the meantime, if you have any questions or need additional information, please feel free to contact us. We look forward to continuing to work with you on this and other important health policy issues.

Sincerely,



Christopher I. Shaffrey, President
American Association of Neurological Surgeons



Ganesh Rao, MD, President
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cc: Members, Energy and Commerce Committee

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