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AMERICAN COLLEGE OF SURGEONS

*Inspiring Quality: Highest Standards, Better Outcomes*

**Statement of the American College of Surgeons**

**To the House Energy and Commerce Health Subcommittee**
**United States House of Representatives**

**RE: Hearing on No More Surprises: Protecting Patients from Surprise Medical Bills**

**June 12, 2019**

The American College of Surgeons (ACS) appreciates the U.S. House Energy and Commerce Committee's interest in the issue of unanticipated or surprise medical billing and thanks the Committee for holding a hearing focused on identifying ways to protect patients. ACS also appreciates the recent opportunity to comment on the Committee's request for feedback on the *No Surprises Act.* ACS believes a viable comprehensive solution is possible and is encouraged to see the Committee's approach of soliciting feedback from all responsible parties including health insurance plans, hospitals, and providers.

ACS believes any legislative efforts to address unanticipated medical bills should focus on all root causes of the problem and that any solution must recognize the need to protect patients, increase insurance plan transparency and accountability, and address narrow and inadequate networks.

## 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 be involved in each component of an episode of care and are certainly not privy to every physicians contract status with each specific insurance plans. Legislative solutions that require physicians to provide information on another provider's in-network/out-of-network (OON) status are simply unworkable because of the current lack of reliable data that exits with regard to a physician's status.

The ACS urges the committee to consider transparency requirements for insurers requiring them to accurately update and make readily available their provider directories on a regular basis. Adding this level of transparency to the system will greatly assist patients and their care providers in avoiding unanticipated medical bills. 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 so that patients can make informed decisions when they are able to choose who will provide their 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, but insurers often control the market leaving the physician with little room for negotiation. According to CMS, 39% of counties in the federally facilitated exchange (FFE) have a single issuer, meaning that 19.8% of enrollees have access to only one insurer. Similarly, five states will have only one issuer in 2019.[1] 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

[1] https://www.cms.gov/newsroom/fact-sheets/data-2019-individual-health-insurance-market-conditions

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 a solution which does not address the health plans' tactic of increasingly providing inadequate networks will not fully address the overall issue of unanticipated medical bills. Insurance plans must be mandated to meet minimum standards of network adequacy to include contracting with an adequate number 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 must be required from both the federal and state governments.

## Proven Independent Dispute Resolution Model

In order to encourage competition and value, a viable solution must strike a careful balance, allowing physicians and insurers to negotiate a final payment while completely protecting patients from unanticipated medical bills.

The ACS supports a proven Independent Dispute Resolution Model and believes arbitration is the most effective tool for addressing unanticipated bills.

### The ACS Encourages Strong Caution on Any Federal Rate Setting

As previously stated, the ACS supports an Independent Dispute Resolution (IDR) process, but has major concerns with the use of the median contracted rate 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 plan's 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 an adequate rate with the physician and could intentionally lower the median rate with each new contract.

Furthermore, setting a benchmark rate could increase consolidation within healthcare. Providers, having no leverage within negotiation, will have to accept the median rate or they will be driven out of network as previously stated or to an employer system. This will continue to disincentive physicians from practicing independently, further driving consolidation. Research continues to demonstrate that mergers and consolidation between competitors leads to increased cost without improved quality or enhanced efficiency.[2]

Accepting a federally benchmarked rate, as some are advocating, could have a significant impact on the U.S. health care system as we know it today. Using rate setting to resolve this issue, could have a striking effect on all physician payment, and open the door to large scale health care reform in a way that requires further debate.

[2] https://www.nytimes.com/2019/02/11/upshot/hospital-mergers-hurt-health-care-quality.html

Congress should think about these large-scale consequences for the U.S. health care system as a whole before applying such a sweeping solution here.

IDR is a Fair Process

Demonstrated IDR models encourage the arbiter to review a variety of factors when making their determination. This brings all parties to the table equally.

Within a successful IDR the arbiter should consider:

- The usual and customary cost of the service (as defined by 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 nonparticipating physicians in the same region;
- Non-participating physicians usual charge for comparable services;
- Individual patient characteristics; and
- Level of training, education, and experience of the physician and the circumstances and complexity of the case.

Concerns that considering the 80th percentile of usual and customary costs would lead to increased rates, has not proven to be the case. 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 New York law, which uses a fair arbitration model, is working well. The study found a 13 percent average reduction in physician payments since the law was enacted. State regulators also report that there has not 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 reduce those payers' costs.

The study acknowledged 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."

**Viable Framework Led by Representatives Raul Ruiz M.D. (D-CA) and Phil Roe M.D. (R-TN)**

ACS supports a framework such as the bipartisan *Protecting People from Surprise Medical Bills Act* released by Representatives Raul Ruiz, MD (D-CA), Phil Roe, MD (R-TN), Joseph Morelle (D-NY), Van Taylor (R-TX), Ami Bera, MD (D-CA), Larry Bucshon, MD (R-IN), Donna Shalala (D-FL), and Brad Wenstrup (R-OH).

That framework is modeled after an effective state law in New York and includes a fair independent dispute resolution (IDR) process. The arbiter is able to consider actual charge data for the same service, in the same geographic area, performed by a qualified specialist or sub-specialist, and is sourced from a statistically significant and wholly independent benchmarking database such as FAIR Health. The outline also incorporates appropriate transparency requirements such as provider directory standards and clear network information provided to patients. It also includes a study that examines the narrowing of networks, which is a critical component of this problem.

## Conclusion

The ACS is grateful to the Committee for holding this hearing and for allowing stakeholder feedback. We look forward to working with you on a comprehensive solution that protects surgical patients and has a positive impact on the health care system. For further questions, please contact Hannah Chargin, ACS Congressional Lobbyist, at hchargin@facs.org.