



AMERICAN SOCIETY OF
PLASTIC SURGEONS®



THE PLASTIC SURGERY
FOUNDATION®

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February 11, 2020

The Honorable Robert C. “Bobby” Scott, Chair
House Committee on Education and Labor
2176 Rayburn House Office Building
Washington, DC 20515

The Honorable Virginia Foxx, Ranking Member
House Committee on Education and Labor
2101 Rayburn House Office Building
Washington, DC 20515

RE: Amend the Ban Surprise Medical Billing Act

Dear Chair Scott, Ranking Member Foxx, and members of the Committee on Education and Labor:

The American Society of Plastic Surgeons (ASPS) opposes the *Ban Surprise Medical Billing Act* (H.R.5800) as introduced and respectfully requests that you amend it during committee markup. As currently structured, the proposal will fundamentally change the balance of power within carrier-provider contract negotiations and institute government rate setting for medical services. It will lead to a race to the bottom in network adequacy, and it will decimate access to care, especially in rural settings. This is not the comprehensive solution to unanticipated medical bills that patients deserve. We urge you to amend the legislation by:

- changing the current structure for the initial payment for emergency out-of-network services, which relies on price-setting, so that it does not reference the median contracted rate and instead calls on payers to provide a non-benchmarked, commercially-reasonable amount.
- changing the structure of the independent dispute resolution (IDR) process from its current form, which is heavily biased toward insurance companies and set to an unrealistic threshold, to one that allows for consideration of all factors that are relevant to each party in the dispute.
- adding true network adequacy standards and real consequence for insurance companies who have poor networks and/or inaccurate network information.

Remove price-setting at median in-network rates

An in-network rate is determined only by the insurance company, with no outside input from the federal government, providers, or patients as to whether the methodology is representative of the cost of care. These amounts are calibrated for in-network providers and adjusted down to reflect the increased access to patients, decreased billing disputes, and more timely payment those providers receive. In other words, providers receive non-financial benefits, and in exchange, insurance companies get to pay us a deeply discounted rate.

Basing payments on that rate outside of that contracting environment forces nonparticipating providers who were unable to reach a fair deal to accept a discounted rate with none of the aforementioned benefits. This is coercive contracting, and it disrupts the contracting environment. This legislation is a gift to the for-profit insurance industry.

It does not make sense, and is one-sided, to set reimbursement based on unilaterally-controlled rates determined by whatever the insurers want to pay. This approach is particularly worrisome when considered in light of the insurance industry's history of data manipulation and restriction of patients' access to care.¹

Ultimately, this payment structure will completely alter the physician-insurer negotiation process (both inside and *outside* of out-of-network disputes) by removing any incentive for the carrier to negotiate in good faith during contract discussions. This *has happened* in California, and network adequacy has suffered.² Any federal solution must require the carrier to make an initial reasonable payment based on market value, *a la* the New York model. If that is the structure, and a legitimate route to appealing unfair payment is in place, you will see instances of surprise billing plummet and low rates of arbitration. This *has happened* in New York.³

Restructure the independent dispute resolution process to make it fair and accessible

The structure of an independent dispute resolution (IDR) system is critically important. It needs to allow appropriate factors to be considered, and it needs to be benchmarked to an appropriate rate so that the arbitration process is balanced. Having the benchmark considered by the arbiter be the median in-network rate is not balanced, as articulated above, and that does not even account for of the inherent bias that is introduced into the arbitration process by using the same rate for both the initial payment and the appropriate reference point the arbiter is going to use to render a decision. This imbalance is deepened by the prohibition on the inclusion of any charge-based data.

The IDR structure may ultimately be a moot point, though, because the \$750 physician threshold to initiate the IDR process is not realistic in many circumstances. In the real world, many physician charges would not reach this threshold, making it unattainable. If a congressional solution must include a lower, real-world threshold; permit bundling of claims to meet the threshold; allow billed amounts to be considered by the independent reviewer; and require the IDR system to reference an independent, conflict-free nonprofit claims database.

Institute strong network adequacy and transparency provisions

¹ A sampling of citations of carrier rate manipulation and fraudulent behavior:

1. http://s3.amazonaws.com/fcmd/documents/documents/000/003/228/original/UnitedHealth_Group_-_NYAG_OON_Investigation_NYAGPR.pdf?1426791839
2. <https://www.managedcaremag.com/archives/2009/5/ingenix-aftermath>
3. <https://www.motleyrice.com/article/cigna-medical-upcharge-claims>
4. <https://khn.org/news/medicare-advantage-overbills-taxpayers-by-billions-a-year-as-feds-struggle-to-stop-it/>
5. <https://www.homecaredaily.com/2017/10/25/cigna-facing-claims-committed-fraudulent-billing-least-one-client/>
6. <https://www.fiercehealthcare.com/payer/cigna-cost-shifting-second-suit-american-specialty-health-lawsuits>
7. <http://www.startribune.com/federal-judge-says-unitedhealthcare-medicare-fraud-case-can-move-forward/473851213/>
8. <https://news.bloomberglaw.com/health-law-and-business/unitedhealth-subsiary-optumrx-sued-for-30-million-in-ohio>
9. <https://www.lawyersandsettlements.com/legal-news/health-insurers-denying-medical-claims-bad-faith/united-healthcare-faces-class-action-lawsuit-arbitrary-therapy-p-23010.html>
10. <https://www.bna.com/unitedhealth-hit-again-n57982082861/>
11. <https://www.cnn.com/2019/03/06/health/unitedhealthcare-ruling-mental-health-treatment/index.html>
12. <http://avym.com/blue-cross-blue-shield-il-sued-for-fraud-robbing-chicago-taxpayers/>

² <https://www.cmadoocs.org/Portals/CMA/files/public/CMA%20Suprise%20Billing%20Survey%20Results%202019.pdf>

³ <https://georgetown.app.box.com/s/6onkj1jaiy3f1618iy7j0gpzdoew2zu9>

State laws on network adequacy vary greatly in requirements, enforcement, and philosophy. Since the promulgation of 82 FR 18346 in April 2017⁴ – a rule that all but abdicated the federal government’s network adequacy enforcement responsibility to the states and private organizations – there are virtually no federal mechanisms to ensure states appropriately protect patient access to high-quality care through high-quality insurance products. Enforcing network adequacy requirements is essential to protecting American healthcare consumers, and it is essential to reducing patient encounters with out-of-network providers. Network adequacy standards stop insurers from creating even-narrower networks that prevent patients from receiving the necessary specialty and subspecialty care they need when they need it.

To ensure that patients have in-network access to necessary specialty care providers, we ask that the Committee amend H.R.5800 to reverse 82 FR 18346 and incorporate specific, quantitative standards that require insurers to:

- **Design adequate networks** with a specific minimum number of active primary care and specialty physicians available, subject to appropriate time and distance standards, adjusted by appropriate population density and geographically-impacted factors;
- **Promote transparency** by providing accurate and timely fee schedules to patients and physicians;
- **Ensure patient choice** by offering out-of-network options when their network does not offer access to physicians the patients’ need; and
- When there are no specialists in a network who can meet a patient’s need and a non-network provider must deliver specialty care, or when insurers fail to maintain accurate and timely physician directories, **insurers should compensate those providers at their full fee.** In these cases, the insurer has created an inadequate network, and they, not the patient, should bear the entire responsibility of ensuring patient access outside what is available in the network. This will enable adequate network provisionbs to have real teeth

H.R.5800 must not pass in its current form. It does not offer the comprehensive solution to unanticipated medical expenses that patients deserve. We strongly encourage the Committee to continue the substantial progress that has been made on this issue and incorporate the recommended changes included in this letter. Doing so will finally produce the truly equitable solution that you have worked so hard to find.

Thank you for your consideration of our concerns and for your efforts to address this very difficult issue. Please do not hesitate to contact Patrick Hermes, Director of Advocacy and Government Relations, at phermes@plasticsurgery.org or (847) 228-3331 to request any additional information or with any questions.

Sincerely,



Lynn Jeffers, MD, MBA, FACS
President, American Society of Plastic Surgeons

cc: Members of the House Committee on Education and Labor

⁴ <https://www.federalregister.gov/documents/2017/04/18/2017-07712/patient-protection-and-affordable-care-act-market-stabilization>