June 5, 2019

The Honorable Lamar Alexander, Chair
Senate Health, Education, Labor and Pensions Committee
455 Dirksen Office Building
Washington, D.C. 20510

The Honorable Patty Murray, Ranking Member
Senate Health, Education, Labor and Pensions Committee
154 Russell Senate Office Building
Washington, D.C. 20510

Dear Chairman Alexander and Ranking Member Murray:

The American Society of Anesthesiologists (ASA) applauds your leadership and effort in tackling surprise billing. A recent study found that over 90% of anesthesiologists’ claims are in-network.¹ However, we recognize that surprise billing issues do arise as part of anesthesia services and that they can make care unaffordable for many patients. As a result, we are committed to working with you to address this issue by holding patients harmless while creating a fair mechanism to resolve payment disputes between insurance companies and physicians.

Key Points

- ASA opposes “Option 1: In-Network Guarantee”: This mandated model is untested and diminishes physician autonomy.

- ASA encourages further consideration of “Option 2: Independent Dispute Resolution:” The “STOP Surprise Medical Bills Act,” put forward by Senator Cassidy and the Bipartisan Price Transparency Working Group is the best starting point of the Committee’s three options. ASA encourages the Committee to give full consideration to seeking alignment with “The Protecting People from Surprise Medical Bill Act,” as proposed by Representatives Raul Ruiz (CA) and Phil Roe, M.D. (TN) in the U.S. House of Representatives.

- ASA opposes “Option 3: Benchmark for Payment:” This approach promotes non-transparent, insurance-defined payment rates and risks insurance company “gaming” of payment rates.

Replicate Existing Successful Models

ASA shares your goals of ending “surprise medical bills” and protecting patients from unanticipated bills from out-of-network providers and encourages the committee to adopt a solution which matches the problem. ASA believes that these goals can be met by replicating well-tested, successful state models already in place. New York state has such a model. It ensures patients are put first, holding them harmless and removing them from the middle of out-of-network payment disputes. We hope that any

solution included in final legislation puts patients first, creates a fair mechanism for resolving billing disputes and ensures greater transparency in our health care system.

Independent Dispute Resolution

First, ASA believes that an independent dispute resolution process, as outlined in Option 2, is imperative to resolving payment disputes between providers and insurance companies. ASA recommends that binding arbitration, or ‘baseball style’ arbitration, such as outlined in “The Protecting People from Surprise Medical Bill Act,” be used as a model for final legislation. It provides efficient and cost-effective resolution of payment disputes because it enables a level playing field for plans and providers, while holding patients harmless.

In New York, this model has already been implemented and the literature has identified it as both fair and successful. To illustrate, in New York, the patient is removed from the process of determining out-of-network payment. An out-of-network provider or health insurer may submit a dispute regarding payment to an Independent Dispute Resolution Entity (IDRE). The IDRE must select either the physician’s charges or the insurer’s payment (“baseball style”) and with a few exceptions, the losing party pays for the dispute resolution process. The law also sets up a market-based reasonable, usual and customary cost (see definition\(^2\)) to guide the IDRE process toward a fair and reasonable payment solution.

A May 2019 study from Georgetown University found that the New York independent dispute resolution process was fair to all parties and is working as intended to protect consumers from a significant source of financial hardship. Additionally, a NYS Health Foundation found that the percent of out-of-network emergency department services that were billed decreased from 20.1 percent in 2013, before the law was passed, to 6.4 percent in 2015, after the implementation of the New York surprise billing reforms. Moreover, the number of disputes that went to arbitration totaled around 1,200— a tiny percent of all claims filed in the state of New York. Also, there has been no evidence that this model increases insurance premiums for consumers.

The current draft proposal appears to only apply the independent dispute resolution process to out-of-network non-emergency services at an in-network facility. ASA believes that any final legislation should apply the dispute resolution process, “baseball style” arbitration, to all payment disputes for emergency services. Additionally, we urge you to consider expanding your proposal to apply the dispute resolution process to emergency services. This process would ensure fair payment for these necessary and vital services.

Median Contracted Rate

ASA believes that the independent dispute resolution process criteria for determining a reasonable fee should be market-based and should not be linked to the median-contracted rate.

There is a wide variation in contracted rates based on what a provider can deliver in care. By using a median, all the high-quality providers who are above the median will not be afforded any incentive by the

---

\(^2\) For purposes of this section, “usual and customary cost” shall mean the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent. The nonprofit organization shall not be affiliated with an insurer, a corporation subject to article forty-three of this chapter, a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter, or a health maintenance organization certified pursuant to article forty four of the public health law. McKinney’s Insurance Law § 3217-a
insurer to continue payments for high quality care. Moreover, ASA is concerned about the potential for the “gaming” in insurer-reported rates.

Benchmarking to a non-conflicted, independent and transparent database of billed charges within a specific geographic region for a specific service is ASA’s preferred approach. This is the same approach that has been successful in New York. ASA recommends that the Committee base out-of-network payments on provably, reasonable physician charges for the same service in the same geographic area. 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 charges 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.

ASA recommends that physician triggered independent dispute resolution should be permitted in instances where a provider’s unique background or skills are not accounted for within a minimum benefit standard. Additionally, ASA recommends that the IDRE be authorized to consider the level of training, education and experience of the out-of-network provider in determining a reasonable payment offer.

Other Concerns

ASA has reservations about the implications of Option 1, establishing an in-network facility guarantee to patients and health plans that every practitioner at that facility will also be considered in-network. Hospital contracts generally require anesthesiologist practices to make a good faith effort to be in-network with the plans with which the hospital is in-network, to align with the federal health plans which the hospital participates in, and to conform to the hospital or health system’s charitable care. As noted previously, this provision would remove any incentive for insurers to negotiate with physician practices in good faith. Moreover, physician practices should not be penalized when an insurer determines that the practice does not represent a significant share of their market or when the insurer fails to offer a reasonable rate of payment.

Notice and Consent Provisions

ASA supports the robust transparency requirements regarding out-of-network coverage in the Lower Health Care Costs Act. Patients need to know when a service is out–of–network and the costs that are associated with out-of-network providers. Plans should be required to determine and document for patients what out-of-pocket costs patients can reasonably expect to bear for the out-of-network coverage. Insurers should also be required to provide readily accessible, consumer-oriented information about the coverage their plans provide, and up to date information as to which providers are in-network.

Network Adequacy

Finally, ASA is concerned that there are no network adequacy provisions in the discussion draft. Network adequacy standards can be aligned with definitions created through the Affordable Care Act (ACA). This will help ensure patient access to necessary services and support providers to negotiate sound contracts with insurers. Failure to maintain network adequacy is a significant factor in physicians being out of network in their patients’ health plans. We would point to the October 2018 consent order in which the
Texas Department of Insurance found one of the state’s largest insurers to have failed to provide an adequate number of physician anesthesiologists in-network in four of Texas’s most densely populated counties.

Thank you for your time and consideration. We are committed to working together to ensure a better health care system for our patients and practitioners and look forward to working with you to address surprise billing. Please contact Manuel Bonilla, Chief Advocacy and Practice Officer, at 202-289-2222 or m.bonilla@asahq.org if we can be of any assistance.

Sincerely,

Linda Mason, M.D., FASA
President
American Society of Anesthesiologists

---