October 8, 2018

The Honorable William Cassidy, MD
520 Hart Senate Office Building
United States Senate
Washington, DC 20150

Dear Senator Cassidy:

On behalf of the more than 38,000 members of the American College of Radiology (ACR), I appreciate the opportunity to provide comments on the latest draft of the "Protecting Patients from Surprise Medical Bills Act." It is our understanding that this legislation is largely the byproduct of a bipartisan Senate working group designed to empower patients through increased health care price and information transparency, improved health care quality, and lower health care costs. ACR provided detailed comments in response to the working group's February 2018 Request for Information and the College remains committed to enhancing price and information transparency for patients. Nevertheless, ACR is concerned with several aspects of this draft legislation, including the use of the phrase "surprise medical bills," the lack of robust network adequacy standards, as well as the federal ban on balance billing and caps on reimbursement for physicians providing care to patients that are deemed out-of-network by an insurer. ACR supports the bill's underlying goals and we hope that our comments offer meaningful ways to improve the draft legislation. The College stands ready to work with you and your bipartisan Senate colleagues to enhance the Protecting Patients from Surprise Medical Bills Act so that it properly balances the needs of patients, insurers, and physicians.

The preliminary draft bill attempts to mitigate the negative impact of what the media and insurers commonly refer to as "surprise medical bills." "Surprise medical bills," or charges assessed to patients after receiving care from out-of-network physicians and hospitals that they reasonably believe are in-network, occur in a variety of situations. For example, "surprise bills" might be issued for medical services performed on an unconscious or incapacitated patient at an out-of-network hospital for emergency services performed by out-of-network Emergency Department (ED) physicians. "Surprise medical bills" also arise from individuals experiencing emergency health events and being transported to in-network hospitals, yet the ED physicians, Radiologists or other specialists involved in their care are not within the beneficiaries' network of providers.

Patients can also experience unexpected medical bills stemming from scheduled care that requires services rendered from ancillary specialists, such as Radiologists, Pathologists, Anesthesiologists and even Surgical Assistants. Under this scenario, beneficiaries receive care at an in-network hospital but their ancillary physicians are deemed out-of-network by the insurer. The ramifications for patients seeing out-of-network physicians at an in-network facility are typically higher cost-sharing (e.g. copayments, coinsurance, and deductibles) and balance bills, or treating providers billing individuals directly for the remaining cost of the service rendered above the negotiated rate assessed by the insurance company to in-network providers.

The College, however, views "surprise bills" as an issue largely stemming from the actions of private insurers and this nomenclature shifts too much of the blame to physicians for patients experiencing high bills when treated by out-of-network providers. Instead, ACR urges the bipartisan Senate health care price transparency working group to define this issue as "surprise gaps in insurance coverage." In reality, it's more accurate to associate "surprise medical bills" with insurers capitalizing upon consumers' desire for low-cost insurance and failing to disclose potentially costly flaws in their plans, including the impact of inadequate provider networks. Too often, patients only look at the associated price of the plan and come to find out, usually after they've either been diagnosed with a serious ailment or suffered major trauma, that the physicians needed to render medically necessary care are

not within their narrow network of providers. ACR is concerned that the draft legislation is far too deferential to the viewpoints of the insurance industry and fails to recognize that business decisions rendered by purchasers and private payers are the root cause for surprise gaps in insurance coverage.

To solve the glaring problem of surprise gaps in insurance coverage, the ACR urges the legislation to include robust network adequacy protections. To ensure narrow networks actually provide sufficient patient access to all types of physician specialties, this new section should require an adequate ratio of ancillary physicians, especially Radiologists, based on the size of the beneficiary population covered by a given health plan. With respect to Radiologists, network adequacy thresholds should not be permitted to be satisfied via teleradiology. In other words, health insurers need to provide an adequate number of in-network Radiologists at local, in-network facilities. To ensure that patients in rural areas have ample access to all types of physicians, narrow network provisions 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 or 30 miles to access in-network ancillary physicians at in-network facilities and appointments should be secured within a week of initial outreach. Patient-to-physician ratios, as well as standards for geographic, driving distance, and appointment wait times, may need to vary based on a state's size and population density.

The network adequacy section should also include provisions requiring the insurance carriers to regularly update their directories of participating providers. 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. All of these concepts closely mirror current network adequacy policies established by the American Medical Association (AMA) which state:

> *"Our AMA advocates that health plans should be required to document to regulators that they have met requisite standards of network adequacy including facility- and hospital-based physician specialties, (i.e. Radiology, Pathology, Emergency Medicine, Anesthesiologists, and Hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible."*[1]

We hope that updated versions of the Protecting Patients from Surprise Medical Bills Act will not include cursory network adequacy provisions akin to simply deferring to existing state laws. Instead, ACR urges the health care price transparency working group to include similar network adequacy provisions to those contained within the AMA's model state legislation addressing surprise gaps in insurance coverage[2]. In addition, either the Secretary of Health and Human Services or the State Insurance Commissioner should certify all health insurance plans sold by private payers comply with all necessary network adequacy provisions. **More robust network adequacy standards should be included in the updated legislation. More robust network adequacy standards essentially render excessive bills stemming from surprise gaps in insurance coverage moot because patients will be less likely to be treated by out-of-network ED or ancillary physicians.**

The ACR also urges the Senate health care price transparency working group to make amendments to sections pertaining to balance billing and reimbursement caps stemming from patients receiving care from physicians outside of an insurer's provider network. Under the current draft bill, patients are only required to pay in-network cost sharing rates when receiving either emergent or scheduled care from out-of-network physicians. In addition, the legislation explicitly prohibits ED or ancillary physicians from balance billing patients even when they receive care outside of their insurance carrier's provider network.

---

[1] American Medical Association Policy on Network Adequacy H-285.908.11
[2] American Medical Association's "Truth in Out of Network Healthcare Benefits Act." Accessed via the web site at: https://www.ama-assn.org/sites/default/files/media-browser/specialty%20group/arc/truth-out-network-healthcare-benefits.pdf

More specifically, the draft bill states that ED physicians providing emergency services to an out-of-network beneficiary must be paid in accordance with limitations established by existing state law. If a state does not regulate out-of-network emergency services, the ED physician can only receive reimbursement equivalent to the greater of the median in-network amount negotiated (i.e. contracted rate) by the applicable health plan (the bill is silent regarding what data is used to calculate the median rate) or the usual, customary, and reasonable rate (UCR). The bill defines UCR as 125 percent of the average allowed amount by private insurers for the service provided by a physician in the same or similar specialty practicing in the same geographical area available from a "statistically significant benchmarking database maintained by a nonprofit organization." The UCR could also be calculated from a state's all-payer claims database if administered by a nonprofit.

If patients require more treatment in the ED after being stabilized, the hospital or provider must notify the beneficiary in writing that they may be required to pay higher cost-sharing than if they received these services at an in-network facility. Patients must provide written consent before receiving additional services and be given the option to transfer to an in-network facility. **ACR supports this section of the legislation requiring stabilized patients to be made aware of the fact that they're being treated either in an out-of-network ED or by out-of-network ED physicians. Obtaining written consent before providing additional non-emergent or scheduled services and granting patients the ability to transfer to an in-network facility are also sensible policies. It should be noted that obtaining informed consent should never be an impediment to patients receiving timely care, including after they have been stabilized following an emergent health care issue.**

Yet, the bill also defers to existing state law for scheduled care performed by *any* other type of out-of-network provider, including ancillary physicians, at in-network facilities. In the absence of any state laws, the bill also imposes federal caps on reimbursement stemming from care delivered to patients by out-of-network physicians. The draft legislation states that out-of-network physicians can only receive reimbursement equivalent to the greater of the median in-network amount negotiated (i.e. contracted rate) by the health plan (again, the bill is silent regarding what data is used to calculate the median rate) or a UCR. The legislation also defines UCR as 125 percent of the average allowed amount by private insurers for the service provided by a physician in the same or similar specialty practicing in the same geographical area available from a "statistically significant benchmarking database maintained by a nonprofit organization." The UCR could also be calculated from a state's all-payer claims database if administered by a nonprofit.

While the College supports beneficiaries being held financially harmless (i.e. paying in-network cost-sharing) for bills stemming from surprise gaps in insurance coverage, physicians need to be adequately compensated for the care they provide patients. As a result, ACR is concerned that the legislation automatically bans balance billing for both emergent and scheduled care, including in states that have not passed legislation addressing surprise gaps in insurance coverage. The College urges the revised Protecting Patients from Surprise Medical Bills Act to view states that have already passed legislation banning balance billing differently than states that have taken no action on this policy. **In states that ban balance billing, out-of-network physicians delivering scheduled care should have the option of pursuing either alternative dispute resolution (ADR), including but not limited to mediation or arbitration, with the patient's insurance carrier or some other form of UCR.** It's important to note that the NAIC's model legislation includes provisions related to ADR, specifically a Provider Mediation Process[3].

While sensitive to issues of federalism, ACR believes automatically deferring to existing state laws is a policy that is far too deferential to the business interests of the insurance industry and could present patients with issues surrounding access to care. **Some existing state laws banning balancing billing mandate that physicians treating**

[3] ADR provisions contained in NAIC's "Health Benefit Plan Network Access and Adequacy Model Act." Accessed via the web site at: https://www.naic.org/store/free/MDL-74.pdf

out-of-network patients receive reimbursement equivalent to a percentage of existing Medicare rates, which is insufficient to cover the associated costs of delivering the care. As a result, ACR strongly supports physicians having the option to pursue ADR or alternative types of UCR reimbursement.

The College actively opposes the use of the median in-network amounts *negotiated by insurers* or *average allowed amounts payable* by the health plans, as well as basing the UCR off a percentage of Medicare rates for the service in question. Mandating the use of discounted insurance rates or a percent of existing Medicare fees essentially eliminates any financial incentive for the insurer to negotiate meaningful reimbursement rates for all providers, especially ED or ancillary physicians (e.g. Radiologists), regardless of whether they choose to be in or out-of-network. We urge the bipartisan Senate health care price transparency working group to amend this provision to ensure physicians are not subjected to distorted market incentives.

With respect to alternative UCRs, the ACR supports out-of-network physicians receiving reimbursement *at least* equivalent to the 80th percentile of charges contained in the FAIR Health Database. Furthermore, the 80th percentile should represent a floor, not a ceiling, for reimbursement for services rendered by out-of-network physicians. The FAIR Health Database, an independent collection of more than 25 billion private health care and 20 billion Medicare claims, is typically regarded as the gold standard for analyzing and establishing UCRs for care delivered by out-of-network physicians. The 80th percentile is a more reasonable mathematical calculation and, therefore, translates into more meaningful reimbursement in comparison to 125 percent of the database described in the Protecting Patients from Surprise Medical Bills Act.

Once again, we appreciate the opportunity to provide detailed comments regarding this draft legislation and hope our comments lead to a more meaningful revised draft of the Protecting Patients from Surprise Medical Bills Act. We stand ready to work with you to craft a piece of legislation that assuages the concerns of patients and balances the needs of insurers and physicians. Should you have any questions, please do not hesitate to contact Cynthia Moran, Executive Vice President, Economics, Government Relations and Health Policy, American College of Radiology, either via phone (202-223-1670) or email (Cmoran@ACR.org).

Sincerely,

William T. Thorwarth, Jr., MD, FACR
Chief Executive Officer
American College of Radiology

cc: The Honorable Michael Bennet
The Honorable Chuck Grassley
The Honorable Todd Young
The Honorable Tom Carper
The Honorable Claire McCaskill