

May 28, 2019

Re: Request for Comment on the No Surprises Act

Dear Chairman Pallone and Ranking Member Walden:

Thank you for the opportunity to provide feedback on your recent surprise billing discussion draft. The proposal in your draft would be an improvement over the status quo that would likely reduce insurance premiums and federal deficits while protecting patients from surprise bills, although refinements to the proposal could increase its benefits. Our comments first address what we consider to be important strengths of the proposal, then turn to some concerns with the current draft and discuss how they could be ameliorated. Finally, we provide feedback on issues that are not directly addressed in the discussion draft but are important to consider.¹

Strengths of the Discussion Draft

The discussion draft would represent an important step forward that would meaningfully protect patients. As discussed below, we believe it addresses the market failure at the heart of surprise billing, appropriately uses notice and consent exceptions, and establishes a minimum insurer payment that would likely avoid increasing health care spending relative to the status quo.

Recognizes and Addresses the Market Failure

The major strength of this discussion draft is that it clearly recognizes and addresses the core market failure that leads to surprise out-of-network billing: provider types that patients do not choose have a lucrative opportunity (not available to other physicians) to remain out-of-network and still be guaranteed a flow of patients. This is not a problem of network adequacy or of inadequate physician payment rates, but rather a problem that arises from the incentives these types of providers face.² Therefore, any solution must close off the out-of-network billing option for providers that patients do not choose.

¹ Many of these comments are adapted from a recent Health Affairs blog coauthored by several scholars affiliated with the USC-Brookings Schaeffer Initiative for Health Policy. See Adler, Loren, Paul B. Ginsburg, Mark Hall, and Erin Trish. May 2019. “Analyzing the House E&C Committee’s Bipartisan Surprise Out-Of-Network Billing Proposal.” *Health Affairs Blog*. <https://www.healthaffairs.org/do/10.1377/hblog20190514.695693/full/>.

² For further discussion of why network adequacy is not the correct framework to address surprise billing, see Young, Christen Linke, Loren Adler, Paul B. Ginsburg, Mark Hall. May 2019. “The Relationship Between Network

The discussion draft does this clearly and unequivocally by prohibiting out-of-network providers that patients do not choose from balance billing (although, by setting a minimum insurer payment that reflects current inflated rates, it would not return payment rates to the level that would prevail without the market failure). It takes the further appropriate step of requiring insurance plans to treat these amounts as in-network for patient cost-sharing, thereby fully insulating patients from any extra costs when they are treated by an out-of-network provider they did not choose.

Limits Notice and Consent Exceptions Appropriately

Another important feature of this draft is that it creates an appropriately narrow role for any notice and consent exceptions that would allow providers to charge insurers and consumers out-of-network amounts higher than the bill's limit. As your draft recognizes, there is no need for an exception for ancillary and similar clinicians—since patients do not choose these providers and therefore cannot give meaningful consent. For other specialties, allowing for a notice and consent exception is a reasonable approach. This tailored approach would serve patients well.

Directly Establishes a Minimum Insurer Payment that Avoids Increasing Health Care Spending

We commend the committee for directly establishing a minimum insurer payment that would likely avoid increasing health care spending. We believe establishing this minimum payment directly, rather than relying on arbitration, is the best approach: it is transparent, limits administrative costs, and ensures a predictable system for all market participants.

Further, we believe that basing that minimum payment on insurers' median in-network rates, as the legislation proposes do, would not increase health care spending relative to the status quo (at least if certain technical shortcomings in how the legislation proposes to compute that payment standard, discussed further below, are addressed). In contrast, some state laws set a minimum payment derived from physician charges, which are not market determined and face very few constraints, which likely would increase health care spending relative to the status quo.

In addition, using median (rather than mean) contracted rates is wise. Median contracted rates for these clinicians are typically lower than the mean (due to a minority of physician groups garnering especially high rates). For example, in one study of commercial claims data, mean reimbursement for the highest-level emergency physician service was 306 percent of Medicare's payment for the same service, whereas median reimbursement was 257 percent of the Medicare rate.³ Therefore, because we expect the payment standard to effectively place a ceiling on in-network payment rates, relying on median rates should actually reduce health care spending compared to the status quo.

Concerns with the Discussion Draft

Although the discussion draft would be a step forward, there are important areas in which the draft could be improved. First, we believe that the minimum insurer payment established under the draft

Adequacy and Surprise Billing.” *The Brookings Institution*. <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/05/10/the-relationship-between-network-adequacy-and-surprise-billing/>.

³ Trish, Erin, Paul Ginsburg, Laura Gascue, and Jeffrey Joyce. 2017. “Physician Reimbursement in Medicare Advantage Compared with Traditional Medicare and Commercial Health Insurance.” *JAMA Internal Medicine*. 2017;177(9):1287-1295. <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2643349>.

is too high and locks in a substantial fraction of today's unnecessary spending. Second, we have concerns that calculating the median in-network rate used to determine the minimum payment using issuer-specific data that would be updated over time would create opportunities for gaming that could lead to unpredictable and unintended results, while potentially also creating an unlevel playing field across insurance plans. Finally, we believe the draft could be improved by expanding its protections to encompass a slightly broader set of clinicians and services.

Minimum Payment Would Partially Lock in Today's Excessive Payment Rates

Today, emergency physicians and ancillary clinicians benefit from the ability to bill patients out-of-network not only when they actually collect high out-of-network bills, but also because they can use the threat of surprise billing to obtain greater *in-network* payment rates. Basing the out-of-network payment standard on today's in-network rates will lock in these unnecessarily high prices. Emergency physicians and anesthesiologists appear to obtain in-network payment rates more than 3 times what Medicare pays for the same services.^{4,5} This contrasts starkly with payment rates for non-emergency and ancillary specialists: one study found that employer-sponsored insurance payments for office visits provided by specialists averaged about 117 percent of Medicare;⁶ and a Medicare Payment Advisory Commission (MedPAC) analysis of commercial PPO claims from one large national insurer found that contracted payment rates nationwide for all physicians averaged 128 percent of Medicare rates.⁷

To fully ameliorate the consequences of the current market failure, the minimum insurer payment should reflect the normal market rate that would be negotiated in the absence of the ability to surprise bill patients. One way to achieve that goal would be to set a minimum payment equal to the same multiple of Medicare payment rates that other specialists in the same geographic region receive in their contracts with insurers. Patients do choose these other specialists, so payment rates in these specialties are likely to more closely resemble normal market rates. For instance, if specialists other than emergency and ancillary physicians in a geographic area were paid, on average, 130 percent of the relevant Medicare rate, then the minimum insurer payment to emergency and ancillary physicians would be 130 percent of the Medicare rate for their services.

We note that setting the minimum payment too high misses an opportunity to reduce health care spending and, thereby, reduce patients' premiums and out-of-pocket costs. On the other hand, there is little risk in setting the payment standard too low. If the rate is set too low, facilities will ensure adequate staffing in these specialties by either demanding insurers pay in-network rates that exceed

⁴ Ibid.

⁵ Stead, Stanley W., Sharon K. Merrick. 2018. "ASA Survey Results for Commercial Fees Paid for Anesthesia Services— 2018." *ASA Monitor* 10 2018, Vol. 82, 72-79.
<http://monitor.pubs.asahq.org/article.aspx?articleid=2705479>.

⁶ Biener, Adam I., Thomas M. Selden. 2017. "Public and Private Payments for Physician Office Visits." *Health Affairs*. Vol 36 No. 12. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0749>.

⁷ MedPAC. March 2017. "Report to the Congress: Medicare Payment Policy."
http://medpac.gov/docs/defaultsource/reports/mar17_entirereport.pdf.

the payment standard or, alternatively, by directly supplementing these specialists' compensation and negotiating higher facility payment rates to fund this supplemental compensation.

Method for Calculating Median Contracted Rates Could Have Unintended Consequences

The discussion draft sets the minimum insurer payment by directing each insurer to calculate a median contracted rate separately for each plan offering in a geographic area. It appears to assume that those rates would be updated over time. This approach could create two unintended consequences.

First, this approach would create incentives for insurers to terminate contracts with physicians who they are currently paying more than the median and create incentives for physicians to terminate contracts with insurers who are currently paying them less than the median. These types of strategic contract terminations could cause the median contracted rate to evolve in unpredictable and unintended ways. Contract terminations could also be disruptive for patients and providers (although the bill's patient protections would mitigate many of the consequences for patients). These problematic incentives could be avoided by calculating the median contracted rate using data from a period before the legislation took effect and then trending that rate forward for future years. For example, an insurer could be directed to calculate the ratio of its median rate to the Medicare rate for each set of services in a prior year and apply that same ratio to the Medicare rate to compute the minimum payment in future years.

Second, using insurer-specific rates could lock in an unlevel playing field across insurers. Some insurers are paying high rates today, perhaps because they placed a particularly high value on limiting how often their enrollees were balance billed, while other are paying lower rates. Basing payment rates in this legislation on those issuer-specific rates could lock in these differences across insurers, potentially putting some insurers at a competitive disadvantage going forward. This problem could be addressed by establishing a common payment standard for all services delivered in a given geographic area or nationally. Suitable payment rates could be calculated by the Secretary using data from existing commercial claims databases; alternatively, insurance plans meeting certain size criteria could be compelled to provide the Secretary with de-identified summary information on their payment rates.

Protections Do Not Encompass Some Cases Where Surprise Billing Occurs

We believe the draft could be improved by slightly expanding the types of providers to which it applies. It would be useful to include certified nurse anesthetists (CRNAs) in the list of "facility-based providers," as they appear to also be a common source of surprise out-of-network bills (per forthcoming research of ours). Laboratory services referred by an in-network provider also warrant protection under the bill. In addition, while the draft clearly protects consumers receiving emergency services, there may remain a risk of patients receiving surprise bills for post-stabilization services performed at an out-of-network facility. One way of ameliorating this concern is to extend protections from surprise out-of-network facility bills to 24 hours after stabilization from an emergency and require that the facility offer transfer to an in-network facility for continued care.

Other Issues

Finally, we wish to briefly discuss several additional issues that you may wish to consider as you continue to pursue legislation in this area.

Ambulances

Ambulances, both ground and air, represent a significant source of surprise out-of-network bills.^{8,9} Ambulance services should be treated similarly to emergency services at out-of-network facilities, as they face similar market dynamics. Addressing air ambulances is particularly critical because states are unable to regulate their practices, and there is no way for a functioning market to develop on its own. Ground ambulances, at least, are often regulated by local governments. However, this is insufficient to fully address the problems in this market, and a federal solution would be appropriate.

Preemption of State Laws

Given that certain existing state laws have gaps in their protections and may lead to higher premiums and out-of-pocket costs than the federal approach, state preemption provisions should be crafted carefully. One option to address this risk while still allowing for state flexibility would be to rely on the approach already built into the Public Health Service Act—to continue enforce state laws that are at least as protective to consumers as federal standard. The federal legislation could then include language clarifying that to be considered at least as protective, state protections must not increase premiums or include a payment standard tied to amounts greater than those established in federal law.

There is also a narrower question to be resolved regarding how preemption would function for state laws that have a method for determining out-of-network payment but exempt surprise bills below a certain dollar amount, such as in New York or Arizona. A federal law should at least serve as the default for the surprise bills currently not protected against by such state laws. Similarly, certain state surprise billing laws only apply to specific physician specialties, and it should be clarified that the federal default would then apply to other specialties providing out-of-network services for enrollees in state-regulated, fully insured plans.

Other Approaches to Addressing Surprise Billing at In-Network Facilities

Finally, there have been a number of other recent proposals related to surprise out-of-network billing, which address the market failure in different ways. While the Committee's proposal would be an improvement over the status quo, we note that these alternative approaches have important advantages, at least with respect to addressing surprise billing by emergency and ancillary clinicians at in-network facilities.

⁸ Garmon, Christopher, Benjamin Chartock. 2017. "One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills." *Health Affairs*. Vol 36. No. 1. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0970>.

⁹ U.S. Government Accountability Office (GAO). March 2019. "Air Ambulance: Available Data Show Privately-Insured Patients are at Financial Risk." Report to Congressional Committees. GAO 19-282. <https://www.gao.gov/assets/700/697684.pdf>.

Most importantly, unless the Committee revises its proposal to specify a lower payment standard, these alternative approaches would likely drive overall payments to these clinicians closer to the normal market rate for these services. As a result, these approaches would likely lead to lower health care spending than the discussion draft, which would translate into lower premiums and out-of-pocket costs for enrollees and lower deficits for the federal government.

Both of these alternative approaches are a version of what we term “contracting regulation.”¹⁰ There are at least two forms of this regulation that would eliminate the current market failure that allows surprise out-of-network billing and create a platform that would allow market dynamics to determine payment rates in these specialties. These two approaches are as follows:

1. **Network Matching.** The so-called “network matching” approach, which was proposed as an option in the recent Senate Health, Education, Labor, and Pensions (HELP) Committee discussion draft, would require emergency, ancillary, and similar clinicians to contract with all the same health plans that the facility at which they practice accepts. In a blog post for *Health Affairs*, two of us, along with Benedic Ippolito, an economist at the American Enterprise Institute, explain in detail how this approach would function and why it would achieve the goal of generating market prices for emergency and ancillary services.¹¹
2. **“Bundling.”** This approach would prohibit emergency, ancillary, and similar clinicians from separately billing either health plans or patients for their services. Instead, they would seek compensation from the facility at which they practice, which would then build that cost into the rates they negotiate with health plans. The fact that facility and these clinician services would be paid for together is why this approach is often referred to as “bundling.” This payment structure is analogous to how nurses’ services are paid for today.

This approach would entirely eliminate surprise billing by emergency or ancillary physicians at in-network facilities because those physicians would no longer be allowed to bill separately for their services in these cases. The market negotiation between facility and facility-based physician would then determine payment, without the need for price setting or arbitration. We have written extensively about this proposal,¹² and it has also been recommended by Zack Cooper, Fiona Scott Morton, and Nathan Shekita at Yale University,¹³ Benedic Ippolito at AEI, and David Hyman at CATO.¹⁴

¹⁰ Adler, Loren, et al. February 2019. “State Approaches to Mitigating Surprise Out-of-Network Billing.” *The Brookings Institution*. <https://www.brookings.edu/research/state-approaches-to-mitigating-surprise-out-of-network-billing/>.

¹¹ Adler, Loren, Matthew Fiedler, Benedic Ippolito. May 2019. “Network Matching: An Attractive Solution to Surprise Billing.” *Health Affairs Blog*. <https://www.healthaffairs.org/doi/10.1377/hblog20190523.737937/full/>

¹² Adler et al., Feb 2019.

¹³ Cooper, Zack, Fiona Scott Morton, Nathan Shekita. January 2019. “Surprise! Out-of-Network Billing for Emergency Care in the United States.” *National Bureau of Economic Research (NBER)*. <https://www.nber.org/papers/w23623>.

¹⁴ Ippolito, Benedic N., David A. Hyman. March 2019. “Solving Surprise Medical Billing.” *American Enterprise Institute (AEI)*. <https://www.aei.org/wp-content/uploads/2019/03/Solving-Surprise-Medical-Billing.pdf>.

Thank you very much for the invitation to comment on the discussion draft. Of course, if we can provide any additional information, we would be happy to do so.

Sincerely,

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