AMERICAN SOCIETY OF PLASTIC SURGEONS ®
THE PLASTIC SURGERY FOUNDATION ®

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February 13, 2018

The Honorable Fred Wood, MD, *Chair*
Committee on Health and Welfare
Idaho House of Representatives
P.O. Box 83720
Boise, ID 83720

RE: In opposition to H.B. 495

Dear Chair Wood:

As constituents and practicing physicians, we are writing on behalf of Idaho board-certified plastic surgeons and members of the American Society of Plastic Surgeons (ASPS) in opposition to House Bill 495. ASPS is the largest association of plastic surgeons in the world, representing more than 94 percent of all board-certified plastic surgeons in the United States. Our mission is to advance quality care for plastic surgery patients and promote public policy that protects patient safety.

In addition to our comments below, we have included ASPS' official Position Statement on Out of Network Billing. This detailed analysis focuses on ways to ensure that patients are: (1) properly informed about the costs associated with their medical care; and (2) removed from patient disputes.

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. ASPS believes 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 Idaho 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. Retain a balance billing option

Banning balance billing outright is an unfair giveaway to insurance companies that forces doctors to accept artificially low reimbursements for their services. Therefore, we appreciate the exception created in 41-6505, as it allows balance billing in instances when a patient has been adequately informed. This allows for the focus to be on ensuring that physicians' bills and payers' reimbursements are appropriate and adequate. However, we believe the onus should be on the insurance carrier – not the physician – to provide up-to-date resources so that a patient can determine if the physician they want to see is in-network.

In nonemergent situations, it is the responsibility of the insurance carrier to give the patient (or the physician's office, upon request) an accurate estimate of both the payment to the physician, as well as the patient's out-of-pocket amount. If the information provided to the patient and/or physician is inaccurate, the insurance carrier should then be responsible for upholding the information it provided (i.e., the patient would not be responsible for any amount in excess of the original quote from the carrier and the physician's payment would be no less than what was quoted).

3. Fair and timely payment

H.B. 495 would force physicians to accept the greater of: (1) 85 percent of the contracted in-network rate; or (2) 145 percent of Medicare. The former approach is problematic because it discounts an already-discounted in-network rate, while the latter approach is problematic because Medicare rates – which are politically-derived and have little or no relation to the cost of providing care – are notoriously low.

A better, alternative approach would be to utilize an independent, third-party fee schedule to resolve out-of-network billing disputes. 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:

> *(i) "**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 with an insurer, a corporation subject to article forty-three of the insurance law, a municipal cooperative health benefit plans certified pursuant to article forty-seven of the insurance law, or a health maintenance organization certified pursuant to article forty-four of the public health law.*[1]

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. We strongly recommend that Idaho adopt this definition for "usual and customary cost" to set the fee schedule for resolving billing disputes as an alternative to the "greater of" provision in the current version of the legislation.

For the reasons listed above, we urge you to oppose H.B. 495. Thank you for your consideration of ASPS' comments. Please do not hesitate to contact Patrick Hermes, Director of Advocacy and Relations, with any questions at phermes@plasticsurgery.org or (847) 228-3331.

Sincerely,

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cc: Members, Committee on Health and Welfare

[1] New York Financial Services Law, art 6, § 603