AMERICAN SOCIETY OF PLASTIC SURGEONS ®
THE PLASTIC SURGERY FOUNDATION ®

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May 23, 2019

The Honorable Kelly Hancock
P.O. Box 12068
Capitol Station
Austin, TX 78711

The Honorable Tom Oliverson
State Capitol Building
Room E2.412
Austin, TX 78768

RE: S.B. 1264

Dear Senator Hancock and Representative Oliverson:

On behalf of the American Society of Plastic Surgeons (ASPS), we appreciate your consideration of our comments regarding S.B. 1264, which strives to protect patients from unanticipated medical bills. 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 653 board-certified plastic surgeons in Texas. Our mission is to advance quality care for plastic surgery patients and promote public policy that serves patients.

We commend your efforts to address this issue and appreciate your willingness to work with stakeholders in Texas to build upon the trailblazing surprise billing legislation that was passed in 2009. We support several measures within the bill that will rectify some of the current issues with out-of-network billing, including provisions that require the carrier to directly reimburse the physician for all out-of-network payments through automatic assignment of benefits. This will effectively remove patients from billing disputes – the ultimate goal of this legislation.

While we appreciate several aspects of the legislation, we have reservations about two others, which could be improved in a manner that would provide a more complete solution to out-of-network billing for all stakeholders – patients, physicians, facilities, and carriers. We encourage you to introduce floor amendments to the bill or advance future legislation that:

1. Allows physicians to be fairly reimbursed for their services

The bill defines the "usual and customary rate" as the relevant allowable amount as described by the applicable master benefit plan document or policy. The allowable amount is a fee agreed upon by an in-network provider and the carrier through contract negotiations. In agreeing upon an allowed amount, the physician has access to more patients and the carrier ensures access to medical services for its consumers. However, the allowable amount is never an appropriate amount for out-of-network services, as it automatically forces the provider to accept in-network rates without any of the benefits that come with a carrier contract.

Furthermore, any rate determined by an insurance carrier lacks transparency and accountability as the carriers do not disclose their methodologies because they believe they are proprietary. If carriers continue to block access to those methodologies, there will be no way to hold them accountable for the

reimbursements they provide. Following the Ingenix investigation in New York, the New York Attorney General stated that, "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 Texas as a result of S.B.1264.

Rather, the usual and customary rate should be determined by an independent, third party database administered by an entity that is not affiliated with any insurance carrier. We recommend that usual and customary rate be defined as:

> *Usual and customary rate 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 commissioner. The nonprofit organization shall not be affiliated, financially supported and/or otherwise supported by a health insurance company.*

2. Strengthens the arbitration requirements

While arbitration is not our preferred approach, we recognize the success that a similar system has experienced in New York. However, the list of criteria that an arbitrator is required to consider when deliberating a final determination is overwhelmingly biased toward insurers. This is worrisome for physicians, as paid fees are not always representative of market value for services.

We recommend the removal of "the 50th percentile of rates paid" as a consideration during the arbitration process and instead require consideration of only the 80th percentile of all billed amounts. A percentile of ***billed*** amounts collected by FAIR Health is currently used in the following states, with the respective benchmarks:

- Connecticut: 80th percentile benchmark is designated as the usual customary standard for emergency services
- New York: 80th percentile of billed amounts is designated as the benchmark for consumer cost transparency and dispute resolution
- Pennsylvania: "usual and customary" standard in the state's workers' compensation program is based on the FAIR Health 85th percentile
- Alaska: 80th percentile of billed services is used as a benchmark as the usual customary standard for emergency services

ASPS believes the 80th percentile of billed amounts is representative of the market rate for out-of-network physicians who have been unable to contract a fair in-network reimbursement rate with a carrier. The 80th percentile of a third party, independent charge database such as FAIR Health Inc. (FAIR Health) means that 80 percent of all charges are equal to or lower than the presented amount. This eliminates the outliers by removing the upper 20 percent (i.e., providers who charge above the norm).

[1] https://ag.ny.gov/press-release/attorney-general-cuomo-announces-historic-nationwide-reform-consumer-reimbursement

Aetna,[2] Emblem Health,[3] Oxford Health Plan,[4] and UnitedHealthcare[5] all use the 80th percentile of charges to reimburse out-of-network expenses for their various plans. Support for the 80th percentile paradigm has been growing outside of insurance carrier circles, where the National Council of Insurance Legislators (NCOIL) adopted model legislation that defines the "usual, customary, and reasonable rate" as the 80th percentile of charges based on an unbiased charge database. It is clear that using the 80th percentile would be in line with current industry standards and there is no need to also refer to the 50th percentile of paid rates.

ASPS recognizes the tremendous progress that Texas has made on this policy issue and respectfully requests that you amend this legislation to improve the out-of-network climate for all affected stakeholders. We look forward to continuing to work with you on this important issue and thank you for your consideration of our comments. 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,

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

[2] https://www.humbleisd.net/cms/lib/TX01001414/Centricity/Domain/19/2017a/Medical/Aetna_pays_OutofNetwork_benefits.pdf
[3] https://www.emblemhealth.com/~/media/Files/PDF/OON_ReimburseExamples_GHI.pdf
[4] https://www.oxhp.com/secure/policy/OXHPLgGrpEx.pdf
[5] https://www.uhc.com/legal/information-on-payment-of-out-of-network-benefits