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

AAOS
AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS
AMERICAN ASSOCIATION OF ORTHOPAEDIC SURGEONS

October 10, 2018

The Honorable Bill Cassidy, MD
United States Senator
520 Hart Senate Office Building
Washington, D.C. 20510

RE: Protecting Patients from Surprise Medical Bills Act

Dear Senator Cassidy:

On behalf of the American Society of Plastic Surgeons (ASPS) and the American Association of Orthopaedic Surgeons (AAOS), we are writing in regard to bipartisan Senate health care price transparency working group's (Working Group) draft legislation, the *Protecting Patients from Surprise Medical Bills 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. AAOS is the world's largest medical association of musculoskeletal specialists and represents over 34,000 board-certified orthopaedic surgeons. Our collective mission is to advance quality care for patients and promote public policy that protects patient safety.

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.

1. Ensure adequate insurance networks

Insurers need to make available a truly up-to-date directory via the internet and be held accountable for decisions made based on content in their directories. If a patient makes a care decision based on an inaccurate directory, the insurer should be held responsible for treating the situation as if their directory is accurate. Insurers must also provide in-network and out-of-network benefits information to patients and providers in an easily accessible manner, necessary for providers and patients to determine anticipated out-of-pocket expenses and differences in seeking in-network and out-of-network care.

Currently, the structures in place across the states to ensure that these basic network quality characteristics are present differ wildly in resourcing and sophistication, operational effectiveness, and – frankly – philosophical alignment with regard to whether insurance companies or patients

should be primarily served by network standards. Since the promulgation of 82 FR 18346 in April 2017[1] – a rule that all but abdicated the federal government's network adequacy enforcement responsibility to the states and private organizations – there has been a clear lack of a necessary second system for ensuring patient access to high-quality care through high-quality insurance products.

We reviewed the private organizations that accredit insurance networks – the NCQA Health Plan Accreditation (HPA) program, the Accreditation Association for Ambulatory Health Care (AAAHC) QHP Accreditation program, and the URAC Accreditation for Marketplace Plans – when 82 FR 18346 was finalized and were left concerned that specialty and subspecialty physicians were not accurately nor adequately captured in network adequacy standards. Nothing has happened in the last 18 months to address those concerns. As noted, states have a patchwork of network adequacy laws and regulations, with varying staff sizes, proactivity/reactivity in monitoring, and politicization of the insurance commissioner role. Enforcing network adequacy requirements is essential to protecting American healthcare consumers, yet there are states that rely on the federal exchanges that lack the necessary staff to take on the labor-intensive oversight of those regulations.

Therefore, to be certain that patients have in-network access to necessary specialty care providers, we urge Congress to reverse 82 FR 18346 and instead incorporate specific, quantitative standards within the *Protecting Patients from Surprise Medical Bills Act* that require insurers to:

- Design networks with a specific minimum number of active primary care and specialty physicians available, adjusted by appropriate population density and geographically-impacted factors;
- 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 offer access to the physicians the patients' need; 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. Hold patients harmless under all circumstances

We applaud the Working Group for holding patients harmless and directing carriers to reimburse providers directly. In some cases, when patients receive a check from an insurer, they do not immediately recognize it as physician payment for out-of-network care. In these scenarios, the funds are frequently never received by the intended provider, and ultimately the patient may still receive a balance bill. Automatic assignment of benefits removes them from the process of resolving billing

[1] https://www.federalregister.gov/documents/2017/04/18/2017-07712/patient-protection-and-affordable-care-act-market-stabilization

disputes. We encourage you to expressly prohibit carriers from sending funds to patients and impose financial penalties when this assignment of benefits is not respected by the health plans.

3. Retain a balance billing option

Section 2 (3) bans balance billing for emergency services. While we understand that concessions must be made to ensure that patients do not bear the burden of excessive emergency department expenses, we believe the draft legislation favors insurance companies and forces doctors to accept artificially low reimbursements for their services. Instead, we recommend retaining a balance billing option in which patients may assign their benefits to their provider. This will remove patients from the negotiations and instead allow the carriers and providers to directly negotiate adequate reimbursement.

In nonemergent situations, balance billing should be permitted if the patient is adequately informed about the likelihood of out-of-network care and the opportunity to seek care from an in-network provider. It is also 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 out-of-network 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). Allowing informed patients to choose out-of-network care encourages patient choice and flexibility in determining what is best for their healthcare need.

4. Fair and timely payment

The discussion draft directs carriers to pay providers "the greater of the median in-network rate negotiated by health plans and participating providers or 125 percent of the average allowed amount for all private health plans for the services provided by a provider in the same or similar specialty and provided in the same geographical area." These approaches are problematic because they would force physicians to accept either: (1) an already discounted in-network rate; or (2) rates that are unilaterally controlled by insurers.

The draft requires the usual and customary rate (UCR) to be determined by a database selected by the state that is maintained by a non-profit that is not affiliated with the health plans. We applaud this intention, because there are a number of such databases that appear to be unaffiliated with payers but are *de facto* subsidiaries. To ensure that a truly independent price database is used as the baseline for resolving out-of-network payments, we urge you to amend the definition of "usual, customary, and reasonable rate" as currently defined in the discussion draft (pp. 4-5) and adopt instead our red-lined additions. So far, the only database we have identified that meets the standard set in the revised language is FAIR Health, Inc.

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. FAIR Health has the nation's largest unbiased collection of privately-billed medical claims data, Medicare claims data, and geographically-organized healthcare

cost information. This produces relevant, reliable, and regionally-specific cost information. This in turn allows states to avoid using opaque insurer data – a practice that often leads to lawsuit-inducing data manipulation practices on the part of insurers[2] – and protects American citizens from being exposed to potential corruption.

While use of a comprehensive data set to determine a fair minimum benefit standard is important, we would be remiss if we did not specifically address the problems present in the use of state-run all-payer claims databases (APCDs). There has been a push in the states for state-run APCDs in recent years. While we appreciate the efforts to eliminate confusion for patients, we believe that state-run APCDs actually exacerbate that confusion because they lack uniform data sets and access processes. Furthermore, including any APCD that considers CMS payments should be expressly prohibited, as those rates are politically-derived and notoriously low. As Congress seeks to determine a nationwide standard benchmarking database, it should not promote wasting state government resources when nonprofit entities such as FAIR Health are already doing the work.

5. Clearly address ERISA plans

The discussion draft is unclear regarding ERISA health plans, and we urge you to clearly address surprise billing for health plans regulated by ERISA.

According to the Kaiser Family Foundation, in 2017, approximately 60 percent of employees receiving health benefits through their employers are receiving those benefits through ERISA plans.[3] Section 514 of ERISA (the federal Employee Retirement Income Security Act of 1974) provides that ERISA supersedes any and all state laws insofar as they relate to any employee benefit plan. Courts have held that ERISA supersedes some state healthcare initiatives, such as employer insurance mandates and some types of managed care plan standards, if they have a substantial impact on employer-sponsored health plans.

Given the broad preemption language within ERISA and that States have not generally had the authority to regulate those entities, it is unclear whether the language in the discussion draft related to the state law (i.e., "an amount determined, and payable in such manner, in accordance with the law of the applicable State, county, parish, or tribal government") is intended to refer to state laws that do not directly relate to ERISA plans and the potential interaction of ERISA preemption under section 514 and these new provisions. If the intent is to allow states to develop the appropriate payments, then a clearer preemption statement may be warranted.

Further, given that states generally do not have authority to regulate ERISA plans, it is unclear whether the charge databases developed by the states would have the necessary data from ERISA plans.

We appreciate the work you and the rest of the Working Group are doing to look broadly at the cost of health care in America and specifically on the impact of surprise insurance gaps on patients. We know that out-of-network billing is emerging as a significant area of federal focus; therefore, we

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

[3] https://www.kff.org/report-section/ehbs-2017-section-10-plan-funding/

strongly urge you to amend the discussion draft as outlined above to ensure that protecting American patients is truly Congress' priority.

Please do not hesitate to contact ASPS Director of Advocacy Patrick Hermes (phermes@plasticsurgery.org) or AAOS Senior Manager of Government Affairs Catherine Boudreaux Hayes (hayes@aaos.org) with any questions.

Sincerely,

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

David A. Halsey, MD
President
American Association of Orthopaedic Surgeons

cc: Hon. Michael Bennet, United States Senator
Hon. Charles Grassley, United States Senator
Hon. Tom Carper, United States Senator
Hon. Todd Young, United States Senator
Hon. Claire McCaskill, United States Senator