AMERICAN SOCIETY OF PLASTIC SURGEONS ®
THE PLASTIC SURGERY FOUNDATION ®

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March 6, 2018

The Honorable Kate Brown
Governor of Oregon
Somerville Building
775 Court St. NE
Salem, OR 97301

RE: Veto S.B. 1549

Dear Governor Brown:

I am writing on behalf of the American Society of Plastic Surgeons (ASPS) in opposition to S.B. 1549. 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 – including 84 board-certified plastic surgeons in Oregon. Our mission is to advance quality care for plastic surgery patients and promote public policy that protects patient safety.

1. Future deliberations

While we appreciate the formation and continuation of the Advisory Group, we believe that codifying the egregious reimbursement rate that is offered in the bill would be detrimental to future efforts to set rates that reflect fair and adequate reimbursement. For that reason and the reasons listed below, we urge you to oppose S.B. 1549.

2. Ensure adequate insurance networks

Since 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 believes payers, facilities, and providers all share responsibility for communicating network-related information to patients.

To be certain that patients have in-network access to necessary specialty care providers, though, we urge Oregon to develop specific, quantitative standards that require insurers to:

- Design networks with a minimum number of active primary care and specialty physicians available by population density;
- 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 have adequate physicians to meet the patient's needs; 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.

3. Fair and timely payment

S.B. 1549 would force physicians to accept the median allowed amount paid to in-network healthcare providers by commercial insurers in Oregon. Physicians accept discounted rates to join networks in exchange for access to a greater number of patients. Forcing an out-of-network provider to take the median allowed amount – which is determined by insurer-owned, proprietary data – is problematic because it discounts an already-discounted in-network rate.

A better, alternative approach would be to utilize an independent, third-party fee schedule to resolve out-of-network billing disputes. FAIR Health Inc. has the nation's largest collection of privately billed medical claims data – and its healthcare cost information is organized geographically, allowing it to provide relevant cost information that is regionally specific. This would allow states to avoid using opaque insurer data and exposing American citizens to potential corruption. For example, New York's Emergency Medical Services and Surprise Bills Law – which we feel is the most successful out-of-network policy in place – determines fair reimbursement for out-of-network providers as:

> *(i) "**Usual and customary cost**" 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 superintendent. The nonprofit organization shall not be affiliated, financially supported and/or otherwise supported by a health insurance company.*[1]

To ensure fees paid to out-of-network providers are both fair and unbiased, New York utilizes Fair Health, Inc. as its independent nonprofit organization. We strongly recommend that Oregon adopt this definition for "usual and customary cost" to set the fee schedule for resolving billing disputes as an alternative to the "greater of" provision in the current version of the legislation.

[1] New York Financial Services Law, art 6, § 603

For the reasons listed above, we urge you to veto S.B. 1549. Thank you for your consideration of ASPS' comments. Please do not hesitate to contact Patrick Hermes, Director of Advocacy and Relations, with any questions at phermes@plasticsurgery.org or (847) 228-3331.

Sincerely,

Jeffrey E. Janis, MD, FACS
President, American Society of Plastic Surgeons