AMERICAN SOCIETY OF PLASTIC SURGEONS
THE PLASTIC SURGERY FOUNDATION
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ROBERT H IVY SOCIETY FOUNDED 1954 PLASTIC SURGEONS

December 15, 2017

The Honorable Donald C. White, *Chair*
The Honorable Sharif Street, *Minority Chair*
Committee on Banking and Insurance
Pennsylvania State Senate
Senate Box 203041
Harrisburg, PA 17120

RE: S.B.678

Dear Chairman White and Minority Chairman Street:

On behalf of the Robert H. Ivy Pennsylvania Society of Plastic Surgeons (Ivy Society) and the American Society of Plastic Surgeons (ASPS), we are writing in response to S.B.678. The Robert H. Ivy Pennsylvania Society of Plastic Surgeons is the largest association of plastic surgeons in Pennsylvania, and in conjunction with our national affiliate the American Society of Plastic Surgeons, collectively represent 305 board-certified plastic surgeons in the state. Our mission is to advance quality care for plastic surgery patients and promote public policy that protects patient safety.

In addition to our comments below, we have included ASPS's official Position Statement on Out of Network Billing. This detailed analysis focuses on ways to ensure that patients are properly informed about the costs associated with their medical care and removed from patient disputes.

1. The use and citation of usual and customary rate (UCR) is a critical component. However, the UCR as defined in the amendment to the bill needs revision

Section 102 of the amendatory language defines the "usual, customary and reasonable rate" as:

> *The seventy-fifth percentile of all allowed amounts for the particular health care service performed by a facility or health care practitioner in the same or similar specialty and provided in the same geographical area, as reported in an approved benchmarking database.*

The same section defines the "allowed amount" as:

> *The maximum dollar amount that an insurer will consider reimbursing for a covered health care service. This dollar amount may not be the amount ultimately paid to the insured, facility or health care practitioner as it may be reduced by any co-insurance, deductible or amount beyond the annual maximum.*

This is a remarkable giveaway to the insurance industry. Not only does this language peg out-of-network reimbursement to the allowed amount – an already deeply discounted rate relative to a provider's charge, determined and discounted because a provider is choosing to contract with a payer – but it further lowers those reimbursements to 75 percent of the already discounted rate. ASPS and the Ivy Society recommend tying reimbursement to a percentage of charge data in an independent database.

Many health plans rely upon the 80th percentile of all charges for the particular healthcare services performed by a provider in the same or similar specialty, and provided in the same geographical area as reported in a benchmarking database (i.e., FAIR Health Inc.). Furthermore, a recent study by the National Opinion Research Center (NORC) at the University of Chicago evaluated, and confirmed, the importance and reliability of calculating UCR data based upon independent sources such as FAIR Health Inc.[1]

Pennsylvania should take every precaution not to utilize an insurer-influenced list of reimbursements in its health-related data and statistics, because insurers have a storied and documented history of rate manipulation. In New York, United Healthcare and Aetna were ordered to pay a $350 million legal settlement over the use of Ingenix, a United Health Group health data subsidiary that was found to be manipulating usual and customary rate data to defraud its customers. It was as a result of this settlement that FAIR Health, Inc. was created solely to provide objective healthcare cost information to providers, patients and insurance companies. After the settlement in New York, United Healthcare rebranded Ingenix as Optum. In 2016, ambulatory surgical centers in California won a $9.5M settlement against Optum and United Healthcare for continuing the same corrupt practices.

Consequently, we recommend revising the definition of the UCR to mirror that used in New York, which is defined as:

> *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 with an insurer, a corporation subject to article forty-three of the insurance law, a municipal cooperative health benefit plan certified pursuant to article forty-seven of the insurance law, or a health maintenance organization certified pursuant to article forty-four of the public health law.*

2. Ensuring adequate insurance networks

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

[1] "Quantitate Assessment of Databases for Out-of-Network Physician Reimbursement," Final Report, NORC at the University of Chicago, May 24, 2017.

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 the Ivy Society believe 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 Pennsylvania 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. Retain a balance billing option

Section 303.(a)(1) provides that an out-of-network provider may not surprise bill the insured for any amount in excess of cost-sharing amounts that would have been imposed if the service had been rendered in-network. Banning balance billing outright is an unfair giveaway to insurance companies that forces doctors to accept artificially low reimbursements for their services. A better approach is to allow balance billing in instances when a patient has been adequately informed that they could be seeing an out-of-network provider, and instead focus on ensuring that physicians' bills and payers' reimbursements are appropriate and adequate.

4. Assignment of benefits

We applaud the legislature for including Section 303.(c)(2), as we also believe that patients who receive a surprise bill should be allowed to retroactively assign benefits to the provider. This removes them from the process of resolving billing disputes.

5. While we prefer a fee schedule based on a well-structured repository – such as FAIR Health Inc. – to settle billing disputes, should an Independent Dispute Resolution (IDR) process be used, we recommend the structure modeled after the New York law

Section 305 establishes an "Arbitrated dispute resolution" process. As stated above, we believe that an independent, third-party fee schedule should be utilized to resolve 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.

However, if Pennsylvania decides to forego this option, we would ultimately recommend the IDR process that is modeled after the New York law. Including criteria for dispute resolution is an important step in benchmarking data points for consideration by an independent entity. Determining the reasonable charge during this proceeding is integral to ensuring fair payment for services rendered. Looking at New York, the state law on independent resolution reads, "Criteria for determining a reasonable fee. In determining the appropriate amount to pay for a health care service, an independent dispute resolution entity shall consider all relevant factors, including: (c) the physician's usual charge for comparable services with regard to patients in health care plans in which the physician is not participating and (f) the usual and customary cost of the service."

We strongly recommend the utilization of a third-party claims data repository to set the fee schedule for billing dispute resolution. However, if this is not the preferred option, we urge you to model Pennsylvania's IDR process after the New York law, and to dismiss any efforts to weaken this resolution process or the criteria used therein.

We look forward to continuing to work with the Legislature on this important issue. Please do not hesitate to contact Patrick Hermes, Director of Advocacy and Government Relations, at phermes@plasticsurgery.org or (847) 228-3331 with any questions or concerns.

Sincerely,

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

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President, Robert H. Ivy Pennsylvania Society of Plastic Surgeons