AMERICAN SOCIETY OF PLASTIC SURGEONS
THE PLASTIC SURGERY FOUNDATION
444 East Algonquin Road • Arlington Heights, IL 60005-4664
847-228-9900 • Fax: 847-228-9131 • www.plasticsurgery.org

WSPS
WASHINGTON SOCIETY of PLASTIC SURGEONS

February 19, 2019

The Honorable Tim Ormsby
Chair, House Appropriations Committee
315 John L. O'Brien Building
Olympia, WA 98504-0600

The Honorable Drew Stokesbary
Ranking Member, House Appropriations Committee
411 John L. O'Brien Building
Olympia, WA 98504-0600

RE: Amend H.B. 1065

Dear Chair Ormsby and Ranking Member Stokesbary:

On behalf of the Washington Society of Plastic Surgeons (WSPS) and American Society of Plastic Surgeons (ASPS), we appreciate your consideration of our comments regarding H.B. 1065. As physicians, we support the underlying goal of the bill to protect our patients and as such, recommend that the legislature adopt four key changes to strengthen the bill. The Washington Society of Plastic Surgeons is the largest association of plastic surgeons in the state, and in conjunction with our national affiliate ASPS, we represent 137 board-certified plastic surgeons in Washington. Our mission is to advance quality care for plastic surgery patients and promote public policy that protects patient safety.

The following provides four characteristics that ASPS believes are critical in developing out-of-network billing legislation, and it provides our assessment of how well the bill addresses each: ASPS believes a balance billing solution should:

1. Ensure Transparency & Patient Notifications

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 and WSPS believe payers, facilities, and providers all share responsibility for communicating network-related information to patients. That is why we support provisions in the bill that enhance transparency and patient notifications.

Finally, we are encouraged to see Section 13 of the bill, which requires health insurance carriers to update their website provider directory and provide a clear description of a health plan's out-of-network benefits. Insurance carriers must be held accountable for the information that they provide to patients and prospective patients. Patients are not intentionally choosing very limited care. They simply do not understand what they are being sold, or what the serious financial implications of inadequate insurance coverage are. This is a core driver of the surprise bill problem. To better address this issue, we recommend that the bill be amended to require provider directories to be updated within fifteen days rather than thirty days should a provider be terminated or added to a network. We also recommend that the legislation includes the following clause:

> *If a patient receives care from a provider listed in the directory as participating, but unintentionally receives out-of-network care due to an inaccurate carrier directory, the carrier is required to compensate the provider at the provider's billed rate at no expense to the patient beyond their regular cost-sharing obligation for in-network services.*

2. Provide for Fair and Timely payment

ASPS and WSPS have specific concerns with the initial reimbursement established in Section 7 (2) of the bill. In this section, it states that out-of-network providers "shall be reimbursed limited to a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area." This reimbursement method unfairly favors health insurance carriers and strips any incentive for the insurer to negotiate in good faith with providers.

To ensure that out-of-network providers receive fair reimbursement, it should be tied to a percentile of billed amounts (we believe the 80th percentile is most appropriate), as reported through a third party, independent charge database, such as FAIR Health, Inc. We believe charge data is a much less-skewed representation of the market rate for out-of-network physicians who have been unable to contract a fair in-network reimbursement rate with a carrier. A percentile-based approach is optimally because it eliminates outliers by removing providers who charge above the norm. This benchmark is a fair industry standard that is used by 5 states and by insurance carriers such as Aetna,[1] Emblem Health,[2] Oxford Health Plan,[3] and UnitedHealthcare.

We recommend that you revise the current language to adopt this approach. It will better reflect the marketplace, instead of the preferences of the insurance carriers. However, we also understand that this approach is no longer under consideration. We have profound reservations about the provision as-written, and would respectfully request that you make at least the following amendment:

> *The allowed amount paid to an out-of-network provider for health care services described under section 6 of this act shall be* ~~*limited to*~~ *a commercially reasonable amount.*

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1 https://www.humbleisd.net/cms/lib/TX01001414/Centricity/Domain/19/2017a/Medical/Aetna_pays_OutofNetwork_benefits.pdf

2 https://www.emblemhealth.com/~/media/Files/PDF/OON_ReimburseExamples_GHI.pdf

3 https://www.oxhp.com/secure/policy/OXHPLgGrpEx.pdf

3. Avoid Arbitration

ASPS and WSPS do not support the use of arbitration to resolve out-of-network billing disputes between providers and carriers. Instead, we believe that an independent third-party claims database should be used to set a fair fee schedule. However, we understand that the legislature is not amenable to the use of a database set fee schedule and therefore offer necessary changes to the proposed arbitration process that can make it less weighted against for physicians.

For example, arbitrators should not utilize the median in-network and out-of-network allowed amounts as prepared by the Washington state all payer claims database when determining a fair reimbursement rate. Forcing an out-of-network provider to accept the median allowed amount – which is ultimately determined by the insurance carrier– is problematic because it limits provider reimbursement to the maximum amount that insurance carriers are willing to cover for in-network and out-of-network services. That willingness is going to be a function of the insurer's profit motive, not a desire to fairly compensate for services.

In-network contracted providers accept reduced in-network rates 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 as an arbitration criterion, the bill would undermine the carrier's initial good faith attempt to contract with any provider and places providers on an unlevel playing field with insurance carriers during the arbitration process. We strongly urge you to amend this section to remove the median allowed amount as an arbitration criterion.

Similarly, Medicare is not appropriate for consideration during these determinations. It was conceived to provide reliable, quality care for elderly, disabled, and end-stage renal disease patients, not the general population. Horseshoeing other patient groups into the Medicare paradigm – no matter how fiscally appealing – is structurally unworkable. Medicare does not even have rates for certain important areas of care (i.e., pediatrics or obstetrics). This is apparent from a lack of the full range of services in the official American Medical Association (AMA) Current Procedural Terminology (CPT) codes, which federal regulation requires be used in billing and record-keeping. Moreover, not only do Medicare rates not include certain segments of the patient population, they also have historically been manipulated to favor and/or encourage specific types of care rather than others (i.e., primary care rather than specialized services). Lastly, Medicare payment rates are insufficient, resulting in the program reimbursing providers at less than cost for many services. Using Medicare rates within the arbitration process is totally inappropriate.

Lastly, we believe that the final decisions in the arbitration process should be publicly sealed so insurance carriers cannot actively attempt to create a floor in initial reimbursement rates. As such, we recommend that the bill be amended to require that both parties enter into a nondisclosure agreement before engaging with an approved arbitrator.

4. Steer Clear of an ERISA Opt-In

In Washington, half of the insurance market is self-insured plans governed by the federal Employee Retirement Income Security Act of 1974 (ERISA). Section 514 of ERISA provides that ERISA supersedes any and all state laws insofar as they relate to any employee benefit plan, as determined in *Gobeille v. Liberty Mut. Ins. Co.*. Furthermore, in *FMC Corp. v. Holliday,* the ERISA "deemer clause" was determined to "relieve plans from state laws 'purporting to regulate insurance.'" Therefore, we believe that these self-insured plans would be legally prohibited from participating in an ERISA opt-in as outlined in Section 23.

We appreciate the work that you are doing to protect patients from surprise medical bills and to ensure strong network adequacy standards. For the reasons listed above, we urge you to amend H.B. 1065. 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,

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

Shannon Colohan, MD, MSc, FRCSC, FACS
President, Washington Society of Plastic Surgeons

cc: Members, House Appropriations Committee