AMERICAN SOCIETY OF PLASTIC SURGEONS ®
THE PLASTIC SURGERY FOUNDATION ™
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February 26, 2019

The Honorable Matt Lesser, Co-Chair
The Honorable Sean Scanlon, Co-Chair
Joint Committee on Insurance and Real Estate
Connecticut General Assembly
Hartford, CT 06106

RE: Opposition to S.B. 905

Dear Co-Chairs Lesser and Scanlon:

I am writing on behalf of the American Society of Plastic Surgeons (ASPS) in opposition to S.B. 905. ASPS is the largest association of plastic surgeons in the world, representing more than 93 percent of all board-certified plastic surgeons in the United States – including 93 board-certified plastic surgeons in Connecticut. Our mission is to advance quality care for plastic surgery patients and promote public policy that protects patient safety.

The following provides four characteristics that ASPS believes are critical in developing a fair approach to out-of-network billing for patients, providers and carriers. We also have included ASPS's official Position Statement on Out of Network Billing to provide further clarification on our stance on this issue. We believe a balance billing solution should:

1. Hold patients harmless

Foremost, we applaud the legislature for holding patients harmless and directing physicians to bill carriers directly, as we also believe that patients should be removed from the process of resolving billing disputes.

2. Provide fair and timely payment

We strongly encourage the legislature to maintain existing statute and continue to utilize the greatest of the following amounts: (1) the usual, customary and reasonable (UCR) rate for services, (2) the in-network rate, (3) and the amount that Medicare would reimburse for such services.

The Connecticut Office of the Healthcare Advocate defines UCR as "The rate of payment to a doctor based on the commonly charged or prevailing fees for health services within a geographic area. A fee is considered to be reasonable if it falls within the parameters of the average or commonly charged fee for the particular service, (e.g. x-ray) within that specific community, (e.g. New Haven County)." ASPS believes that UCR rates based on the 80th percentile of billed amounts, as reported through a third party,

independent charge database, such as FAIR HEALTH, Inc. most accurately represent the market rate for out-of-network physicians who have been unable to contract a fair in-network reimbursement rate.

FAIR Health Inc. has provided a reliable and independent dataset for Connecticut in determining fair reimbursement for emergency services. FAIR Health has the nation's largest collection of privately billed medical claims data – and its healthcare cost information is organized geographically, allowing it to provide relevant cost information that is regionally specific. Utilizing the FAIR Health benchmark allows Connecticut to avoid using opaque insurer data and exposing the state's patients to potential corruption. Furthermore, FAIR Health has proven to be a good partner in the state and has worked with the Connecticut Health Foundation to launch the Engage Health CT initiative. This program provides patients with cost estimates for medical and dental services, further promoting transparency and encouraging patients to make informed decisions about their healthcare options. Therefore, we strongly oppose the omission of the statuary reference to usual, customary and reasonable rate in the underlying bill.

Additionally, we have specific concerns with the proposed replacement of UCR with an amount determined by the insurance carriers. Any rate set by the insurance carriers lacks transparency and accountability. Providers and patients should have access to the methodology used to determine these payments, which will not be possible as the carriers believe their methodologies are proprietary. Therefore, there will be no way for providers to hold the carriers accountable for the way in which these rates are determined and no way of determining if the health plans are engaging in the sort of fraudulent data manipulation that has been seen across the country.[1] As such, we respectfully request that you remove this provision from the bill.

We also have specific concerns with setting physician reimbursement based on Medicare rates, which are politically-derived, have little or no relation to the cost of providing care, and are so notoriously low that they do not cover the cost of many services. However, we recognize that the current system, which reimburses at the highest of the three amounts, has worked well in Connecticut. Given the functionality of the state's current system, we encourage the legislature to maintain existing statute to ensure that providers receive fair reimbursement that most accurately reflects the market cost of providing care.

3. Avoid Arbitration

ASPS has specific concerns with the new system to settle reimbursement disputes for emergency out-of-network services, which will be founded on a "baseball style" arbitration process. This new system will allow both parties to submit their best and final offer. This structure will only encourage arbitration, increasing the number of cases brought through the system as well as the costs of the program. Baseball

[1] A few sample stories of carrier rate manipulation:
https://www.managedcaremag.com/archives/2009/5/ingenix-aftermath
https://www.motleyrice.com/article/cigna-medical-upcharge-claims
http://www.startribune.com/federal-judge-says-unitedhealthcare-medicare-fraud-case-can-move-forward/473851213/
https://www.lawyersandsettlements.com/legal-news/health-insurers-denying-medical-claims-bad-faith/united-healthcare-faces-class-action-lawsuit-arbitrary-therapy-p-23010.html
https://www.bna.com/unitedhealth-hit-again-n57982082861/

arbitration is a time-consuming process that will take us, as practicing surgeons, away from our patients. Furthermore, this type of system has historically benefitted insurance companies – not the patients nor the providers who offer care.

We do not support the use of arbitration to resolve out-of-network billing disputes between carriers and providers, especially as outlined in Section 3 (C). As written, insurance carriers are granted the authority to establish and run a dispute resolution system – a responsibility that should be given to the state or a conflict-free third party. There is a direct conflict of interest for one of the engaged parties to play any role in management of the dispute resolution system. We insist that this be removed from the bill.

Additionally, as written the bill would only allow facility-based providers to participate in the mediation program and offers no opportunity for private practice physicians to dispute their reimbursement. Approximately 45 percent of U.S. plastic surgeons are in solo practice, and due to the small size of their medical practice already face an uphill battle with insurance carriers in contract negotiations. If non-facility-based providers are unable to challenge unfair reimbursements, then they are left at a disadvantage. While we do not support a dispute resolution system, and instead believe that the carrier should be required to reimburse at the "greatest of three", we request that all physicians are permitted to participate in a dispute resolution system, if established.

Finally, we respectfully request further clarification on Section 3 (C) (iii), which states that a dispute resolution system is not available if the patient pays the out-of-network provider for the services. We believe that this section is in direct conflict with Section 8 (b), which explicitly states that "it shall be an unfair trade practice in violation of chapter 735a for any health care provider or facility to request payment from an enrollee…" Section 8(b) makes it illegal for this action to take place. We therefore request Section 3(C)(iii) to be removed.

4. Ensure adequate insurance networks

ASPS believes out-of-network care is often the direct result of narrow, inadequate and non-transparent networks that leave patients – often in emergency situations – with few in-network options. These narrow networks are a cost savings measure insurance carriers have turned to as a way to improve their bottom line after in the wake of the Affordable Care Act, and many times carriers do not engage in good faith contact negotiations with physicians, thus failing to produce an in-network contract.

To be certain that patients have in-network access to necessary specialty care providers, we urge Connecticut to develop specific, quantitative standards that require insurers to:

- Design networks with a minimum number of active primary care and specialty physicians available by population density;
- Maintain accurate and timely physician directories, with robust enforcement to prevent carriers from continuing to provide patients with inaccurate directories;
- Provide accurate and timely fee schedules to patients and physicians to improve cost transparency;
- Offer out-of-network options to ensure that patients have choices when their network does not have adequate physicians to meet the patient's needs; 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, insurers should compensate those providers at their full fee. In these cases, the insurer has created an inadequate network, and they should bear the entire responsibility of ensuring patient access outside what is available in the network.

For the reasons listed above, we urge you to oppose S.B. 905. Thank you for your consideration of ASPS' comments. Please do not hesitate to contact Patrick Hermes, ASPS' Director of Advocacy and Government Relations, at phermes@plasticsurgery.org with any questions.

Sincerely,

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

CC: Members, Joint Committee on Insurance and Real Estate