



AMERICAN ACADEMY OF
ORTHOPAEDIC SURGEONS

AMERICAN ASSOCIATION OF
ORTHOPAEDIC SURGEONS

February 18, 2019

Bill Cassidy, MD
United States Senator
520 Hart Senate Office Building
Washington, DC 20510

Michael F. Bennet
United States Senator
216 Russell Senate Office Building
Washington, DC 20510

Todd Young
United States Senator
400 Russell Senate Office Building
Washington, DC 20510

Tom Carper
United States Senator
513 Hart Senate Office Building
Washington, DC 20510

Lisa Murkowski
United States Senator
522 Hart Senate Office Building
Washington, DC 20510

Margaret Wood Hassan
United States Senator
330 Hart Senate Office Building
Washington, DC 20510

Dear Members of the Working Group on Health Care Price Transparency:

On behalf of the American Association of Orthopaedic Surgeons (AAOS), thank you for allowing us to respond to your February 6 letter calling for data and potential solutions relating to surprise medical billing. AAOS represents over 34,000 orthopaedic surgeons and residents, as well as musculoskeletal patients nationwide. Due to the complex nature of some questions, we are unable to report on all of the questions with the time allotted. You will find our answers to your questions as follows:

What percentage of amounts paid for overall emergency care, by both patients and payors, can be attributed to balance billing (dollar amounts and/or percentage amounts)? How about for other specialty departments (e.g., anesthesiology, radiology, pathology, etc.)? If possible, please provide data showing the amounts (or percentages of overall emergency care) paid for services by out-of-network providers at in-network facilities, as well as in-network providers at out-of-network facilities. If possible, please provide data to compare private versus public payments in these scenarios. Please also provide a breakdown of surprise medical bills attributable to each provider specialty.

The total incidence of balance billing, including the percentage comprised within emergency care costs, is unclear because most data sources do not capture whether providers send their patients balance bills or seek to collect them. The Affordable Care Act (ACA) requires health plans in and out of the Marketplace to report data on out-of-network costs to enrollees, though this provision has not yet been implemented. In one study, researchers found that 14 percent of ED visits were likely to produce a surprise bill as were 9 percent of hospital stays. The risk is even greater for patients admitted to the

hospital via the emergency department—20 percent of such patients were likely to receive a surprise bill.¹ Another study showed that of the 8 percent of privately insured individuals used out-of-network care in 2011, 40 percent of those claims involved surprise out-of-network claims and the majority were related to care in an emergency department.²

As it relates to specific medical specialties, a survey by the New York Department of Finance Services suggested that the specialty areas of physicians most often submitting surprise bills were anesthesiology, lab services, surgery, and radiology. Out-of-network assistant surgeons, who often were called in without the patient’s knowledge, on average billed \$13,914, while insurers paid \$1,794 on average. Surprise bills by out-of-network radiologists averaged \$5,406, of which insurers paid \$2,497 on average.³

What specific recommendations do you have to facilitate in-network contracting between providers and plans in the context of federal legislation to address surprise medical billing?

AAOS and other specialty societies support the “New York Model” or the National Conference of Insurance Legislators model legislation. In New York, plans must establish a reasonable payment amount and disclose their method for determining it. Plans also must show how that amount compares to usual and customary rates, defined as the 80th percentile of all charges for a health care service made available by FAIR Health, an independent entity that maintains a consumer database.

To ensure network adequacy, the bill should incorporate specific, quantitative standards that require insurance networks to maintain a minimum number of active primary and specialty physicians, accurate updated physician directories, and provide transparent out-of-network payment options for patients.

We support the draft’s proposal to take patients out of the middle. Patients must be held harmless. Carriers should reimburse providers directly avoiding confusion caused by misunderstood reimbursements to patients.

The proposal should retain a balance billing option. In nonemergent situations, balance billing should be permitted if the patient is adequately informed about the likelihood of out-of-network care. The patient should have every opportunity to seek care from an in-network provider in order to preserve choice and competition.

The proposal should rely on a truly independent database, not just a non-profit, to determine usual and customary rates. FAIR Health is an example of an independent and trusted database, relied upon by New York and other states. By simply setting payment to “median in-network amounts” insurers have little incentive to contract with on-call providers as they can rely on the statutory rate.

As written, the draft relies first on state payment methodology, which could lead to a patchwork of 50 different standards for health insurance plans, leading to administrative and compliance burdens that will reduce access to care for patients.

Can you identify specific states where providers have a lower-than-average contracting rate?

Though AAOS does not have data on contracting rates by state, we have noticed a trend where some insurers have much lower-than-average contracting rates compared to their competitors within a state. For instance, extensive data collected by the Texas Medical Association shows a wide discrepancy between in-network and out-of-network emergency physicians by health insurance plans. This chart, for a single city served by the three carriers, illustrates the problems that plague network coverage and directories in Texas. For instance, a specific insurer was able to contract with many emergency service providers while other insurers had no in-network contracts at all for emergency services for the same area or hospital. In about 54 percent of its in-network Texas hospitals, one-particular insurer had no contracts with emergency department physicians. The same insurer has no network radiologists in 31 percent of its in-network hospitals. It has no contracts with anesthesiologists in 36 percent of those hospitals.

In your view, is there a state model that has worked particularly well at protecting patients from surprise medical billing? If so, why has it worked well? Please provide the details of this model, including its impact on contracting rates and out-of-network payment rates, and describe the data and policy rationale underlying this state legislation.

In 2015, New York State enacted the most ambitious patient protections act for out-of-network medical services and the law is a success⁴. Prior to this, insured patients were getting surprise bills because someone who treated them was out of network (unbeknownst to the patient), with providers charging patients the difference between hospital charge rates and the plan's out-of-network coverage.

Almost immediately after the New York law was passed (and before the required implementation date), there was a marked reduction in out-of-network billing in the state. The out-of-network rate in New York in 2013 was 20.1 percent. Two years later, the rate was 6.4 percent, and the reduction in out-of-network rates was driven by reductions in out-of-network rates across nearly all hospitals, including those that previously had high rates of out-of-network billing.⁵

The New York law has two components. The first is a hold harmless provision that prohibits balance billing patients and requires patients who are treated by an out-of-network physician to pay no more than what they would have paid in cost sharing should the physician have been in-network. The second component is an arbitration process to determine what providers are paid when they treat a patient and do not participate in the patient's insurer's network. New York's law stipulates that insurers must develop reasonable payment rates for out-of-network care and illustrate how their out-of-network payments were calculated. Usual and customary rates are defined in the New York State law as the 80th percentile of charges based on the Fair Health database. The law also requires new disclosures to patients regarding costs or network status, as well as hospital audits by the New York State Department of Health to ensure compliance.

The New York and Connecticut laws on out of network billing consider market dynamics better than any other in the country. Regulated prices will create adverse impacts to contracting, either the insurer or the physician could take advantage of a government regulated price that favors them. If the regulated payment is at or near in-network rates, insurers will not want to form networks because they can rely on a statutorily created rate and not invest the necessary resources required to build and maintain an adequate health insurance network.

Colorado's law illustrates the successes of a bare-bones approach. The law says that insurers must hold consumers harmless for any balance bill for surprise out-of-network services received when admitted by to an in-network facility.

What percentage of balance bills are more than \$750?

According to data from the New York State Department of Financial Services and testimony from the Texas state legislature, of the 239 eligible requests from April 2015 to March 2016 in New York's dispute resolution process, 171 decisions were rendered with 104 final amounts chosen. 15 of the 104 cases resolved for under \$500, 37 cases resolved between \$500-\$1,000, and 52 cases resolved above \$1,000.⁶

I greatly appreciate your time and consideration of our feedback. Please feel free to contact Jordan Vivian, AAOS Manager of Government Relations (vivian@aaos.org), if you have any questions or if the AAOS can further serve as a resource to you.

Sincerely,



Wilford Gibson, MD
Chair, Council on Advocacy
American Association of Orthopaedic Surgeons

¹ C. Garmon and B. Chartock, "One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills," Health Affairs Web First, published online Dec. 14, 2016

² Kyanko, K. A., Curry, L. A. and Busch, S. H. (2013), Out-of-Network Physicians: How Prevalent Are Involuntary Use and Cost Transparency? Health Serv Res, 48: 1154-1172. doi:[10.1111/1475-6773.12007](https://doi.org/10.1111/1475-6773.12007)

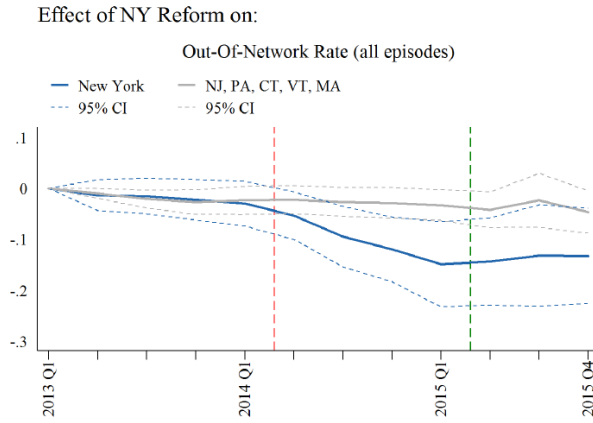
³ Data from New York State Department of Financial Services

⁴ Figure 8 and Figure 9 from the NATIONAL BUREAU OF ECONOMIC RESEARCH

⁵ "Law to curb surprise billing shows promising results" <https://www.crainsnewyork.com/article/20160407/PULSE/160409923/law-to-curb-surprise-billing-shows-promising-results>

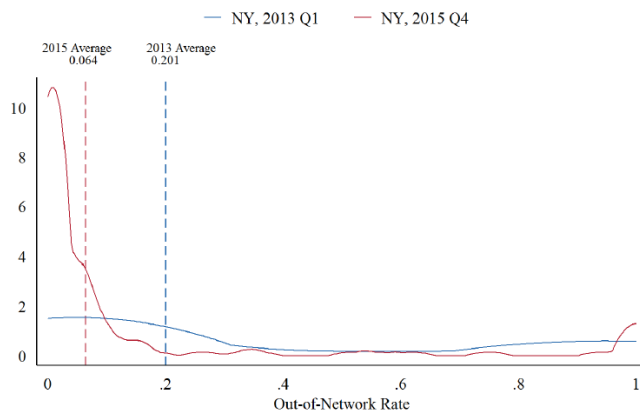
⁶ Data from New York State Department of Financial Services

Figure 8: Out-of-Network Billing Rates in New York Versus Surrounding States



Notes: The figure presents least-squares estimates of an episode-level regression where the dependent variable is whether or not a patient at an in-network ED received a bill from an out-of-network physician. We regress that against an indicator for whether the episode occurred in the state of New York, a vector of quarterly fixed effects, and the interaction of the New York indicator and the quarterly fixed effects. Patient age, gender, race, and Charlson scores are included as controls. The omitted category is Q1 2013. We include a vector of hospital fixed effects. The control group is composed of ED episodes that occurred in New Jersey, Pennsylvania, Connecticut, Vermont, and Massachusetts. Standard errors are clustered around hospitals. The red dotted line denotes when the NY vote passed, and the green dotted line denotes when the NY law was enacted.

Figure 9: The Distribution of Out-of-Network Billing in New York in 2013 and 2015



Notes: The figure shows the kernel density distribution of hospital out-of-network rates in New York in 2013 and 2015