AMERICAN SOCIETY OF PLASTIC SURGEONS ®
THE PLASTIC SURGERY FOUNDATION ®

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November 6, 2017

The Honorable Stanley Rosenberg, *President*
The Honorable Bruce Tarr, *Minority Leader*
Massachusetts State Senate
24 Beacon Street
Room 332
Boston, MA 02133

RE: SB 2202

Dear Members of the Massachusetts Senate:

I am writing on behalf of the American Society of Plastic Surgeons (ASPS) regarding Senate Bill 2202. ASPS is the largest association of plastic surgeons in the world, representing more than 7,000 members and 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's official Position Statement on Out of Network Billing. This detailed analysis focuses on ways to ensure that patients are properly informed about the costs associated with their medical care and removed from payment disputes.

Bill text at 19-21, Section 22

Section 16A directs the commission to recommend the noncontracted commercial rates for emergency services and nonemergency services. As an alternative to the commission setting these rates, fee schedules are better when developed using unbiased healthcare claims data, such as that provided by the aptly-named FAIR Health Inc. FAIR Health is an independent not-for-profit that provides objective healthcare cost information to all interested stakeholders. It has the nation's largest collection of privately billed medial claims data, and its healthcare cost information is organized geographically, allowing it to provide relevant cost information that is regionally specific.

Bill text at 51-52, Section 71

Section 228. (d) requires providers to disclose information regarding network status of referred providers. Rather than placing the onus on providers to give in-depth information for other physicians, this section should be deleted and substituted with the following subsection:

(d) When services rendered in a provider's office require referral to, or coordination with, an anesthesiologist, laboratory, pathologist, radiologist, and/or assistant surgeon, the provider or provider's representative initiating the referral or coordination shall give to the enrollee, the following information in writing about the aforementioned who will be providing services to the enrollee: name, practice name,

mailing address, and telephone number, in order for the enrollee to determine in which health benefit plan networks each participates. The information shall be provided to the enrollee at the time of the referral or commencement of the coordination of services.

A referring healthcare provider cannot know another healthcare provider's accepted insurance status. Enrollees should ask their health plan or the actual provider of the service as to whether the referred provider is in-network.

Bill text at 94-96, Section 110

Sections 30. (a)(1)(i and iii) require providers to accept in-network contracted rates for emergency or nonemergency services when they are part of an insured's carrier's network, but not do not participate in the insured's health benefit plan. Providers who participate in some, but not all, in-network plans do so because certain plans that do not reimburse fairly. Forcing them to participate in plans they deem to be unfairly reimbursing physicians removes any contract negotiating power for physicians, as it would make them de facto members of all of the carrier's plans.

Banning balance billing outright is an unfair giveaway to insurance companies that forces doctors to accept artificially low reimbursements for their services. A better approach is to allow balance billing in instances when a patient has been adequately informed that they could be seeing an out-of-network provider, and instead focus on ensuring that physicians' bills and payers' reimbursements are appropriate and adequate.

Sections 30. (a)(1)(ii and iv) require a carrier to pay the noncontracted commercial rate to an out-of-network provider who has delivered emergency or nonemergency healthcare services to the insured. While we oppose options i and iii, we appreciate the noncontracted rate for ii and iv. However, similar to Section 16A, we recommend that the noncontracted commercial rates be developed using unbiased healthcare claims data, such as that provided by FAIR Health Inc.

Bill text at 24, Section 29

Section 10(e) requires private and public health care payers to *submit the payment rates for procedures and services and other information necessary for the center to determine the rate for every provider with which the payer has contracted or has a compensation agreement*. If the objective of the center compiling information from payers is to develop a process for reporting healthcare prices, price information should be included for in-network and out-of-network providers. Non-network participants should be added, not just a disclosure to patients that they may be responsible for out-of-network cost sharing amounts. Furthermore, healthcare pricing information should be derived from physicians' charges for care – not carriers' payment amounts.

Bill text at 84-88, Section 102

Section 11(b-i) directs insurers to create at least one specific plan in certain geographic areas and sets forth further requirements for those plans. It is imperative that insurers maintain adequate networks, as well as provide transparency and notification to patients about their networks. We appreciate the legislature's willingness to tackle the complex issue of network adequacy head on. However, in order to provide adequate networks, insurers must be required to:

1) Design networks with adequate numbers of active physicians in each specialty within a reasonable distance and availability to patients. Leaving the determination of these standards entirely to the discretion of the commissioner increases the risk that the law will not achieve its goals, and ASPS recommends the act be amended to include specific, quantitative standards for the number of physicians required to meet network adequacy;

2) Provide accurate and timely directories of physicians, other providers and facilities. Robust enforcement of the legislated standards for keeping directories up to date will be critical, because insurers are notorious for providing patients with wildly inaccurate provider directories;

3) Provide accurate and timely fee schedules to patients and physicians to improve cost transparency;

4) Inform patients with a clear description of coverage on an on-going basis (not just at the time of enrollment);

5) Offer out-of-network options. This will ensure that patients have choices when their payer network does not have adequate physicians to meet the patient's needs; and

6) Pay an out-of-network provider their full fee in the event that there is no in-network provider available. In these cases, the insurer has de facto created an inadequate network, and we commend the legislature for including provisions preventing the patient's out-of-pocket expenses from exceeding the in-network amount.

Lastly, the proposed legislation includes transparency provisions so patients understand that the insurance product they are purchasing will pay less for some medical procedures. However, insurance companies have a proven track record of not adequately informing their enrollees about their insurance products. The growth of tiered and narrow networks and the lack of patient understanding of the current system has led to a substantial increase in surprise billing. Patients are completely blindsided by surprise bills, because they are unaware of what their insurance covers, who is in or out-of-network and why. If networks are tiered based on medical procedures, this fundamental problem will be made much worse.

Bill text at 60-61, Section 83

Section 66C. (a)(ii)(2) prohibits a registered optometrist from using or prescribing surgical procedures. However, the section later states that *"surgical procedures" shall not include the use of ophthalmic medical devices approved by the federal Food and Drug Association for diagnostic purposes under Subpart B of 21 CFR 886.* As surgeons, we encourage you to uphold the high level of patient care that has been established and maintain current standards that permit only licensed physicians who meet appropriate education, training, and professional standards to perform surgery in the ocular region. The bill includes language that would allow optometrists to perform procedures that fall squarely within the practice of medicine. Alarmingly, the bill also does not include any educational requirements for optometrists to perform surgery. For example, while optometrists and ophthalmologists are both healthcare professionals who specialize in eye care, there are stark differences between the prerequisites to licensure and practice. Optometrists complete four to five years of post-graduate education, while ophthalmologists are required to complete seven to ten years of post-graduate education and training. In summation, allowing optometrists to practice medicine without the requisite medical school and residency training would jeopardize patient safety and lower the standard of surgical care in the state.

We look forward to continuing to work with the legislature to ensure Massachusetts patients receive the best possible quality of care and have access to adequate numbers of active physicians in each specialty. Thank you for your consideration of our positions on these important issues. Please do not hesitate to contact Patrick Hermes, Director of Advocacy and Government Relations, at phermes@plasticsurgery.org or (847) 228-3331 with any questions or concerns.

Sincerely,

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