AMERICAN SOCIETY OF PLASTIC SURGEONS®
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THE GEORGIA SOCIETY OF PLASTIC SURGEONS
FOUNDED 1971

March 11, 2019

The Honorable Richard H. Smith
Chairman, Committee on Insurance
Georgia House of Representatives
220 State Capitol
Atlanta, GA 30334

The Honorable Steve Tarvin
Vice Chairman, Committee on Insurance
Georgia House of Representatives
220 State Capitol
Atlanta, GA 30334

RE: S.B. 56 – The Consumer Coverage and Protection for Out-of-Network Medical Care Act

Dear Chairman Smith and Vice Chairman Tarvin:

On behalf of the Georgia Society of Plastic Surgeons (GSPS) and the American Society of Plastic Surgeons (ASPS), we are writing in support of S.B. 56. The Georgia Society of Plastic Surgeons is the largest association of plastic surgeons in the state and, in conjunction with our national affiliate, ASPS, we represent 199 board-certified plastic surgeons in Georgia. Our mission is to advance quality care for plastic surgery patients and promote public policy that serves patients. S.B. 56 – which is now the only active out-of-network solution before the legislature – contains several important elements, noted below, that accomplish this, and we urge you to pass this measure so Georgia's patients will be adequately protected and physicians will receive fair reimbursement for their services. **GSPS and ASPS support this legislation because:**

1. It protects patients from billing disputes

Protecting patients should be the top priority when passing a bill such as S.B. 56. Therefore, we applaud the legislature for including language in 33-20E-5(b) that requires payments for out-of-network services to be paid directly from insurers to providers. This removes patients from billing disputes.

In some cases, when patients receive a check from an insurer, they do not immediately recognize it as payment for out-of-network care. In these scenarios, the funds are frequently never received by the intended provider, and the patient may ultimately still receive a balance bill. Automatic assignment of benefits removes that potential misunderstanding from play.

2. It ensures patients know about their out-of-network options

Surprise bills are best addressed by removing the surprise, and that is best accomplished though structures that ensure patients receive better information about their insurance networks. SB. 56 accomplishes this through patient notification provisions under 33-20E-3 that ensure patients are fully informed of their potential to receive care from out-of-network providers.

We believe that payers, facilities, and providers share the responsibility for communicating network-related information. Patient interaction with out-of-network providers is fundamentally a network adequacy issue, and health plans are most responsible for balance and surprise billing. As such, insurers should take the

lead in protecting their customers from surprise bills. Furthermore, facilities are well-positioned to inform their patients of potential interactions with out-of-network providers and give them the opportunity to make adjustments to avoid balance bills. Facility-based providers also have a role in addressing this problem, most critically by reducing the confusion patients feel when they receive a balance bill. The legislation effectively addresses all of these areas.

3. It retains a patient- and provider-friendly balance billing option for nonemergent conditions

Section 33-20E-4(a)(6)(d) would require insurers to notify patients of their responsibility to pay the balance of the nonparticipating provider's fee if the rate paid by the plan is below the provider's usual and customary cost. We believe that – 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.

Under the bill, 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 is 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. Therefore, we welcome the inclusion of this provision as it would codify what we believe should be the responsibility of the insurer to notify patients in nonemergent situations.

Relatedly, we are encouraged by the inclusion of provisions in 33-20E-4 that require insurers to maintain accurate physician directories and reimburse physicians at their full rates in certain scenarios. Specifically, we strongly support the provisions that would: (1) require insurers to reimburse healthcare providers at the lesser of the usual and customary cost or MBS in the event that a patient makes a decision based on an out-of-date directory maintained by the insurer; and (2) hold insurers accountable for credentialing delays. To further strengthen Georgia's network adequacy standards, we recommend future measures to design networks with a minimum number of active primary care and specialty physicians available by population density, and reimburse a physician at their full rate if there are inadequate numbers of specialists who can meet a patient's need.

4. It provides appropriate reimbursement for unexpected out-of-network emergency care

When it comes to reimbursement for out-of-network emergency services, the bill would require payment to be set to the lesser of: (1) the nonparticipating provider's actual billed charges; or (2) the minimum benefit standard (MBS).

We appreciate the inclusion of the 80th percentile of charges as reported in a benchmarking database maintained by a nonprofit organization specified by the commissioner as part of the formula used to determine the MBS. 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. 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).

Furthermore, and finally, we are encouraged that the definition of MBS would be tied to 2018 rates which then may be adjusted for inflation according to the Consumer Price Index for Medical Care or another appropriate indicator.

For the reasons listed above, we urge you to pass S.B. 56. Thank you for your consideration of our comments. Please do not hesitate to contact Patrick Hermes, ASPS's Director of Advocacy and Government Relations, at phermes@plasticsurgery.org or (847) 228-3331 with any questions.

Sincerely,

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

Robert C. Dinsmore, MD FACS
President, Georgia Society of Plastic Surgeons

cc: Members, Committee on Insurance