AMERICAN SOCIETY OF PLASTIC SURGEONS ®
THE PLASTIC SURGERY FOUNDATION ®

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May 7, 2019

The Honorable Jared Polis
Governor of Colorado
200 E. Colfax Avenue, Room 136
Denver, Colorado 80203

RE: Veto H.B. 1174

Dear Governor Polis:

I am writing on behalf of the American Society of Plastic Surgeons (ASPS), urging you to veto H.B. 1174, which fails to provide a comprehensive solution to unanticipated out-of-network bills for Colorado's patients. ASPS is the largest association of plastic surgeons in the world, representing more than 7,000 members and 93 percent of all board-certified plastic surgeons in the United States – including 114 board-certified plastic surgeons in Colorado. Our mission is to advance quality care for plastic surgery patients and promote public policy that protects patient safety.

ASPS believes that balance billing is largely a consequence of the decreasing size of insurance networks and unenforced network adequacy standards. Since the passage of the Affordable Care Act, insurers have created products with narrow, inadequate, and non-transparent networks. Insurance companies sell those inadequate products and fail to appropriately disclose the realities of the coverage to their customers. This results in narrow networks and, when insurance companies' customers are uninformed, the "surprise" part of a surprise bill. With the growing prevalence of these highly-profitable narrow networks, it has become clear that patients have a limited understanding of the nuances of their plans. As a result, patients unknowingly receive out-of-network care and are charged high out-of-pocket fees.

To address the root cause of out-of-network billing, there must be a comprehensive solution to safeguard patients' access to necessary specialty care. That is why we respectfully must urge you to veto H.B. 1174 in its current form and encourage your Administration to work with the legislature to enact comprehensive balance billing legislation that would:

1. Establish a fee schedule that fairly reimburses emergency out-of-network care

We have serious concerns with the fee schedule established in Section 4 of the bill for emergency out-of-network care. This provision would require carriers to reimburse out-of-network providers for emergency care at an out-of-network facility at the greater of 105 percent of the carrier's median in-network rate, or the median in-network rate for the prior year based on the Colorado All-Payer Health Claims Database (APCD). We believe that any rate set at an allowed amount determined by the insurance carrier lacks transparency and accountability. Providers should have access to the methodology used to determine these payments, which is not possible as the carriers believe their methodologies are propriety. ASPS also opposes benchmarking to the previous year reported by the APCD because it will not prevent rate manipulation by the insurance carriers starting in the second year after the bill's enactment.

To ensure that out-of-network providers receive fair reimbursement, we requested that the legislature amend the fee schedule for emergency care to 80th percentile of billed amounts from an independent database because it is more representative of the true market rate for out-of-network physicians who have been unable to contract a fair in-network reimbursement rate with a carrier. The 80th percentile of an independent charge database means that 80 percent of all charges are equal to or lower than the presented amount. This eliminates the outliers by removing the upper 20 percent (i.e., providers who charge above the norm). We also believe that this standard would help encourage insurance carriers to negotiate in good faith during network participation agreements with providers.

2. Ensure access and fair reimbursement for elective, non-urgent out-of-network care

ASPS believes that patients should be allowed to knowingly and voluntarily select the services of an out-of-network provider at an in-network facility for non-emergency care. We have specific concerns with provisions within Section 4 that require carriers to reimburse out-of-network providers in such situations at in-network facilities the greatest of 110 percent the carrier's median in-network rate, or the 60th percentile of the median in-network rate for the prior year based on the APCD. These reimbursement rates are inappropriately low and do not reimburse providers at a fair rate that is reflective of the true marketplace for elective, out-of-network services.

In nonemergent situations, balance billing should be permitted so long as the patient is fully informed that they will be financially responsible for the cost of out-of-network care in addition to what their insurer might cover. That's why we encouraged the legislature to amend Section 4(12)(b) of the bill to require the development of clear disclosure forms that allow patients to consent to non-urgent out-of-network care and payment obligations with their provider. Allowing informed patients to choose out-of-network care encourages patient choice and flexibility in determining what is best for their healthcare needs.

3. Avoid Arbitration

ASPS has specific concerns with the proposed system to settle reimbursement disputes for out-of-network care, which will be founded on a "baseball style" arbitration process. Under the new system, both the insurance carrier and provider submit their best and final offer. We believe that this new structure will only encourage arbitration, increasing the number of cases brought through the system as well as the costs of the program. Baseball arbitration is a time-consuming process that will take us, as practicing surgeons, away from our patients.

Furthermore, since there is no specific fee schedule for arbitrators to reference during the dispute process, they will not have the financial insight to determine if the carrier actually reimbursed the provider at the mandated rate established in the bill. Instead, we encouraged the legislature to replace the arbitration process with the utilization of 80th percentile of an independent charge database to set the fee schedule and clearly resolve out-of-network disputes. This clear-cut approach would ensure that providers receive fair reimbursement for their services.

4. Require informative patient notification requirements

We believe that payers, facilities, and providers all share responsibility for communicating network-related information, which is why we support the intent of Section 4(12)(b). However, we have concerns with Section 5, which requires health care providers to educate patients about the "potential effects of receiving

emergency or nonemergency services from an out-of-network provider." Providers should absolutely inform patients of their network status and discuss the patient's cost sharing responsibility if they do not participate with the patient's plan. However, it is **not** the responsibility of the provider to educate the patient about the insurance product they purchased. That is the responsibility of the insurance carrier, who should be responsible for detailing the product's limitations to the patient.

We also recommended that the legislature amend Section 4(12)(b) to include more robust notification requirements for insurers and facilities. Insurers should take the lead in protecting their customers from surprise bills by providing enrollees, at every critical juncture, with notice that, at minimum details payment responsibilities based on coinsurance and the insurer's usual and customary out-of-network payment rates; lists all of the providers and facilities that participate in the patient's network; and flags any request for pre-certification of services. Facilities are also in a position to advise patients about the potential for a balanced bill in advance of nonemergency care and therefore should provide patients with every facility-based provider or group with medical staff privileges at the facility and a list of all insurance plans with which the facility participates. By placing responsibility on all parties involved, we can work to ensure that patients in Colorado are able to make informed health care decisions.

For the reasons listed above, we urge you to veto H.B. 1174 to better protect patients from surprise medical bills and ensure fair provider reimbursement. Thank you for your consideration of our position on this important issue. Please do not hesitate to contact Patrick Hermes, Director of Advocacy and Relations, at phermes@plasticsurgery.org or (847) 228-3331 with any questions.

Sincerely,

Alan Matarasso, MD, FACS
President, American Society of Plastic Surgeons