On behalf of the American Society of Anesthesiologists (ASA), thank you for holding the June 12, 2019, hearing entitled, “No More Surprises: Protecting Patients from Surprise Medical Bills”. ASA commends the Committee’s thoughtful consideration of surprise billing and appreciates the opportunity to share our comments on the issue and proposed legislation from Chairman Frank Pallone (D-NJ) and Ranking Member Greg Walden (R-OR).

The recently released discussion draft entitled the No Surprises Act is an important step to help protect patients from surprise medical bills. A recent study found that over 90% of anesthesiologists’ claims are in-network. 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 putting patients first.

ASA would like to bring your attention to several key concepts that are included in “The Protect Patients, Prevent Surprise Medical Bills” proposal, recently released by Energy and Commerce Committee member Representative Raul Ruiz, M.D. and Representative Phil Roe, M.D. In addition to Representative Ruiz, the proposal also has the support of committee member Representative Larry Bucshon, M.D. The concepts included in Ruiz-Roe are based on tested, successful state models and should be incorporated into the Committee’s proposal as you finalize your discussion draft.

Replicate Existing Successful Models

ASA shares the Committee’s goals of ending “surprise medical bills” and protecting patients from unanticipated bills from out-of-network physicians and other providers. ASA believes that these goals can be met by replicating well-tested, successful models already in place, such as the model in New York state. We hope that any solution included in final legislation holds patients harmless, provides physicians and other providers an appropriate, market-based payment, creates a fair mechanism for resolving billing disputes and ensures greater transparency in our health care system.

Hold Patients Harmless

ASA supports removing patients from the billing dispute between physicians and insurance companies. In out-of-network situations, the patient should be held harmless for any amount in excess of the in-network cost-sharing amount and deductible.

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Appropriate Market-Based Payment

ASA strongly supports the concept included in Ruiz-Roe of an initial or automatic market-based reasonable payment within thirty days of the service being provided. In out-of-network scenarios, the anesthesiologist has already provided the service so a payment from the patient’s insurer to the physician for the services provided is appropriate.

Independent Dispute Resolution

ASA believes an independent dispute resolution process, as contained in Ruiz-Roe, is essential to resolving payment disputes between providers and insurance companies. ASA recommends that binding arbitration, or ‘baseball style’ arbitration 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 1,300—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 of No Surprises Act is missing a mechanism for deciding payment disputes. ASA highly recommends that the Committee incorporate binding arbitration into its final legislation and use Ruiz-Roe and the New York state as a model for resolving payment disputes and determining a reasonable, market-based fee.

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
Concerns with the *No Surprises Act*

*Median Contracted Rate*

The *No Surprises Act* discussion draft establishes a minimum payment standard set at the median contracted (in-network) rate for the services in the geographic area the service was delivered. While we recognize the draft also preserves a state’s ability to determine their own payment standards for plans regulated by the state, we are concerned with the stipulation of a median contracted rate for the minimum payment standard. This approach promotes non-transparent, insurance-defined payment rates and risks insurance company “gaming” of payment rates. ASA strongly opposes federal rate setting and believes that physicians and **insurers should continue to be able to negotiate market-based payment rates**. Accordingly, ASA urges the committee to eschew an insurance company-centric rate-setting approach and seek to incorporate the fairer, more balanced approach of Ruiz-Roe. The criteria for determining a reasonable fee should then be market-based.

There is a wide variation in contracted rates based on what a physician or other provider can deliver in care. By using a median, all the high-quality physicians who are above the median will not be afforded any incentive by the payer to continue payments for high quality care. Moreover, ASA is concerned about the potential for the “gaming” of payer-reported rates. This will establish a ceiling and remove all incentives for insurers to develop comprehensive networks, as there are already an increasing number of narrow networks that exclude certain types of physicians and other providers. If an insurer can pay the same rate to all out-of-network physicians, there is absolutely no motivating factor to entice them into negotiations with physicians to develop robust networks for patients.

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 is working well in New York. 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 physicians. 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 market-based truly reasonable charges.

ASA recommends that the IDRE involved be able to take into consideration the level of training, education and experience of the out-of-network physician in determining a reasonable payment offer.

*All-Payer Claims Databases*

ASA is interested in the provision of the *No Surprises Act* that provides states with the ability to develop all-payer claims databases. The bill defines such as database as one “that may include medical claims, pharmacy claims, dental claims, and eligibility and physician and other provider files, which are collected from private and public payers”.

The Society believes that the New York approach is best through its use of an independent database of billed charges. There are a number of risks associated with state specific all-payer claims databases that can inappropriately skew or report the data. New York has implemented and tested an approach that is fair to all and supported by the literature. We would encourage this tested approach over 50 potential approaches that could subject physicians and other providers to any number of unnecessary challenges.
Transparency

ASA believes that there should be more robust transparency requirements for plans and physicians and other providers in the No Surprises Act. Patients need to know when a service is out-of-network and the costs that are associated with out-of-network physicians and other 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.

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 physicians to negotiate sound contracts with insurers.

About the ASA

Representing more than 53,000 members, ASA is dedicated to raising and maintaining the standards of the medical practice of anesthesiology and to improving patient care. Since 1905, we have acted as an advocate for all patients who require anesthesia or relief from pain. Physician anesthesiologists are committed to providing safe, high quality and efficient care for patients undergoing anesthesia and surgery, and for patients requiring care in the intensive care unit, pain medicine, and palliative care. To ensure ASA members accomplish these goals, the society is committed to advancing patient health and clinical care through research designed to improve the health of patients, identify new and improved ways to care for patients and to provide value-based care that best meets the needs of each patient.

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