AMERICAN SOCIETY OF PLASTIC SURGEONS®
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THE GEORGIA SOCIETY OF PLASTIC SURGEONS
FOUNDED 1971

March 26, 2018

The Honorable David Ralston, *Speaker*
The Honorable Jon G. Burns, *Majority Leader*
Georgia House of Representatives
332 State Capitol
Atlanta, GA 30334

RE: Pass H.B. 314 – A Comprehensive Solution to Surprise Medical Bills

Dear Speaker Ralston and Majority Leader Burns:

On behalf of the Georgia Society of Plastic Surgeons (GSPS) and the American Society of Plastic Surgeons (ASPS), we are writing to ask you to bring H.B. 314 forward for a vote to agree. The Georgia Society of Plastic Surgeons is the largest association of plastic surgeons in the state, and in conjunction with our national affiliate ASPS, we represent 202 board-certified plastic surgeons in Georgia. Our mission is to advance quality care for plastic surgery patients and promote public policy that protects patient safety.

1. Ensure adequate insurance networks

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 their customers are purchasing. 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.

Much of the misinformation about out-of-network coverage can be addressed by fully informing patients of their potential to receive care from out-of-network providers. GSPS and ASPS believe payers, facilities, and providers all share responsibility for communicating network-related information to patients.

To be certain that patients have in-network access to necessary specialty care providers, though, we urge Georgia 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.

2. Hold patients harmless

We applaud the legislature for including language in 33-20E-5(b) that requires payments for out-of-network services to be paid directly from insurers to providers. In some cases, when patients receive a check from an insurer, they do not immediately recognize it is for out-of-network care. In these scenarios, the funds are frequently never received by the intended provider, and ultimately the patient may still receive a balance bill. Automatic assignment of benefits removes them from the process of resolving billing disputes.

3. Fair and timely payment

H.B. 314 would require reimbursement for out-of-network emergency services to be set to the lesser of: (1) the nonparticipating provider's actual billed charges; or (2) the minimum benefit standard. We support the utilization of an independent, third-party fee schedule to resolve out-of-network billing disputes, such as FAIR Health Inc. FAIR Health Inc. 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. This would allow states to avoid using opaque insurer data and exposing American citizens to potential corruption. For example, New York's Emergency Medical Services and Surprise Bills Law – which we feel is the most successful out-of-network policy in place – determines fair reimbursement for out-of-network providers as:

> *Usual and customary cost means the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent. The nonprofit organization shall not be affiliated, financially supported and/or otherwise supported by a health insurance company.*

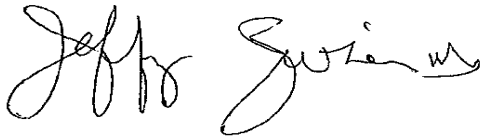
To ensure fees paid to out-of-network providers are both fair and unbiased, New York utilizes Fair Health, Inc. as its independent nonprofit organization. Therefore, we appreciate the definition of

"minimum benefit standard" that is in the "lesser of" provision in the current version of the legislation.

For the reasons listed above, we urge you to bring H.B. 314 forward for a vote to agree. Thank you for your consideration of these comments. Please do not hesitate to contact Patrick Hermes, ASPS' Director of Advocacy and Government Relations, with any questions at phermes@plasticsurgery.org or (847) 228-3331.

Sincerely,

Jeffrey E. Janis, MD, FACS
President, American Society of Plastic Surgeons



Jeffrey Zwiren, MD
President, Georgia Society of Plastic Surgeons

cc: Members, Georgia House of Representatives