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May 28, 2019

The Honorable Frank Pallone
Chairman
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Greg Walden
Ranking Member
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Pallone and Ranking Member Walden:

On behalf of the more than 38,000 members of the American College of Radiology (ACR), thank you for the opportunity to provide comments on the Energy and Commerce Committee's bipartisan discussion draft of the "No Surprises Act." Issues surrounding high out-of-pocket costs and shrinking provider networks present real issues for patients in need of life saving diagnostic imaging and other services provided by our members.

Health insurance plans are increasingly relying on narrow and often inadequate networks of contracted physicians, hospitals, pharmacies, and other providers as one mechanism for controlling costs. As a result, even those patients who are diligent about seeking care from in-network physicians and hospitals may find themselves with unanticipated out-of-network bills from providers who are not in their insurance plan's network, simply because they had no way of knowing and researching in advance all the individuals who are ultimately involved in their care. Physicians and other providers are limited in their ability to help patients avoid these unanticipated costs because they, too, may not know in advance the exact plan in which the patient is enrolled and who will be involved in an episode of care, let alone other providers' contract status with all the insurance plans in their communities.

In addition to providing responses to the Committee's specific questions/areas of interest, the College reiterates the importance of the below principles being utilized as a foundation for legislation. We believe legislation based on these principles would provide strong patient protections, while simultaneously improving transparency, promoting access to appropriate medical care, and avoiding the creation of disincentives for insurers and health care providers to negotiate network participation contracts in good faith. As such, we urge the Committee to include provisions in the "No Surprises Act" to:

- **Create a mechanism for insurer accountability**. Since overly narrow provider networks contribute significantly to this problem, strong oversight and enforcement of network adequacy is needed from both federal and state governments.

- **Establish limits on patient responsibility**. Patients should only be responsible for in-network cost-sharing rates when experiencing unanticipated medical bills. However, legislation should also include provisions to ensure the further education of patients about their co-pays and deductibles so they are not "surprised" when they receive a bill based on the contract they have with their plan, un-related to their provider's network status.

- **Avoid benchmarking payments to Medicare or another arbitrarily low-set rate**. Guidelines or limits on what out-of-network providers are paid should reflect actual charge data for the same service in the same geographic area from a statistically significant and wholly independent database. Medicare rates are inadequate for this purpose because they establish artificial rates based on budgetary constraints. Nor

HEADQUARTERS
1891 Preston White Drive
Reston, VA 20191
703-648-8900

GOVERNMENT RELATIONS
505 Ninth St. N.W.
Suite 910
Washington, DC 20004-2173
202-223-1670

CLINICAL RESEARCH
1818 Market Street
Suite 1720
Philadelphia, PA 19103-3604
215-574-3150

AMERICAN INSTITUTE FOR RADIOLOGIC PATHOLOGY
1100 Wayne Ave., Suite 1020
Silver Spring, MD 20910
703-648-8900

should rates be based on negotiated in-network rates, which would have the effect of eliminating the need for insurers to engage in meaningful negotiations.

- **Mirror viable state laws**. Several states have implemented out-of-network billings laws that present tangible templates for a federal solution.
    - New York: The law includes comprehensive patient protections, holds insurers accountable for maintaining adequate networks of physicians and specialists, establishes reasonable patient benchmarks, and a mechanism for effective alternative dispute resolution (ADR).

- **Apply to all plan types.** Any federal legislative solution to address unexpected out-of-network medical bills should apply to all plan types, including ERISA.

As the Committee's efforts to on this issue continue to evolve, the ACR strongly urges incorporation of the Protecting People From Surprise Medical Bills Act, a legislative framework recently released by Representatives Raul Ruiz, MD, and Phil Roe, MD. We believe it strikes a necessary balance by providing strong patient protections, while simultaneously improving transparency, promoting access to appropriate medical care, and avoiding the creation of disincentives for insurers and health care providers to negotiate network participation contracts in good faith.

In addition, the College is happy to provide the below detailed comments regarding the Committee's request for feedback on the following topics.

- ***Ensuring Network Adequacy.*** *Consumers deserve adequate networks that offer the right care at the right time. The Committee seeks feedback on ensuring that networks are sufficiently meeting the needs of individuals.*

The College has long viewed "surprise medical bills" as an issue largely stemming from actions of private insurers to shift too much blame to physicians for patients experiencing high bills when treated by out-of-network providers. Instead, the ACR believe a more accurate characterization of these scenarios is of "surprise gaps in insurance coverage." This definition is more reflective of the reality of insurers capitalizing upon consumers' desire for low-cost insurance premiums and failing to disclose potentially costly deficiencies in their plans, resulting in greater responsibility for out-of-pocket costs and the financially burdensome impact of inadequate provider networks. The College appreciates the Committee's acknowledgment that ensuring robust provider networks is a critical aspect of protecting patients from surprise medical bills. To ensure that narrow networks actually provide sufficient patient access to all types of physician specialties, legislation should require an adequate ratio of ancillary physicians, especially radiologists, based on the size of the beneficiary population covered by a given health plan. Furthermore, and with respect to radiologists, any forthcoming legislation should bar insurers from utilizing teleradiology as a primary mechanism to comply with any network adequacy standard, as patients should have access to an adequate number of in-network radiologists at local, in-network facilities. Also, to ensure patients in rural areas have ample access to all types of physicians, network adequacy standards should also take into account geographic and driving distances, as well as potential wait times for appointments. Ideally, patients would not have to travel more than 30 minutes for 30 miles to access in-network ancillary physicians at in-network facilities.

The network adequacy section of any forthcoming legislation should also include provisions requiring the insurance carriers to update their directories of participating providers on a regular basis, preferably via a specific set interval (e.g. every two weeks, last day of each month, etc.). As a byproduct of this requirement, insurance carriers should be held financially responsible for patients who are unable to obtain in-network services due to provider directories deemed out-of-date or not reflective of the total number of physicians participating in a narrow network. Finally,

legislation should require insurers to comply with the prudent layperson standard in existing law for determining coverage for emergency care, so that insured patients are not liable for unexpected costs simply because they were unable to accurately self-diagnose ahead of time whether their symptoms were, in fact, due to an emergency medical condition.

The College has also previously voiced concern regarding potential legislative provisions limiting a physician's ability to remain out of network. While the College supports holding beneficiaries financially harmless for bills stemming from surprise gaps in insurance coverage and/or scenarios where the patient was unable to choose their providers, adequately compensating physicians for the care they provide patients is equally important. As such, the College continues to support the inclusion of a mechanism for alternative dispute resolution (ADR), included, but not limited to mediation or arbitration, with the patient's insurance carrier instead of unilateral bans on balance billing in all scenarios. Failure to include such protections will likely result in eliminating the need for insurers to negotiate contracts in good faith.

- ***Encouraging the Development of State All-Payer Claims Databases.*** *All-payer claims databases have the potential to bring greater transparency to health care costs and spur innovative policy solutions. The Committee requests feedback on how to aide states in developing robust all-payer claims databases.*

The College is concerned that the creation of separate state-based claims databases will lead to unnecessary variability in resolving the issue of "surprise" or OON medical bills. Instead, the Secretary of HHS should certify various national independent databases as eligible references for use in arbitration or other processes for determining payment for OON services. For example, the FAIR Health Database, an independent collection of more than 25 billion private healthcare and 20 billion Medicare claims, is typically regarded as the gold standard for analyzing and establishing UCRs for care delivered by OON physicians.

- ***Protecting Consumers from Surprise Bills from Air and Ground Ambulances.*** *While the No Surprises Act does not address the issue of surprise medical bills from ground or air ambulances, the Committee recognizes the need for solutions in these areas and seeks feedback on how to provide relief to consumers burdened with unexpected ambulance bills.*

At this time, the College does not have a formal position relating to the issue of surprise medical bills stemming from ground or air ambulance services.

- ***Establishing a market-based benchmark to resolve out-of-network payment disputes between providers and insurers.*** *Payment disputes between providers and insurers must be resolved in a manner that takes the patient out of the middle, is transparent and does not increase federal healthcare expenditures. The Committee requests feedback on how to adequately provide payment in these situations through a transparent, non-inflationary mechanism.*

The College views average in-network and Medicare fee-for-service payment rates as inadequate payment benchmarks because they are not designed to truly cover the costs of providing care to patients. In-network rates are opaque and easily manipulated by the carrier, and physicians agree to these lower payments in exchange for guaranteed patient populations, prompt payment, etc. Medicare rates simply do not cover the incurred cost of services provided by physicians and can lead to patients being unable to access care. In addition, these rates are inadequate benchmark because they establish artificial rates based on budgetary constraints and policy agendas rather than market forces. We fear these low potential payment benchmarks will eliminate any financial incentive for the insurer to negotiate meaningful reimbursement rates for all providers, regardless of whether they choose to be in or out-of-network. Instead, the College urges payment to be at least equivalent to the 80th percentile of

charges contained in neutral databases unaffiliated with insurers, such as the FAIR Health Database. The FAIR Health database is regarded as the gold standard for analyzing and establishing "usual, customary, and reasonable" rates, and the 80th percentile is a more reasonable mathematical calculation for reimbursement of OON care. In addition, we recommend that any prohibition, whether state or federal, on billing from out-of-network providers not chosen by the patient be paired with a corresponding payment process that is tied to the market value of physician services.

Instead of establishing an arbitrary payment benchmark for OON care, the College urges the Committee to pursue a mechanism for Alternative Dispute Resolution/Independent Dispute Resolution (ADR/IDR). Several states have successfully implemented an ADR process with binding "baseball-style" arbitration and mediation (a negotiated settlement) while patients receive protections from surprise medical bills. For example, New York's statute established a dispute resolution process and enabled the state superintendent of insurance the power to grant and revoke the certifications of independent resolution (IDR) entities. Moreover, the superintendent was charged with promulgating regulations establishing standards for the dispute resolution process. With baseball-style arbitration, the insurer and physician publicly submit unique "final offers" for review by the independent arbiter. The theory behind making the offers public is to encourage the parties to settle outside of the arbitration, as well as to incentivize reasonable bids for review. The ADR/IDR process is particularly important in circumstances where a potential minimum payment standard is insufficient due to factors such as the complexity of the patient's medical condition, the special expertise required, comorbidities, and other extraordinary factors. In addition, the College supports the adoption of the New York statute definition of the usual customary rate:

> "Usual and Customary Cost shall mean the eightieth percentile of all charges for a 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 any insurer, a corporation, a municipal cooperative health benefit plan, a health maintenance organization, or a student health plan. "

Of note, a May 2019 report from the Georgetown University Health Policy Institute's Center on Health Insurance Reforms concluded that in terms of New York, "…the law has been a success. Consumer complaints have declined dramatically. For the most part, insurers and providers appear to be working out their differences without resorting to arbitration. Further, there is not yet clear evidence that the law's use of UCR as a benchmark price has had broadly inflationary effects." The same report indicated that IDR decisions using the New York model have been relatively even between providers and payers, with 618 disputes decided in favor of the health plan and 561 decided in favor of the provider. Given these compelling results, the College strongly encourages the Committee to include an ADR/IDR process that mirrors the New York model in lieu of establishing an arbitrary payment benchmark.

In fact, the experience of physicians in the state of California reflects the pitfalls of establishing a payment rate tied to Medicare or in-network rates. As was predicted by the California Health Benefits Review Program, "by setting the non-contracted effective rate for potentially surprise professional services, "the new law "put downward pressure on contracted rates among the specialties …that are most likely to work in non-contracted medical groups within contracted in-network facilities …". It has also "reduce[d] the negotiated rates for those specialties by setting a ceiling (i.e., based on the Medicare fee schedule) for out-of-network…surprise medical bill payment." According to the California Medical Association, since the passage of the state's surprise medical billing law in late 2016, a substantial number of their member physicians have reported difficulties in renewing contracts with health plans and insurers with which they had longstanding existing contracts for reimbursement greater than 125 percent of the Medicare rate and in obtaining new contracts.

Again, the ACR appreciates the opportunity to provide detailed comments regarding the draft "No Surprises Act," and we look forward collaborating with you to find a federal solution that addresses the issue of surprise medical bills in a comprehensive way that does not compromise access to care through unintended consequences.

If you have any questions and/or would like any additional information regarding the College's comments, please contact Cynthia Moran, ACR's Executive Vice President, Economics, Government Relations and Health Policy, via phone (202-223-1670) or email (cmoran@acr.org).

Sincerely,

William T. Thorwarth, Jr., MD, FACR
Chief Executive Officer