AMERICAN SOCIETY OF PLASTIC SURGEONS ®
THE PLASTIC SURGERY FOUNDATION ®

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November 16, 2018

The Honorable John G. Franchini
Insurance Superintendent
New Mexico Office of the Superintendent of Insurance
1120 Paseo de Peralta
Santa Fe, NM 87501

RE: Surprise Billing Protection Act

Dear Superintendent Franchini,

I am writing on behalf of the American Society of Plastic Surgeons (ASPS) regarding the Office of the Superintendent's (OSI) draft legislation, the Surprise Billing Protection Act. 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 – including 25 board-certified plastic surgeons in New Mexico. 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. 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 New Mexico 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. Assignment of benefits

We recommend that OSI include language 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 as payment for out-of-network care that's intended to be paid by the patient to their provider. In these scenarios, the funds are frequently never received by the intended provider, and ultimately the patient may still receive a balance bill for uncompensated care. An assignment of benefits policy would alleviate this confusion by removing the patient from billing disputes, which we believe to be the legislature's ultimate goal, and require the carriers and providers to directly negotiate appropriate payment.

3. Conflict Free Benchmarking Database

We applaud the OSI for requiring the benchmarking database to be maintained by a conflict free, nonprofit organization that is unaffiliated with any stakeholder in the health care sector. To ensure fair disbursement to providers, we strongly recommend that the OSI uses FAIR Health, Inc. as its database for the purposes of this Act. FAIR Health is one of only six organizations certified by the Centers for Medicare & Medicaid Services (CMS) under its Qualified Entity (QE) Program to receive Medicare Parts A, B, and D claims data for all 50 states and the District of Columbia. The database also 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. FAIR Health allows states to avoid using opaque insurer data and instead offers providers and enrollees access to reimbursement information through their website. Most importantly, it is totally unaffiliated financially and operationally from providers and insurance companies

4. Fair and timely payment

ASPS has specific concerns with the reimbursement methodology established in Section 8 of the draft legislation. The new section would require reimbursement for a surprise bill to be the greatest of: (1) the median amount of any in-network reimbursement rates; (2) the usual, customary and reasonable rate, which is defined as the sixtieth percentile of allowed charges for the provider in a similar specialty; or (3) 150 percent of Medicare. All three of these methodologies are flawed and do not reflect the market's indicators for fair physician reimbursement of necessary emergency services.

Forcing an out-of network provider to accept the median allowed amount – which is determined by insurer-owned, proprietary data – is problematic because it discounts an already reduced in-

network rate. In-network, contracted providers accept this reduced rate in exchange for the benefits of access to enrollees and reduced administrative burdens. When out-of-network providers are unable to agree to fair reimbursement with the insurance plan, they choose not to contract and forego these benefits. By including the median allowed amount, New Mexico strips any incentive for the insurer to negotiate in good faith with providers since the carrier will be able to pay the provider at the discounted rate regardless of network status. Therefore, we strongly urge OSI to remove this reimbursement rate so providers receive fair payment for services provided.

Additionally, we strongly oppose any benchmark tied to Medicare reimbursements. Medicare rates – which are politically-derived and have little to no relation to the cost of providing care – are notoriously low. Instead, they are developed based on federal budgetary and regulatory constraints. Medicare is also only intended for elderly patients, and therefore does not incorporate rates for other patient populations, most notably excluding pediatrics and obstetrics. We encourage the OSI to remove this methodology from consideration, as no percent of Medicare will ever reflect the market cost of providing care over prolonged periods of time.

Finally, we encourage the OSI to revise its definition of "usual, customary and reasonable rate" from 60th percentile of allowed charges to 80th percentile of billed charges. We believe that any rate set at an allowed amount determined by the carrier lacks transparency and accountability. Providers should have access to the methodology used to determine these payments, which will not be possible as the carriers believe their methodologies are proprietary. If the carriers continue to block access to these methodologies, there will be no way to hold them accountable for the numbers they provide. Following the Ingenix investigation, New York Attorney General's office stated: "The Attorney General found that having a health insurer determine the 'usual and customary' rate - a large portion of which the insurer then reimburses - creates an incentive for the insurer to manipulate the rate downward."[1] It would be catastrophic for providers and facilities if this rate manipulation took place in New Mexico.

Instead, we believe that 80th percentile of billed amounts most accurately represents the market rate for out-of-network physicians who have been unable to contract a fair in-network reimbursement rate with a health insurance carrier. The 80th percentile eliminates outliers by removing the upper 20 percent of providers who charge above average for services. There is also both industry and state legislative precedence for the use of 80th percentile of billed amounts. New York's Emergency Medical Services and Surprise Bills Law – the most successful out-of-network policy in place – defines UCR 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*

[1] New York State Office of the Attorney General. (2009). *Attorney General Cuomo Announces Historic Nationwide Reform of Consumer Reimbursement System for Out-of-Network Health Care Charges*. Syracuse, N.Y.

organization specified by the superintendent. The nonprofit organization shall not be affiliated, financially supported and/or otherwise supported by a health insurance company.

A percentile of ***billed*** amounts collected by FAIR Health is currently used by a number of other states to determine adequate reimbursement, including Connecticut, Mississippi, Pennsylvania and Alaska. These states are not alone, as leading health insurance carriers such as Aetna, Oxford Health Plan, and Emblem Health also use 80th percentile of ***billed*** charges based on FAIR Health data to determine the highest level of reimbursement for out-of-network providers. Therefore, using 80th percentile is in line with current industry practices and standards. We strongly encourage OSI to amend the definition of "usual, customary and reasonable rate" to mean the 80th percentile of billed amounts based on a conflict free, nonprofit databased such as FAIR Health.

5. Opt-in for ERISA plans

Section 13 allows for a large group or a self-insured health plan governed by the federal Employee Retirement Income Security Act of 1974 (ERISA) to adopt the provisions of the draft legislation. Section 514 of ERISA provides that ERISA supersedes any and all state laws insofar as they relate to any employee benefit plan. Courts have in fact held that ERISA supersedes some state healthcare initiatives, such as employer insurance mandates and some types of managed care plan standards, if they have substantial impact on employer-sponsored health plans. In *Gobeille v. Liberty Mutual Insurance Co.,* the U.S. Supreme Court determined that:

> *"Pre-emption is necessary in order to prevent multiple jurisdictions from imposing different, or even parallel, regulations, creating wasteful administrative costs and threatening to subject plans to wide-ranging liability. ERISA's uniform rule design also makes clear that it is the Secretary of Labor, not the separate States, that is authorized to decide whether to exempt plans from ERISA reporting requirements or to require ERISA plans to report data…"*

Since most claims databases do not or cannot collect billed or allowed claims data for ERISA plans based on existing statue, we believe it is inequitable to allow these plans to adopt the provisions in the Surprise Billing Protection Act without a clear mechanism to evaluate reimbursement rates for ERISA plans. Therefore, we strongly encourage the OSI to remove this provision from the proposal.

6. Clarification of facility responsibilities for patient notifications

The proposal defines "facility" as an entity providing a health care service and includes hospitals, ambulatory surgery centers and health care provider's office or clinic, among other facility types. In Section 5 (c) of the draft legislation, each "health facility" is required to post information on its facility website for the purposes of advance notification of charges. However, Section 5(c)2 directly mentions hospitals, but does not address the requirements for other facilities. The patient notification requirements within this subsection are relevant for surgical facilities, but require information that is not appropriate for a physician's office where a general consultation is performed. ASPS strongly believes that patient notifications conducted by the carriers, facilities and provider are necessary to alleviate unintentional out-of-network care. However, we

encourage the OSI to amend Section 5 (C) in clarifying the notification requirements for surgical facilities (i.e. hospitals, ambulatory surgery centers) versus health care provider offices.

For the reasons listed above, we urge you to amend the Surprise Billing Protection Act in advance of formal introduction. 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,

Gregory A. Greco, DO
Board Vice President, Health Policy & Advocacy
American Society of Plastic Surgeons