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June 24, 2019

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

RE: S. 1895 The Lower Health Care Costs Act of 2019

Dear Chairman Alexander and Ranking Member Murray:

We are writing to you to express our deep concerns with the above-referenced proposal to address the challenges facing our patients with surprise out of network medical bills. While we very much share your goal of your legislation to hold patients "harmless" in these situations – that is, to assure patients only need to pay what their cost-sharing responsibility would have been had the care been provided by an in-network physician, we are very concerned that this legislation could undermine New York's innovative and balanced approach. We are particularly concerned that this approach could threaten patients' access for immediate and expert on-call specialty care for patients in emergency departments in New York State and perhaps across the country – concerns which New York State officials sought to prevent in establishing its law the way that it did.

Instead, we urge you to revise your proposal in a manner similar to the bi-partisan proposal being advanced by Representative Raul Ruiz (D-CA) and Representative Phil Roe (R-TN), which most closely aligns with New York's approach.

As you may know, New York's law addressing this issue has been hailed as a model for the rest of the country because of the balance it struck among the health care community to protect patients from "surprise" medical bills, while at the same time preserving the ability of hospital emergency departments to maintain adequate on-call specialty physician care. In fact, a recently announced study (https://nationaldisabilitynavigator.org/wp-content/uploads/news-items/GU-CHIR_NY-Surprise-Billing_May-2019.pdf) from the Georgetown University Health Policy Institute and the Robert Wood John Foundation reports that there has a dramatic decline in consumer complaints about surprise bills in New York since the enactment of our law, with one regulator stating that the law has "downgraded the issue from one of the biggest consumer concerns ...to barely an issue."

At the same time, the Georgetown report highlighted the nearly evenly split numbers in Independent Dispute Resolution (IDR) decisions between physicians and health insurers, which has incentivized physicians and insurance to negotiate payment disputes before filing with IDR. Furthermore, the report noted that not only has there not been any indication of an inflationary effect in insurers' annual premium rate filings, out of network payments are down 13% since the law was enacted.

It is clear the New York approach should be a model for the country.

Addressing the Root Causes of Surprise Medical Bills

First, we are very concerned that your proposal fails to address the insurance industry's own fault in creating this problem, including inadequate physician networks and inadequate insurance coverage for out of network physician care. As a reminder, New York's law sought to address some of the root causes of surprise bills by:

- Requiring all health insurance products regulated by the State to meet physician network adequacy requirements, based upon review by New York's Department of Financial Services (DFS);
- Affording patients the right to receive treatment from a OON specialist appropriately qualified to treat a patient's particular condition at no additional cost to the patient, if the health insurer's network fails to include such appropriately qualified specialist;
- Establishing a patient right to have an independent external appeal to be treated by an OON physician if the patient can show that the insurer network is insufficient to meet their health care needs;
- Requires health insurers to describe its OON coverage in a manner that is based upon the percentage of the "usual and customary cost" of OON health care services, including examples of anticipated out of pocket costs for frequently billed OON health care services, and an internet site that enables patients to determine what out of pocket costs they can reasonably expect to face based upon the OON coverage provided by the insurer. *This was to address concerns that OON coverage based upon Medicare or insurer "allowed" amounts were poor predictors to patients of what they could reasonably expect to be their out of pocket costs when treated by an OON physician.*
- Requires health insurers to offer coverage to consumers of policies that cover at least 80% of the usual and customary cost of any OON health care service.

Importantly, the law defines "Usual and customary cost" as the 80th 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". This reflects the manner by which out of network medical services are being regularly collected and reported by publicly available benchmarking services such as Fair Health. Indeed, Fair Health's "usual and customary" data has become the benchmark for many different state programs across the country because of the comprehensiveness of its data.

Furthermore, it employs mechanisms to ensure that "outliers" in charges are deleted from its regional collections of data. Therefore, it is a far more predictive indicator to patients of what their potential out of network costs could be rather than health insurer controlled in-network rates or grossly insufficient Medicare or Medicaid rates.

A Fair Process for Determining Payment for Surprise Bills

Secondly, we have serious concerns regarding the legislation's suggested use of health insurer-dictated in network payments as a federal benchmark for resolving out of network payment disputes. Conversely, the approach advanced by Representatives Ruiz and Rose most closely align with New York's approach because it would, like New York's law, use independently collected charge data as a key benchmark for the arbitrator's decision.

It is important to note that New York's process sought to achieve a critical balance among physicians, hospitals and health insurers, including assuring the availability of needed on-call specialty care in hospital emergency departments across the State. Proposals that could undermine New York's approach could, in turn, reduce specialized care availability for patients in emergency departments across the State. New York's approach has worked well in preserving patient access to needed specialty care in hospital emergency departments – why would we take a chance on a different model?

To ensure fair payment to the physician from the health insurer for an out of network surprise medical bill, New York's law employs the following process:

1. The OON physician submits the claim to the insurer.
2. The health insurer pays what it deems to be reasonable
3. If efforts to informally settle the payment dispute are unsuccessful, either the physician or insurer can bring the claim to an Independent Dispute Resolution (IDR) process.

To encourage reasonableness on both the part of physicians and health plans, the IDR entity must choose between the plan's payment or the non-participating physician's fee (otherwise known as "baseball arbitration"), and may not set their own amount. In rare instances the arbitrator can direct the parties to negotiate a settlement.

As part of the IDR entity's review, they are required to 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 non-par physicians in the same region; The non-par 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. Absent special circumstances, the IDR entity often makes its decision based upon which party – the physician's billed charge or the insurer's offered payment – is closer to the UCR.

To discourage the frivolous bringing of such claims, the IDR is statutorily defined as a "loser pays" process. Moreover, to ensure that claims are not inappropriately "dragged out", the statute requires a decision to be rendered within 30 days of claim submission. The expeditious nature of this process is one of its key features. Given that the price for this process has been relatively reasonable, ranging from \$250-\$395, we are shocked that the insurance industry continues to make outrageous claims about the exorbitant cost of arbitration.

It is important to note that one of key reasons for the benchmark being set as a percentage of billed charge data is the perception of fairness, as such data is collected by an independent entity that is free from insurer or physician control. This is particularly important given the insurance industry's own notorious history in establishing benchmarks for out of network payment. In 2009, then New York AG Andrew Cuomo launched an investigation into United Healthcare's ownership of the Ingenix database. The AG found that, by using a flawed and conflicted database to determine reimbursement rates for out-of-network care, insurers were increasing profits at the expense of patients and physicians. The insurance industry agreed to stop using this conflicted database and agreed to contribute towards the creation of an independent data collection entity, Fair Health, which has become the reference database used by New York.

Contrary to allegations by some that the use of charge data could lead to physician manipulation of such data, Fair Health uses an aggressive outlier methodology to delete charges that are considered to be outside the normal statistical distribution model. It is also important to note that, since as a practical matter the party that is closer to the usual and customary cost of a particular health care service is most likely to be the "winner" in an IDR in New York, there is substantial incentive on the part of physicians to be reasonable in setting charges. Indeed, a recent Fair Health report concluded that there were only minimal increases in the 80th percentile of charges in New York and Connecticut for commonly billed Emergency Department codes from 2015 to 2018.

Given these dynamics, we are extremely concerned with any proposal that would use an insurer determined in-network rate as a benchmark for physician payment. Such rates reflect the fact that physicians agree to significantly discount their usual fees in exchange for contracted benefits, such as increased patient volume, being listed in the plan's provider directory, and prompt payment of claims. With so many physicians already unable to negotiate contracts fairly with insurers due to the insurers' market dominance, setting out-of-network payments at those discounted rates would place physicians at an even worse competitive disadvantage when they attempt to negotiate a fair contract, especially when the repercussions of limited networks on insurers have been removed. Indeed, we have heard disturbing reports from California that health insurers are dropping significant numbers of hospital-based physicians from their networks, after the passage of a law there that greatly limited what insurers had to pay for out of network bills. Again, why do want to take a chance of a similar development occurring in New York?

The bottom line is that S.1895 would even further empower market dominant insurance companies, who already have the power in many markets across the country, to foist 'take it or leave it' contracts on physicians that not only impact

payments for care, but also many other patient care issues, such as excessive prior authorization requirements, minimal prescription medication formularies, and narrow networks—all which limit patients’ timely access to care. Moreover, as you may know, an attorney from the well-regarded law firm Kirkland & Ellis has posited that an in-network default rate potentially violates the U.S. Constitution, noting that “Forcing healthcare providers to furnish emergency services at government-dictated rates—even to those who can pay fair market value—raises all the same takings concerns that courts have expressed when dealing with unfair or confiscatory rate-setting in the context of public utilities and common carriers.” (<https://www.scribd.com/document/414001118/Paul-Clement-Balance-Billing-Constitutional-Implications-June-2019>)

From the statistics, it is clear that New York’s law is working as it was intended. For example, according to the 2018 New York State Consumer Guide to Health Insurance (https://www.dfs.ny.gov/consumer/health/cg_health_2018.pdf - p.64), the “winners” of these IDRs have generally been evenly split between health insurers and providers, with health insurers “winning” slightly more, as noted below.

CATEGORY	EMERGENCY SERVICES	SURPRISE BILLS
Health Plan Payment More Reasonable	203	49
Provider Charges More Reasonable	61	141
Split Decision	102	75
Settlement	109	67

The “50-50” nature of the results has also greatly encouraged informal resolution, which accounts for the relatively few number of claims being brought to the IDR process, particularly when one considers the millions of patient emergency department encounters every year in New York hospitals.

In summary, New York’s comprehensive law sought to address the various circumstances under which a patient’s interaction with the health care system could unfortunately lead to that patient receiving a “surprise” medical bill. It has set a model for the nation. Indeed, following a different path potentially upsets emergency department dynamics that could have the unintentional effect of harming patient care – why would we want to take that chance? Therefore, I urge you to amend S.1895 to delete its use of an insurer-determined in-network default payment for surprise bills, and instead substitute the effective New York approach, that has been best set forth in the Ruiz-Roe proposal.

Sincerely,



ART FOUGNER, MD
MSSNY President