AMERICAN SOCIETY OF PLASTIC SURGEONS ®
THE PLASTIC SURGERY FOUNDATION ®

Executive Office
444 East Algonquin Road • Arlington Heights, IL 60005-4664
847-228-9900 • Fax: 847-228-9131 • www.plasticsurgery.org

June 5, 2017

The Honorable Brian Sandoval
Governor of Nevada
Office of the Governor
State Capitol Building
101 N. Carson Street
Carson City, NV 89701

Oppose AB 382 - Claims for Reimbursement of the Cost of Health Care Services

Dear Governor Sandoval:

The American Society of Plastic Surgeons (ASPS) asks you to veto AB 382. ASPS is the world's largest association of plastic surgeons, representing over 8,700 members with 50 members in Nevada.

Health insurers have created plans with small numbers of physician-providers. These "narrow network" plans do not have enough physicians to provide needed services. Patients may undergo a surgery or other service wherein non-plan physicians are involved, and this results in a "surprise bill". We appreciate the legislature's effort to address surprise billing, but request a solution that is both patient- and provider-equitable.

AB 382 requires a physician who renders out-of-network care to accept a "reasonable rate" offered by an insurance plan. If the physician determines this rate "unreasonable", a period of negotiation follows, and terminates in binding arbitration. The arbitrator must consider: 1) the average amount for in-network care; 2) the Medicare rate; and 3) the usual and customary rate for out-of-network care.

Many health plans offer reimbursement rates that don't cover the overhead cost of providing care. Physicians naturally refuse to contract. If AB 382 passes as written, insurance companies will have no incentive to contract at all, because they will only be liable to pay providers this legislated "discount" payment. This is inherently unfair to patients and physicians. Insurers with narrow networks should instead face penalties and be required to pay fair and equitable reimbursement.

AB 382's out-of-network payment proposal is deeply flawed because:

- Medicare rates are notoriously low, having not kept pace with inflation for the past 20 years.
- Average contracted in-network rates strongly favor insurance companies. Contracted providers accept rates that are discounted from the actual full charge. The provider may accept this rate to gain access to more patients. AB 382 makes all providers *de facto* network participants without the patient access advantage of contracted providers.

- "Usual, customary and reasonable out-of-network" payment relies on the insurers' own data, and insurers have a documented history of rate manipulation. In New York, United Healthcare and Aetna were forced to pay a $350M settlement after manipulating usual and customary rate data to defraud customers. In 2016, ambulatory surgical centers in California won a $9.5M settlement against United Healthcare for these same corrupt practices.

To prevent such abuse, we believe Nevada should instead mandate out-of-network payment be determined from an independent third party claims database such as FAIR Health, Inc.

FAIR Health, Inc. contains the nation's largest unbiased collection of private insurance, Medicare, and out-of-network claims data, and is geographically organized. Using FAIR Health avoids using opaque insurer-based data and its potential for corruption. Importantly, FAIR Health is unaffiliated with any of the involved parties. FAIR Health's independence was a driving factor in a recent conclusion drawn by the National Organization for Research at the University of Chicago (NORC) that FAIR Health data be used to calculate out-of-network physician reimbursement over other methodologies and claims databases.[1]

In addition, any long-term solution requires robustly enforced patient notification and network transparency rules for all insurers. ASPS recommends AB 382 include requirements that providers, facilities, and health insurers better communicate network status to patients. Surprise billing will be reduced by fully informing patients of network coverage, and by requiring insurers to maintain transparent and adequate networks.

ASPS urges the Nevada legislature to consider quantitative health plan standards for the number of primary and specialty physicians required for specific population densities, as well as quantitative limits on the acceptable distances and wait times for appointments as more direct way to address the cause of surprise billing rather than the effect.

Lastly, patients should be allowed to assign benefits to an out-of-network provider. Assigning benefits takes the patient out of the equation in the payment process, and thus reduces confusion.

Because surprise billing is a complex issue that must be legislated appropriately, we ask for you to veto AB 382. Please do not hesitate to contact Patrick Hermes, ASPS's Senior Manager of Advocacy and Government Affairs, with any questions at Phermes@plasticsurgery.org or (847) 228-3331.

Regards,

Debra Johnson MD FACS
President, American Society of Plastic Surgeons

[1] Gabel, Jon, et al. "*Final Report: Qualitative Assessment of Databases for Out-of-Network Physician Reimbursement.*" NORC at the University of Chicago, Apr. 18, 2017, https://olis.leg.state.or.us/liz/2017R1/Downloads/CommitteeMeetingDocument/123378