



Surprise Billing August Recess Action Kit

Take Action

- **Plan a lab tour.** Invite your representative to tour your laboratory as it is the single, most effective way to demonstrate the real-world value of pathology. Legislators also appreciate being able to meet with the many other laboratory employees who live and work in the district. [Learn how to conduct a laboratory tour](#) and a lab tour request template can be found [here](#).
- **Attend a town hall.** Members of Congress conduct numerous town halls during August as way to hear from directly from their constituents. By showing up and conveying the potential consequences of the surprise medical billing legislation in public forum, you can have a major impact on your representative's viewpoint. You can find local town halls by visiting the Town Hall Project at www.townhallproject.com.
- **Request a district meeting.** Don't have time for a laboratory tour or can't make a town hall? Contact your member of Congress for an in-person meeting by calling their local office. If they can't make it, it is likely one of their staffers, who has significant influence over their boss's opinions, can meet. You can request a meeting [here](#).
- **Send emails and contact your member via social media.** You can always send an email your legislator on surprise billing using [CAP's grassroots advocacy system](#). You can even tweet at them using the system.
- **Attend a Fundraiser.** Members of Congress are gearing up for their reelection and many of them have low-cost fundraisers in their home districts during August. Frequently, the information is posted on their Facebook pages or campaign websites. You can even contact them via their campaign sites to find out more information.

Talking Points

- Check to see if your representative is a cosponsor of [H.R. 3502](#). If they are not, the following are key talking points for your representative:
 - Please cosponsor H.R. 3502, Protecting People from Surprise medical Bills Act, which was introduced by Rep. Raul Ruiz and Rep. Phil Roe.
 - The solutions in Protecting People from Surprise Medical Bills Act would accomplish the goal of holding patients financially harmless from surprise medical bills while creating a fair independent arbitration system that keeps patients out of the middle of out-of-network billing disputes.
 - Although the root cause of surprise bills has been insufficient health insurance plan networks, the inclusion of a baseball-style arbitration process would allow physicians and insurers to come together and settle a bill through the consideration of a range of factors reflecting the market value of physician services. I appreciate that the proposal avoids the use of one rate that could be wholly controlled by insurers.
 - The ideas outlined in this legislation represent a commonsense approach that ensures the financial viability of the health care delivery system and preserves patient access to their physicians.
 - I fully support the patient protections in this bill and encourage you to cosponsor this legislation.
- If your representative is a cosponsor, simply thank them for taking action to adequately protect patients from surprise medical bills.
- Talking points for all senators include:
 - As a pathologist and constituent, I am extremely concerned with several provisions in Title 1 of the Lower Health Care Costs Act of 2019, and oppose this legislation as introduced.



- It has always been my position that patients should not be financially penalized for the failure of health insurance plans to establish adequate in-network access to hospital-based physician specialties and we have been continuously engaged with Congress on this issue.
- However, I strongly oppose key pieces of the legislation the Senate HELP Committee introduced, as these provisions contain an inequitable benchmark that would enrich health plans.
- In addition, I am disappointed with the exclusion on an arbitration provision to settle disputes. The legislation as drafted will undermine the economic viability of health care delivery and cause significant harm to my ability to adequately treat my patients in our state, especially in rural areas.
- Since Congress started discussions on rectifying this issue last year, the physician community has forcefully and consistently conveyed that using any payment benchmark tied solely to the median in-network rates is untenable and unacceptable.
- We cannot accept a payment formula that is unilaterally controlled by insurance companies, who have somehow become absolved from paying for the care they promised to patients.
- The documents included in the action kit will provide further information on the current status of the surprise medical billing legislation if needed.

Feedback

Let us know what you're hearing! Please fill out the [feedback form](#) on your activities.

Surprise Billing Current Status

Progress with the House Energy and Commerce Committee

The Energy and Commerce Committee marked up the No Surprises Act with amendments on July 17. An amendment by Rep. Raul Ruiz, MD (D-CA) and Rep. Larry Bucshon, MD (R-IN) added an independent dispute resolution, or appeals, process to the bill. The inclusion of an independent dispute resolution process is a necessary step to stop insurers from controlling patient access to medical services.

Other amendments adopted by the committee would require studies to assess the impact of the legislation on access to providers, network adequacy, premiums, and patient out-of-pocket costs. In addition, an amendment to the bill requires an audit of at least 25 health plans to assure that in-network median rates are being properly calculated. The CAP strongly supported the inclusion of these amendments.

While the CAP is still opposed to the bill and has several concerns—such as the high, arbitrary threshold of \$1,250 that would exclude most pathology services from the appeals process and a reliance on median in-network rates to reimburse out-of-network services—the Energy and Commerce markup of the No Surprises Act represented progress. The CAP will be engaged as this bill moves to two other committees, the House Education & Labor Committee and the House Ways & Means Committee, where additional changes to the legislation may be considered.

CAP Opposition to S. 1895

The main surprise medical billing legislation in the Senate is S. 1895, introduced by the Health, Education, Labor, & Pensions Committee Chairman Lamar Alexander (R-TN) and Sen. Patty Murray (D-WA). The CAP is extremely concerned with several provisions in Title 1 in S. 1895, Lower Health Care Costs Act of 2019, which is designed to address surprise billing. The CAP opposes this legislation as introduced. It has always been the CAP's position that patients should not be financially penalized for the



failure of health insurance plans to establish adequate in-network access to hospital-based physician specialties and we have been continuously engaged with Congress on this issue. However, we strongly oppose sections of the legislation the Senate HELP Committee has introduced, as these provisions contain an inequitable benchmark that would enrich health plans. The CAP is disappointed with the exclusion on an arbitration provision to settle disputes. The legislation as drafted will undermine the economic viability of health care delivery and cause significant harm to the pathologists' ability to serve patients, especially in rural areas. We need all CAP members to urge their senators to oppose S. 1895 unless amended to remove any benchmark payment that pegs to median in-network rates, and replace it with a payment system that balances insurer and physician rates.



To: CAP Members

Subject: Hosting a Laboratory Tour

A laboratory tour is the single best way to advocate for pathology and one of the most effective ways to help you develop a relationship with your Member of Congress. These tours help put a face on the profession and demonstrate pathology's crucial role in the delivery of quality health care. Many of the CAP's strongest allies on Capitol Hill first became acquainted with their local pathologists and the issues affecting their practice during a lab tour.

Tour Preparation

- Send an invitation on your facility's letterhead using the template provided (see page 5) and email or fax to the legislator's scheduler. Contact PathNET@cap.org for scheduler's contact information.
- Invite your facility's top staff to participate in the tour, but avoid having too large a group.
- Map out a route. Plan ahead to select particular areas that illustrate the points you want to make. Demonstrate the process involved in various tests. Create a schedule that allows time for breaks, discussion, and delays.
- If desired, CAP staff will work with the legislator's and your facility's press offices to arrange for local media coverage during the tour.
- Rehearse the day before and have your colleagues ask possible questions. CAP Advocacy staff are also happy to speak with you about legislative issues, send you issue briefs or other policy materials, and provide other assistance.
- Make sure the legislator's office has the laboratory's address and any necessary instructions regarding parking, which entrance to use, etc.
- Provide the legislator's office with a contact name and phone number in case of last minute schedule changes.
- Designate one of the laboratory staff to take photos during the tour.

Conducting the Tour

- Be at the entrance to greet the legislator and staff when they arrive and escort them to the lab.
- Give a brief overview of the planned tour and a general description of your laboratory.
- During the tour, discuss the facility with your legislator, using simple terms and descriptions.
- Introduce employees by name as they are encountered along the tour. The employees are constituents.
- Stay on schedule. Be aware of the time the legislator has available.



After the Tour

- Send a thank you letter to your legislator using the template provided (see page 6). Include the names of any key aides who accompanied the legislator on the tour. Re-emphasize points made during the visit and answer any questions left unanswered during the tour.
- Provide CAP staff with a summary of the visit and photos, so that your successful tour may be featured in STATLINE and/or on the CAP's social media.
- Follow up with the legislator's office and continue to maintain contact. Position yourself to become a resource on pathology for the legislator and staff.

Sample Lab Tour Agenda

All times are approximate. Sample agenda items may be amended where appropriate.

8:00 AM: **Congressman Arrives at the Laboratory**

8:00 AM to 8:05 AM: **Greetings and Introductions**

- Greet the Congressman, introduce him to pathologists and laboratory personnel, and provide him with a brief overview of the facility (i.e. what services are performed here, the role of a pathologist, how many counties and patients it serves). Paint a picture for the Congressman about the importance of your facility, as well as the services you provide to the community.
- If possible, provide him with a lab coat for the duration of the tour.
- Deliver any relevant policy materials.

8:05 AM to 8:35 AM: **Slide Preparation**

- Walk the Congressman through a slide preparation.
- Allow the Congressman the opportunity to view a slide through a multi-headed microscope.
- Use clear, concise terms so that the Congressman understands. Remember, the elected official usually has little knowledge of pathology issues, so it's important to help him understand the process.
- Demonstrate any key technology specific to your laboratory.
- Photos should be taken throughout the demonstration.
- If time permits, walk the Congressman through the differences between "clear" and "unclear" diagnoses. In other words, feel free to show the Representative the debate that ensues when trying to diagnose difficult slides.

8:35 AM to 8:45 AM: **Hospital Tour**

- Highlight key aspects of the facility
- Introduce the Congressman to the hospital administrator.
- Focus on parts of the hospital that are closely related to pathology.



- ***Remember - the majority of the tour should be conducted in the lab to keep the focus on pathology.***

8:45 AM to 9:00 AM:

Question and Answer Session

- Upon conclusion of the tour, the Congressman may prefer to make some brief remarks or solicit some questions from the participants or laboratory employees.
- If the tour incorporates a question and answer session or additional remarks, be sure to incorporate this time into your tour. Be sure to clear any questions for the Congressman with CAP and Congressional staff before the tour.

9:00 AM:

Congressman Departs

- Exchange business cards with the Congressman and key staffers.
- Offer to provide any additional assistance to the Representative or staff on future pathology or health care issues.

SAMPLE LAB TOUR INVITE LETTER FOR MEMBERS OF CONGRESS
(Letter should be placed on your facility's letterhead. Please email a PDF copy to
PathNET@cap.org)

Date

The Honorable [Member's Name]
U.S. House of Representatives OR United States Senate
Washington, DC 20515 (House Zip) OR 20510 (Senate Zip)

Fax:

Attn: [Scheduler's Name]

Dear Representative/Senator [Name]:

On behalf of [insert your lab], its pathologists, and its laboratory professionals, I would like to cordially invite you to tour our laboratory in _____. This laboratory tour will provide me, as well as many of my colleagues that live and work in your Congressional district, the opportunity to acquaint you with the role of anatomic and clinical pathology in the delivery of healthcare.

[Here you can place text that is pertinent to your lab]

[Insert your lab] plays an important role in our community by delivering quality healthcare to thousands of your constituents. I would like to demonstrate some of the diagnostic tests performed in the lab and discuss what I see as the role of pathologists in today's medicine. This educational and entertaining tour will last approximately one hour.

I would appreciate your staff contacting me either by phone, [insert number] or email, [insert email] to discuss the preferred date and time for the tour.

Sincerely,

Your Name
Your Lab



**SAMPLE LAB TOUR THANK YOU LETTER FOR MEMBERS OF CONGRESS
AFTER THE TOUR**

**(Letter should be placed on your facility's letterhead. Please email a PDF copy to
PathNET@cap.org)**

Date

The Honorable [Member's Name]

U.S. House of Representatives OR United States Senate

Washington, DC 20515 (House Zip) OR 20510 (Senate Zip)

Fax:

Attn: [Scheduler's Name]

Dear Representative/Senator [Name]:

Thank you for touring the pathology laboratory at [insert your lab] in _____. I appreciate you taking time out of your busy schedule to visit this facility and learn more about specific legislation that affects pathology. I sincerely hope that the tour was both educational and entertaining!

I thoroughly enjoyed showing you the inner workings of a pathology laboratory and analyzing different specimen slides. In particular, I hope that our discussion regarding the important role pathologists play in the delivery of health care was informative and useful as you and your colleagues work with various regulatory agencies to improve health care in America.

[Please feel free to add any specifics that were discussed during the tour.]

Once again, thank you for touring the pathology laboratory at [insert your lab] and please do not hesitate to contact me either by phone, [insert number], or email, [insert email], with any questions or comments pertaining to pathology or health care policy in general. I look forward to working with you in the future.

Sincerely,

Your Name

Your Lab



**SAMPLE LAB TOUR INVITE LETTER FOR MEMBERS OF CONGRESS (Letter
should be placed on your facility's letterhead. Please email a PDF copy to
PathNET@cap.org)**

Date

The Honorable **[Member's Name]**
U.S. House of Representatives OR United States Senate
Washington, DC 20515 (House Zip) OR 20510 (Senate Zip)

Attn: **[Scheduler's Name]**

Dear Representative/Senator **[Name]**:

On behalf of **[Name of Lab]**, its pathologists, and its laboratory professionals, I would like to cordially invite you to tour our laboratory in **[city location]**. This laboratory tour will provide me, as well as many of my colleagues that live and work in your district, the opportunity to acquaint you with the role of anatomic and clinical pathology in the delivery of healthcare.

[Here you can place text that is pertinent to your lab]

[Name of Lab] plays an important role in our community by delivering quality healthcare to thousands of your constituents. I would like to demonstrate some of the diagnostic tests performed in the lab and discuss what I see as the role of pathologists in today's medicine. This educational and entertaining tour will last approximately one hour.

I would appreciate your staff contacting me either by phone at **[insert number]** or email, **[insert email]** to discuss the preferred date and time for the tour.

Sincerely,

Your Name
[Name of Lab]



COLLEGE of AMERICAN PATHOLOGISTS

July 11, 2019

The Honorable Frank Pallone, Jr.
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Greg Walden
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
2322 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pallone and Ranking Member Walden:

With the scheduled markup of the No Surprises Act, it is clear the committee is moving forward to address the issue of surprise out-of-network medical bills. The College of American Pathologists (CAP) has been constructively and actively engaged on this issue because we are committed to working together to protect patients and ensure continued access to high-quality health care. It has always been our strong stance that patients should not be financially penalized for the failure of health insurance plans to establish adequate in-network access to hospital-based physician specialties. However, the No Surprises Act fails to properly address the issue. Instead, this legislation pushes forward with a benchmark payment that can be unilaterally manipulated by insurers, which will only serve to further enrich health insurers and create a clear economic incentive for health plans to continue narrowing their physician networks.

The CAP continues to believe that to protect patients from narrow insurer networks and gaps in coverage, insurers and providers should settle all payments without the patient's involvement, including through the use of an optional baseball-style, independent dispute resolution process. Network adequacy standards for health plans should be set, so that at a minimum, an appropriate number of specialty physicians are available to provide medically necessary services at "in-network" facilities. Additionally, as is emphasized above, it is critically important that out-of-network payment mechanisms not deter, displace, or discourage equitable health plan contracting for physician services.

For these reasons, we urge you to consider needed improvements to your draft legislation. Specifically, the CAP supports reimbursement for out-of-network services that does not result in market manipulation, inclusion of an arbitration system to resolve payment disputes, and network adequacy standards.

CAP opposition to use of in-network payment rates

To encourage health plans to contract for physician services and to avoid undermining the economic viability of health care delivery, a fair market rate should be paid for physician services. Unfortunately, the No Surprises Act establishes a minimum payment standard set at the median contracted in-network rate. The CAP has consistently argued that 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 independent database (such as FAIR Health Inc. or a state's All Payor Claims Database).

Benchmarking out-of-network payments to the median in-network rate will result in payor manipulation of network rates and eliminate the need for insurers to negotiate contracts in good faith. Insurers will undoubtedly have an incentive to lower rates as far as they can and have the unilateral ability to do so, leaving physicians with little leverage to negotiate tenable reimbursement. As we expand on below, the vast majority of providers, including pathologists, wish to contract with health plans. Out-of-network pathologists frequently settle or forgive payments with patients rather than undertaking administrative and emotional costs of collection. However, health plans have deliberately and systematically denied network participation to, or ejected pathologists and clinical laboratories from network participation. Setting the benchmark at the median in-network rate will exasperate this problem and leave physicians with no power to fight it.

Support for fair, transparent commercial benchmarking and arbitration process

The CAP has urged legislators to create a system whereby insurers and providers can come to agreement independent of the patient, who should only pay for care at an in-network rate. We are extremely concerned that after meetings, comments, feedback, and stakeholder input, the No Surprises Act still lacks an independent dispute resolution (IDR) process. This can help address payment disputes when set up appropriately. If there is a disagreement over payment between an insurer and provider, an independent arbitrator can step in and consider several factors pertaining to the case. An arbitrator should be able to consider things like complexity and duration, but also other factors that either the insurer or provider may submit. Parameters that include geographically-based charges by providers and payments from insurers should be used to determine the fair market value of the physician service. It is imperative that a benchmarking rate based on in-network rates not be a factor in determining a starting point or an outcome for any arbitrator, as this would immediately bias the process and defeat the goal of IDR.

For example, the law enacted by New York State, which we believe is the optimal approach to protect patients from surprise medical billing, includes mediation/arbitration between insurers and providers. The payment methodology upon which the "usual and customary rate" (UCR) is calculated is based upon the 80th percentile of FAIR health database charges to reflect the market value of physician services. And it is clear this approach is working. Researchers at Georgetown University recently determined that "insurer, provider, and consumer stakeholders generally agree that the implementation of New York's Surprise Billing law went smoothly, was relatively fair to all parties, and is working as intended to protect consumers from a significant source of financial hardship."¹ The Georgetown study also notes that state officials have reported a dramatic decline in consumer complaints about balance billing and physicians are

¹ <https://georgetown.app.box.com/s/6onkj1jaiy3f1618iy7j0gpzdoew2zu9>



COLLEGE of AMERICAN PATHOLOGISTS

largely satisfied with the process and its results. Finally, concerns about inflated charges are thus far proven unfounded, as one study found a 13 percent average reduction in physician payments since the law was enacted in New York.

For these reasons, we are confounded at the fact that any IDR proposal counts against the budget. The process is cheap, it is expedient, and it pushes physicians and insurers to settle payment disputes fairly. It's also proven to work – even when charges are used for the calculation of rates, physician payments have decreased, and patients are protected. It is imperative that there be a system set up to address payment disputes, or insurers will continue to consolidate their ability to control rates and pricing in the market.

Support for hospital-based physician network adequacy standards

The CAP strongly believes inadequate networks are the root cause of surprise bills. Unfortunately, the No Surprises Act does nothing to address the issue. Without adequate networks of contracted physicians, a patient cannot be properly guarded from out of network health care at an in-network facility. If there are fewer out of network providers to begin with, there will be fewer patients receiving their bills.

It is important to recognize that the vast majority of providers, including pathologists, wish to contract with health plans. Health plans have deliberately and systematically denied network participation to, or ejected pathologists and clinical laboratories from network participation, and states are starting to take notice. In December of 2017, the Washington State insurance commissioner fined a health insurer \$1.5 million and detailed steps it must take to fix its provider networks. Most recently, in Texas, the Center for Public Policy Priorities reported in 2014 that one health plan in the state had no pathologist providers at 20 percent of their in-network hospitals. Then, in October 2018, this health plan was fined \$700,000 by the Texas Department of Insurance for failure to contract with a hospital-based physician specialty in multiple counties.

The CAP supports federal enactment of network adequacy requirements similar to the law of Louisiana (Network Adequacy Act 22§1019.1 et seq.) that expressly require health insurance plans to “maintain a network of providers that includes but is not limited to providers that specialize in mental health and substance abuse services, facility-based physicians, and providers that are essential community providers.” Facility-based physicians are defined in the Louisiana Act to include: “anesthesiologist, hospitalist, intensivist, neonatologist, pathologist, radiologist, emergency room physician, or other on-call physician, who is required by the base health care facility to provide covered health care.” Such requirements should be subject to regulatory oversight and enforcement to ensure that patients have reasonable and timely access to in-network physician specialists at in-network hospitals and facilities. California (Code of Regulations (CCR) Title 10, Section 2240.5 (d) (14)) and New Hampshire (RSA 420.J:7 II(e)) are two other states with specific hospital-based physician network adequacy requirements. However, at present, the vast majority of states have no such hospital-



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based physician network adequacy requirement and thus should be compelled under federal law to adopt such requirements.

The CAP is appreciative of the inclusion of a report from the Department of Labor on network adequacy, and we look forward to seeing the report and how Congress will incorporate its recommendations.

Summary

As the world's largest organization of board-certified pathologists and leading provider of laboratory accreditation and proficiency testing programs, the CAP serves patients, pathologists, and the public by fostering and advocating excellence in the practice of pathology and laboratory medicine worldwide. As you mark up the No Surprises Act, it is of paramount importance to strike a compromise that holds patients harmless but also allows providers and insurers to come to agreement on outstanding bills. We urge you to consider revisions that would better support fair reimbursement for out-of-network services, include an arbitration system to resolve payment disputes, and add hospital-based physician network adequacy standards.

Thank you for your consideration of this important issue and we look forward to working with you to come up with the best solution for ensuring patients have in-network access to physician services or are otherwise protected from out-of-network charges that result from health plan inadequacies. If you would like to meet, or have any questions, please contact Michael Hurlbut, Assistant Director, Legislation and Political Action, at mhurlbu@cap.org or 202-354-7112.

The College of American Pathologists

June 25, 2019

The Honorable Lamar Alexander
Chairman
Committee on Health, Education,
Labor and Pensions
U.S. Senate
428 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Patty Murray
Ranking Member
Committee on Health, Education,
Labor and Pensions
U.S. Senate
428 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Alexander and Ranking Member Murray:

As organizations representing over 148,000 physicians, we oppose the Lower Health Care Costs Act of 2019 (S. 1895) as introduced. The physician community has been constructively engaged with Congress on addressing the issue of surprise medical billing, with a united goal of ensuring that patients are left out of the middle. It has always been our position that patients should not be financially penalized for the failure of health insurance plans to establish adequate in-network access to physician specialties. However, we strongly oppose key pieces of the legislation you introduced, as these provisions contain an inequitable benchmark that would enrich health plans. In addition, we are disappointed with the exclusion of an arbitration provision to settle disputes fairly. S. 1895 will undermine the economic viability of health care delivery and cause significant harm to physicians and hospitals in rural areas. The long-term unintended consequences of using a federally set benchmark payment rate will have a striking impact on the U.S. health care system as we know it today. Furthermore, according to a recently released legal analysis, it is highly questionable as to whether your legislation is constitutional.

Since Congress started discussions on rectifying this issue last year, our groups have forcefully and consistently conveyed that using any payment benchmark tied to the median in-network rate is untenable and unacceptable. We will not accept a payment formula that is unilaterally controlled by insurance companies, who have somehow become absolved from paying for the care they promised to patients. As providers of health care, small businesses, and integral parts of the health care delivery system, it is essential that physicians can contract in good faith, without the federal government concentrating decisive negotiating power in the hands of one party. Using federally set benchmarked payment tied to the median in-network rate for out-of-network physicians will impact contract negotiations for all physicians.

Providing disproportionate power to the insurance companies in contract negotiations could increase consolidation within healthcare. Physicians, having no leverage within the negotiation, will have to accept the in-network rate, or they will be driven out-of-network and then paid at the median contracted rate — which over time will become lower and lower. This will continue to disincentivize physicians from practicing independently, further driving physicians to become employed.

Your failure to include an arbitration provision is another major shortfall of the legislation. We have pointed to the success of the New York model and the lack of premium increases or abuse of the arbitration process. At the June 18 HELP Committee hearing, you heard from Marilyn Bartlett, the witness from Montana, who clearly stated that they have had an arbitration process in the state since 2017, but no one has had to use it.

We have offered alternatives that would not only take the patient out of the middle but allow any differences to be quickly and inexpensively arbitrated between insurers and physicians. We have even given a road map for policies that would severely reduce surprise bills by ensuring physician networks have adequate representation of medical professionals. Time and time again, our suggestions have been ignored.

For 20 years, Congress fought against the sustainable growth rate formula in the Physician Fee Schedule, warding off drastic cuts to physician payments to help ensure the best physician workforce was available for the American people. We wonder today why that concern is suddenly gone, and Congress feels insurers should not have to negotiate fairly with doctors across the country.

We urge you to remove any federally set benchmark payment rate tied to the median in-network rate. We encourage you to adopt legislation that will bring insurers, physicians and hospitals to the table on equal footing so they can negotiate payment rates that ensure access to care for patients. We hope that you will consider the long-term consequences contained in S. 1895 and work with all stakeholders to fairly resolve the issue of surprise billing.

Thank you for considering our views.

Sincerely,

American Association of Neurological Surgeons
Congress of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Surgeons
American Society of Plastic Surgeons
College of American Pathologists



Georgetown University Health Policy Institute

**CENTER ON HEALTH
INSURANCE REFORMS**

MAY 2019

New York's 2014 Law to Protect Consumers from Surprise Out-of-Network Bills Mostly Working as Intended: Results of a Case Study

By Sabrina Corlette and Olivia Hoppe



Robert Wood Johnson
Foundation

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the Robert Wood Johnson Foundation. The
views expressed here do not necessarily
reflect the views of the Foundation.

Authors

Sabrina Corlette and Olivia Hoppe



Georgetown University Health Policy Institute

CENTER ON HEALTH INSURANCE REFORMS

The Center on Health Insurance Reforms (CHIR), based at Georgetown University's McCourt School of Public Policy, is composed of a team of nationally recognized experts on private health insurance and health reform. We work regularly with a multidisciplinary group of faculty and staff dedicated to conducting research on issues related to health policy and health services.

CHIR faculty and staff study health insurance underwriting, marketing and products, as well as the complex and developing relationship between state and federal rules governing the health insurance marketplace. CHIR provides policy expertise and technical assistance to federal and state policy-makers, regulators and stakeholders seeking a reformed and sustainable insurance marketplace in which all consumers have access to affordable and adequate coverage.

Introduction

In March 2014, the New York legislature passed the Emergency Services and Balance Billing Law (“Surprise Billing” law), which went into effect in March 2015.¹ The law protects consumers from charges for out-of-network (OON) services not paid by an insurance plan, in cases of emergency or circumstances in which the patient did not have a reasonable choice between an in-network and out-of-network provider. New York’s law has been touted as a model for other states as

well as potential federal legislation because of its unique “baseball-style” arbitration approach to settling payment disputes, which generated broad buy-in among a set of stakeholders that typically have strongly opposing views.² Five years post-enactment, this study assesses the implementation of New York’s law and how it is working for consumers, providers, and insurance company stakeholders today.

Background

What is a surprise balance bill?

Surprise bills can arise from both emergency and planned health care services, and can lead to significant financial liability for patients, even though they have health insurance. For many consumers, a “surprise bill” is any bill they receive from a medical provider that is larger than expected. A “balance bill” is a bill the patient receives from a medical provider that charges the balance remaining after the insurer makes a payment and any plan cost-sharing or deductible is applied; it may or may not be larger than expected. Insured patients may receive *surprise* balance bills in the case of an emergency when they unknowingly receive services from an out-of-network provider, in the case of a scheduled procedure when they make a good faith effort to ensure that the facility and treating physician are in-network but receive services from a non-participating provider, or when they are misinformed about a provider’s network status

by their health plan or provider (New York’s law defines a surprise balance bill somewhat more narrowly; see Glossary).

Insurers and providers participate in negotiations to determine the rate the insurer will pay for the provider’s services. Typically, in-network providers agree to accept rates that are lower than what they would otherwise charge (often called the “allowed amount”; see Glossary) in return for the guarantee of patient volume among the insurer’s members. Some physicians, such as anesthesiologists, emergency room physicians, radiologists, and pathologists, gain patients by practicing within a particular facility, and do not have the same incentive to participate in a plan’s network. They can often earn more revenue by charging a higher, out-of-network price for their services. For example, out-of-network emergency department physicians charge, on average, 2.4 times more than the in-network rate for their services.³

Glossary of Key Terms

Allowed amount: The maximum amount a health plan will pay for a covered health care service. In-network providers typically agree to accept this amount as payment (plus any patient cost-sharing) and not to balance bill the patient.

Baseball-style arbitration: Also referred to as “final offer” arbitration. Each party to the dispute (the payer and the physician) must submit to the arbiter their best offer. The arbiter must choose one of the two offers without compromising between the two sides. This encourages the parties to submit reasonable bids.

Emergency services bills (as defined by New York law): Bills that arise from a medical screening examination conducted within the emergency department of a hospital, including ancillary services routinely available within the emergency department needed to evaluate and, if needed, stabilize the patient with an emergency condition.

Health Maintenance Organization (HMO): An HMO is a network-based health insurance product. Enrollees generally need to receive a referral from a primary care provider for specialty services and HMOs typically do not cover the cost of care delivered by an out-of-network provider.

Participating hospital or physician: A provider who has a contract with a health insurer to provide services to their members. These providers typically agree to accept the insurer's allowed amount as payment (plus any patient cost-sharing) and not to balance bill the patient.

Preferred Provider Organization (PPO): A PPO is a network-based health insurance product. Unlike an HMO, enrollees are typically allowed to see the providers of their choice without a referral from a primary care provider. Additionally, the plan may cover a portion of the cost of care received from an out-of-network provider.

Self-funded health plan: A plan in which the sponsor (typically a large employer) takes on the risk of paying its members' health care claims. State laws that relate to such plans are generally preempted by the federal Employee Retirement Income Security Act (ERISA).

Surprise bills (as defined by New York law): Bills that arise from non-emergency services (1) in a participating hospital or ambulatory surgical center when an in-network physician is unavailable, or an out-of-network physician renders services without the patient's knowledge; (2) when a participating physician refers a consumer to an out-of-network provider without the consumer's consent; or (3) for uninsured or self-insured patients when disclosure is not made.

Usual and Customary Rate (UCR) (as defined by New York Law): The 80th percentile of all (non-discounted) charges for a particular health care service performed by a provider in the same or similar specialty within the same geographic area. New York law requires these charges to be reported by a benchmarking database maintained by an independent nonprofit organization.

Surprise medical bills are a top concern for consumers. Thirty percent of privately insured Americans received a surprise bill between 2013 and 2015, with 76 percent left unresolved or unsatisfactorily resolved.⁴ Between 2008 and 2011, the New York Department of Financial Services (DFS, which houses New York's insurance department) received 8,339 consumer complaints related to reimbursement for health care services. The DFS investigation found systemic challenges for consumers, including the inability to compare out-of-network benefits

across competing insurers, a lack of disclosure of providers' network participation, excessive billed charges for emergency services, inadequate provider networks and coverage of out-of-network services, and administrative complexity in submitting out-of-network claims.⁵

New York's Surprise Bills Law

Various states have implemented policies designed to curb surprise bills, but most states lack comprehensive consumer protections. New

York is one of just 9 states with laws that extend protections to both emergency and in-network hospital services, apply protections across all types of state-regulated insurance, hold

consumers harmless from extra provider charges, and adopt either an adequate payment standard or establish a dispute resolution process.⁶ See Text Box.

New York Surprise Billing Law: New Requirements for Insurers and Providers

Consumer Protections

- Requires insurers to protect consumers from all out-of-network emergency room (ER) bills.
- Requires both insurers and physicians to protect consumers from non-ER out-of-network claims:
 - > In a participating hospital or ambulatory surgery center when a participating physician is unavailable, or an out-of-network physician renders services without the consumer's knowledge, or unforeseen medical services arise at the time the health care services are rendered; or
 - > Whenever a participating physician refers the consumer to an out-of-network provider without the consumer's consent; or
 - > For uninsured or consumers in self-funded plans, unless certain disclosures are made.

Dispute Resolution

- Establishes an independent dispute resolution (IDR) process for out-of-network ER services and surprise bills for non-ER services.
 - > IDR chooses either the provider bill or the insurer's payment as reimbursement for services.
 - > IDR must consider (1) whether there is a gross disparity between the provider charge and (a) fees paid to the involved physician for the same services rendered by the physician to other patients in health care plans in which the physician is not participating; and (b) fees paid by the health care plan to reimburse similarly qualified physicians for the same services in the same region who are not participating with the health care plan; (2) the provider's training, education, experience, usual charge, the complexity of the case, individual patient characteristics, and UCR as reported by a benchmarking database.
 - > The loser pays for the cost of the IDR process.

Consumer Disclosures

- Requires insurers to disclose their reimbursement methodology for out-of-network services and provide examples of out-of-pocket costs for frequently billed out-of-network services.
- Requires insurers to keep provider directories up to date (web updates within 15 days)
 - > When a service is scheduled in advance:
 - > Requires insurers to inform the consumer which of their providers are out-of-network and the reasonably anticipated out-of-pocket costs;
 - > Requires hospitals to make public the health plans in which the hospital is a participating provider and disclose the physician groups that the hospital has contracted with to provide services. Hospitals must also inform consumers how to determine the health plans in which these physicians participate.
 - > Requires physicians to inform the consumer whether they participate in their health plan. Physicians who are arranging a scheduled hospital service must inform the patient which other physicians will be providing services.

Network Adequacy

- Extends state network adequacy requirements to non-HMO plans (i.e., PPOs).
- Requires insurers to hold consumers harmless for out-of-network cost-sharing if the insurer does not have an appropriate in-network provider.

Importantly, the requirements of New York's law do not extend to self-funded health plans, as the state is preempted from regulating such plans. In addition, while insurers and out-of-network physicians are subject to the IDR process described above, other out-of-network providers, including hospitals, ambulances, and dialysis facilities are not. In the case of out-of-network emergency services, insurers must protect

enrollees from out-of-network charges, but only the physician fees are subject to the IDR process; hospital charges are not. The law also does not protect consumers who are misinformed about their provider's network status, either because they relied on an out-of-date provider directory or were given inaccurate information by their physician's office staff.

Case Study Approach

This brief evaluates the implementation and operation of New York's Surprise Billing law, 5 years post-enactment. The findings herein are based on a review of New York's law and implementing regulations and published reports and analyses about New York's experience to

date. In addition, we conducted ten structured interviews with state regulators, consumer advocates, insurance company representatives, physician and hospital representatives, and expert observers. The interviews took place between January 16 and March 20, 2019.

Findings

Insurer, provider, and consumer stakeholders generally agree that the implementation of New York's Surprise Billing law went smoothly, was relatively fair to all parties, and is working as intended to protect consumers from a significant source of financial hardship. However, several stakeholders noted continued gaps in consumer protections, as well as the potential that the IDR process could lead some physicians to inflate their charges.

Implementation eased by front-loaded legislative process

Negotiating and drafting New York's law was, by all accounts, a "pretty intense process." Stakeholders gave extra credit to DFS and the Governor for their commitment to the issue, beginning with the publication of a 2012 DFS report quantifying the level of consumer complaints associated with surprise balance billing.⁷ That report was "a really important first step," said one stakeholder. "We have this law because [the regulator] gives a damn...and embraced the idea of putting the consumer first." At the same time, the report put provider

advocates on the defensive, prompting media coverage of high provider charges and raising public awareness.

DFS' efforts to subsequently draft a bill that all parties could support – or at least agree not to oppose – were lauded by all sides. Stakeholders credit the agency for listening to their feedback and making changes to the bill in response. "It was a collaborative process," shared one industry stakeholder. Indeed, key to the bill's success were the administration's efforts to bring all the relevant interest groups together. As one observer put it: "The message [from the administration] was: 'This is going to happen, so you better be here.'"

The emergence of baseball-style arbitration as a mechanism to solve provider-payer disputes was critical to the bill's passage. "It was easier for these interest groups to agree to [IDR] because it's not forcing them to adopt a religious position with which they violently disagree," said one observer. "IDR allows both sides to come to the middle." Ultimately, the bill was enacted thanks to support from "elated" consumer groups, provider groups who were "mostly ok," and insurer groups

who were “concerned,” but did not actively oppose it.

That front-end negotiation, while “intense,” generated stakeholder buy-in and ultimately eased the path from enactment to implementation. The bill that was passed is quite detailed and “got into the weeds,” leaving few post-enactment battles to be fought. “All the hard work, hard decisions – it was front-loaded,” commented one insurance expert.

Stakeholder consensus: New York regulatory agencies managed implementation well

Recognizing that implementing the broad and complicated Surprise Billing law would be no small lift, New York lawmakers provided a year of lead time for the agencies – DFS and the Department of Health (DOH) – to draft regulations, prepare and publish templates for provider and plan disclosure notices, and educate the public about their rights and obligations under the new law.

Engaging stakeholders

State officials worked hard to reach out to provider, payer, and consumer stakeholders and incorporate their feedback and concerns during implementation. For example, many health plans were concerned that the IDR process would lead automatically to provider reimbursements set at the 80th percentile of UCR, an amount typically much higher than negotiated in-network rates. This, in turn, would create a disincentive for affected physicians to join the health plans’ networks and incentives for physicians to increase their billed charges. Insurers pushed DFS to ensure that IDR reviewers could consider other factors, including negotiated (allowed) rates as well as Medicare rates, in rendering a decision. DFS was able to help alleviate payers’ concerns by clarifying their ability to submit alternative fees for the IDR reviewer to consider.⁸

Consumer advocacy organizations had words of praise for DFS’ efforts to engage them in the review of draft regulations and disclosure forms. “They consulted us on the mechanics,” said one advocate, particularly with respect to how consumers interact with providers and payers in both emergency and elective health care scenarios, and whether and how they would

likely respond to the language of the required disclosure notices.

Provider representatives also reported “lots of meetings and discussions” with the implementing agencies and applauded their willingness to listen and modify certain requirements. For example, hospital representatives reported working closely with the agencies to design a monitoring and audit program to assess hospitals’ compliance with the law.

Leveraging existing resources

Proactive efforts to generate stakeholder buy-in paid off, as the agencies were able to leverage the infrastructure and dissemination capabilities of the state’s provider and payer associations and consumer advocacy organizations to educate stakeholders and the public about the new law. DFS also tapped an existing help line for consumers with insurance problems – run by the Community Service Society of New York – to help consumers with balance billing issues. Their phone number, along with information about how to protest a surprise balance bill, now appears on the “Explanation of Benefits” form that patients receive after claims are submitted on their behalf.⁹

New York was also able to streamline implementation by taking advantage of relationships it had in place with external appeal organizations. These are independent, third-party entities that make determinations on consumers’ plan appeals regarding utilization review issues. As such, they had many of the same personnel and policies needed to step in as IDR review entities, making it easy for the state to implement the IDR process. Unfortunately, not all states have a similar external review infrastructure in place.¹⁰

Stakeholder consensus: Law has achieved its primary goal; views are mixed about impact

Virtually all stakeholders we interviewed reported that New York’s law has successfully helped protect consumers from a major source of surprise balance bills. “[The law] is working great...it works really well for consumers,” said one consumer advocate. An analysis of calls to the Community Service Society’s consumer help line related to surprise balance billing found that 57 percent were resolved thanks to the law’s protections.¹¹

State officials report a “dramatic” decline in consumer complaints about balance billing: “It’s downgraded the issue from one of the biggest [consumer concerns our call center receives] to barely an issue,” said one regulator. Insurance company representatives also reported a decline, although they were unable to quantify it. Further, several stakeholders reported that the accuracy of insurers’ provider directories had improved since the law was enacted (although there are still problems); others suggested that many consumers have become savvier about the risks of out-of-network billing and are asking more questions about providers’ network status prior to scheduled procedures.

In general, respondents viewed the IDR process as fair, although providers were more bullish on it than insurers. As of October 2018, IDR decisions have been roughly evenly split between providers and payers, with 618 disputes decided in favor of the health plan and 561 decided in favor of the provider (see Table 1). However, insurers have tended to win the majority of out-of-network emergency services disputes (534-289), while providers have won the majority of surprise bill disputes (272-84). Additionally, insurers and

physicians appear to be making “a real concerted effort” to work out their payment disputes before filing with IDR; experts on the IDR process assert that filed complaints represent just “a tip of the iceberg” of the number of relevant payment disputes that occur.

Physician representatives appear largely satisfied with the process and its results. One specialist representative reported “the law worked better than we ever anticipated.” Physician-members of his association who had used the IDR process had “no complaints.... They appreciate the fairness of it,” he said. He also observed that the law may have prompted insurers to “be a little looser” during network negotiations, offering his members higher reimbursements to be in-network than they had prior to the law. Insurers too told us that the incentives are for their networks to be as “expansive as possible.” This observation is consistent with a recent analysis of claims data, which found a 34 percent drop in out-of-network billing in New York since the law was in effect.¹² State officials reported receiving some complaints from providers, but that they tend to be from physicians who have traditionally charged very high rates.

Table 1. Independent Dispute Resolution Results: Emergency Services and Surprise Bills (as of October 25, 2018)

IDR Results for Bills for Emergency Services							
Total Received	Not Eligible	Still in Process	Decision Rendered	Decided in Favor of Health Plan	Decided in Favor of Provider	Split Decision*	Settlement Reached
2,104	534	150	1,431	534	289	364	244
IDR Results for Surprise Bills**							
Total Received	Not Eligible	Still in Process	Decision Rendered	Decided in Favor of Health Plan	Decided in Favor of Provider	Split Decision**	Settlement Reached
1,294	399	186	709	84	272	211	142
IDR Results, Total							
Total Received	Not Eligible	Still in Process	Decision Rendered	Decided in Favor of Health Plan	Decided in Favor of Provider	Split Decision**	Settlement Reached
3,398	933	336	2,104	618	561	575	386

Source: Oechsner T. “New York’s Out-of-Network Legislation.” (Presentation to the NYS Health Foundation, October 29, 2018). On file with authors.

*A split decision occurs when more than one CPT code is submitted in a dispute and the IDR entity finds in favor of different parties for different codes.

**See Glossary for definition of “surprise bill.”

Insurers and other observers raised concerns that IDR reviewers' use of the 80th percentile of UCR as a benchmark for settling payment disputes could open the door for "the provider community to...just drive up the UCR." Further, they noted that certain specialty groups (neurosurgeons and emergency doctors in particular) now have "no real incentive" to join plan networks because they can gain higher reimbursement through IDR. However, insurer respondents acknowledged that the ability to submit alternative data, such as in-network or Medicare rates, to the IDR reviewer enables them to make the best possible case for a reasonable rate. "We're creating ways to present [rate] information to the IDR that's outside the 80 percent UCR...to create a willingness to change the pricing," said one insurer representative.

It may be too soon to know whether New York's approach to settling billing disputes will lead providers to inflate their out-of-network charges. Indeed, one study found a 13 percent average *reduction* in physician payments since the law was enacted.¹³ State regulators report that there has not been, as yet, an indication of an inflationary effect in insurers' annual premium rate filings. Observers further noted that, prior to the law, New York HMOs were required to pay out-of-network doctors' full billed charges for emergency services if the provider would not agree to a negotiated rate; the IDR process has likely reduced those payers' costs.

In short, IDR is not perceived as "a slam dunk for either side." But observers do believe the legislation has sent a signal to insurers and providers alike to "just be reasonable and work it out amongst yourselves if you can."

Stakeholders identify needed improvements, continued challenges for consumers

Although it helped solve two types of surprise billing problems for consumers, the New York law has left them exposed to others. First, stakeholders across the spectrum noted with

regret that self-funded plans are not subject to requirements to hold the consumer harmless, as state regulation of those plans is preempted under ERISA.

Second, advocates identified network "misinformation" as the biggest remaining problem for consumers receiving surprise bills. "It's enraging," one said. When a consumer gets a balance bill after they've relied in good faith on information that the provider is in-network, "that's a surprise bill." In some cases, consumers may rely on inaccurate, out-of-date plan provider directories (although New York has created its own provider look-up tool, which consumer advocates report has been helpful).¹⁴ In others, they are misinformed by physicians' office staff, who represent that they participate in the patient's network when in fact they do not. The representative of a consumer help line has reported that complaints about inaccurate network information represent 35 percent of calls about surprise bills, with the source of the problem roughly evenly split between plan directories and providers' office staff.¹⁵ Although regulators report that they require insurers to hold consumers harmless if the consumer files a complaint showing they relied on an inaccurate plan provider directory, they are as yet unable to hold providers similarly accountable.

Advocates – and insurers – have also called for the legislature to amend the law to subject out-of-network hospital facilities to the IDR process. In an emergency, if a patient is taken to an out-of-network hospital by an out-of-network ambulance, health insurers must limit the patient's out-of-pocket costs to the in-network cost-sharing. If there is a balance bill, the insurer must pay it. However, several observers noted that these providers often submit "excessive charges," knowing the insurer is on the hook to pay them. Further, advocates noted that these hospitals often initially send the bill directly to the patient, "which is completely confusing." Many patients pay it without realizing they don't need to.

Conclusion

Health care is complicated. Determining how providers set prices for their services, how insurers determine what to pay for those services, or ultimately what those services should actually cost is “three-dimensional chess.” New York’s Surprise Billing law doesn’t attempt to answer any of those questions. It simply says that patients should not be the ones expected to figure it out. On that score, 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. However, it can take time for a policy change to change behavior, including the billing practices of a diverse array of specialty physicians.

The law also contains some significant gaps, particularly with respect to surprise balance bills that occur when patients are misinformed about their providers’ network status and when patients are taken to out-of-network facilities in an emergency. Additionally, like all states, New York must await federal action to amend ERISA before it can act to protect patients enrolled in self-funded employer plans.

Endnotes

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