AMERICAN SOCIETY OF PLASTIC SURGEONS ®
THE PLASTIC SURGERY FOUNDATION ®

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December 28, 2018

The Honorable Jeanne Shaheen
United States Senator
506 Hart Senate Office Building
Washington, D.C. 20510

RE: S.3541 – the Reducing Costs for Out-of-Network Services Act

Dear Senator Shaheen:

I am writing on behalf of the American Society of Plastic Surgeons (ASPS) regarding S.3541, the *Reducing Costs for Out-of-Network Services Act*. ASPS is the largest association of plastic surgeons in the world, representing more than 7,000 members and 93 percent of all board-certified plastic surgeons in the United States. Our mission is to advance quality care for plastic surgery 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

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

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 *Reducing Costs for Out-of-Network Services 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

The bill lacks a provision that would explicitly require assignment of benefits. 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 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 2729 (b) bans balance billing in all circumstances. 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 legislation unfairly 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 legislation directs carriers to pay providers as a maximum reimbursement rate one of: (1) 125 percent of Medicare; (2) 80 percent of the usual and customary rate (UCR) as determined by a database of usual, customary, and reasonable charges chosen by an applicable state authority and approved by the Secretary; or (3) 100 percent of the allowed in-network charges.

This approach is problematic because it would use: (1) politically-derived Medicare rates; (2) a percentage – rather than a percentile – of the UCR; or (3) already discounted in-network rates as benchmarks for out-of-network reimbursement. Medicare was conceived to provide reliable, quality care for elderly patients. Shoehorning other age groups into the Medicare paradigm – no matter how fiscally appealing – is structurally unworkable. Medicare does not even have rates for certain important areas of care (i.e., pediatrics or obstetrics). Further, surveys of insurance companies have shown that most do not use Medicare rates as benchmarks for reimbursement, and that in some states – notably Texas – balance billing complaints increased when insurers used solely Medicare for reimbursement.

Secondly, ASPS believes 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, comprised of providers who charge above the norm.

A percentile of billed amounts collected by FAIR Health is currently used in the following states, with the respective benchmarks:

- Connecticut: 80th percentile benchmark is designated as the usual customary standard for emergency services
- New York: 80th percentile of billed amounts is designated as the benchmark for consumer cost transparency and dispute resolution
- Pennsylvania: "usual and customary" standard in the state's workers' compensation program is based on the FAIR Health 85th percentile
- Alaska: 80th percentile of billed services is used as a benchmark as the usual customary standard for emergency services

In addition to the use of a percentile of billed amounts for reimbursement, insurance carriers across the U.S. are using a percentile – usually the 80th – to determine the highest level of reimbursement. For example: Aetna,[2] Emblem Health,[3] Oxford Health Plan,[4] and UnitedHealthcare[5] all use the 80th percentile of charges to reimburse out-of-network expenses for their various plans. Horizon BCBS of New Jersey currently offers group administrators options pursuant to the 70th, 80th, or 90th percentile of FAIR Health for out-of-network expenses.[6] Support for the 80th percentile paradigm has been growing outside of insurance carrier circles, where the National Council of Insurance Legislators (NCOIL) adopted model legislation that defines the "usual,

[2] https://www.humbleisd.net/cms/lib/TX01001414/Centricity/Domain/19/2017a/Medical/Aetna_pays_OutofNetwork_benefits.pdf

[3] https://www.emblemhealth.com/~/media/Files/PDF/OON_ReimburseExamples_GHI.pdf

[4] https://www.oxhp.com/secure/policy/OXHPLgGrpEx.pdf

[5] https://www.uhc.com/legal/information-on-payment-of-out-of-network-benefits

[6] https://www.horizonblue.com/members/education-center/understanding-your-coverage/out-of-network-payments

customary, and reasonable rate" as the 80th percentile of charges based on an unbiased charge database. It is clear that using the 80th percentile would be in line with current industry standards.

Finally, we believe that any rate set at an allowed amount determined by the insurance carrier lacks transparency and accountability. Providers should have access to the methodology used to determine these payments, which will not be possible as the carriers believe their methodologies are proprietary. If carriers continue to block access to those methodologies, there will be no way to hold them accountable for the numbers they provide. Following the Ingenix investigation in New York, the New York Attorney General stated that, "The Attorney General found that having a health insurer determine the "usual and customary" rate – a large portion of which the insurer then reimburses – creates an incentive for the insurer to manipulate the rate downward."[7] It would be catastrophic for providers and facilities if this rate manipulation took place on a national scale.

As the bill is currently written, it gives states a significant level of deference in deciding reimbursement rates. This is confusing because there are states that currently have out-of-network reimbursement laws in place. Any federal legislation on this topic should create a baseline for reimbursement and patient cost-sharing obligations so that there is not ambiguity at the state level. This is important, as patient safety and understanding must be at the forefront of any effort to reform out-of-network billing. Those states that have out-of-network reimbursement laws in place utilize the "greatest of" a list of options in order to determine what they deem to be fair reimbursement. When employed in a manner that includes fair reimbursement rates, the greatest of three rule reduces uncertainty for patients and providers, and increases transparency from insurance carriers.

5. Determining the fee schedule

The legislation references the usual, customary, and reasonable charge for a given service, as determined by a charge database. We applaud the inclusion of a charge database in the legislation; however, we recommend that the legislation incorporate a definition of the minimum benefit standard (MBS) – and require that it be determined by a benchmarking database maintained by a nonprofit organization specific by the Secretary of Health and Human Services. The nonprofit organization must not be affiliated, financially supported, and/or otherwise supported by the stakeholders who would be affected by this legislation. This is important 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 database is used as the baseline for resolving out-of-network payments, we urge you to include the definition of "minimum benefit standard" and "usual, customary, and reasonable rate" as outlined in our red-lined recommendations. So far, the only database we have identified that meets the standard set above 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. In turn, this allows states to avoid using opaque insurer data – a practice that often leads to lawsuit-inducing data manipulation practices on the part of insurers, like what occurred with Ingenix – and protects American citizens from being exposed to potential corruption.

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

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 reimbursements from public payers 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.

6. Clearly address ERISA plans

While we continue to urge caution regarding the need for legislation in this area, if Congress opts to act, we urge you to ensure that there is consistency among all insurance products regarding the surprise billing practices within the state. As states have begun to address the topic, providers have found it difficult to maintain compliance when it is unclear which plans are subject to the new rules and regulations. This is particularly relevant with respect to self-insured ERISA plans, which are generally exempt from state law. Therefore, we urge you to clearly address surprise billing for health plans regulated by ERISA and, in doing so, ensure that those plans are treated similarly to other plans within the state. 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.[8] 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.

For these reasons, while we understand your legislation is intended to address the uninsured and the individual insurance market, with grants to work toward addressing the group market, we urge Congress to take a more comprehensive approach in this policy area to provide consistency to aid in provider compliance.

7. Remove the clarification clause under PDF at 6, lines 18-22

(5) Clarification – PDF at 6, lines 18-22 – reads:

> *In selecting a rate under paragraph (1) or (2) for a health care service, the applicable state may select a rate that differs from the rate selected under such paragraph for a different health care service.*

Given that part of the intent of the legislation is to eliminate surprise bills and diminish confusion surrounding how those bills are determined, we recommend striking this clause. As the bill is currently written, it gives states a significant level of deference in deciding reimbursement rates. This is confusing because there are states that currently have out-of-network reimbursement laws in place. Any federal legislation on this topic should create a baseline for reimbursement and patient cost-sharing obligations so that there is not ambiguity at the state level. This is important, as patient safety and understanding must be at the forefront of any effort to reform out-of-network billing. Those states that have out-of-network reimbursement laws in place utilize the "greatest of" a list of options in order to determine what they deem to be fair reimbursement. When employed in a manner that includes fair reimbursement rates, the greatest of three rule reduces uncertainty for patients and providers and increases transparency from insurance carriers.

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

We appreciate the work you are doing to look at the cost of healthcare in America and specifically on the impact of surprise insurance gaps on patients. We are also aware of the legislation that Senator Hassan has introduced. As out-of-network billing is emerging as a significant area of federal focus, ASPS believes that a more comprehensive, cohesive piece of legislation would be a better starting point. Therefore, we strongly urge you to amend the legislation as outlined above to ensure that protecting American patients is truly Congress' priority.

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.

Sincerely,

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