AMERICAN SOCIETY OF PLASTIC SURGEONS ®
THE PLASTIC SURGERY FOUNDATION ®

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December 28, 2018

The Honorable Margaret Hassan
United States Senator
330 Hart Senate Office Building
Washington, D.C. 20510

RE: S.3592 – the No More Surprise Medical Bills Act

Dear Senator Hassan:

I am writing on behalf of the American Society of Plastic Surgeons (ASPS) regarding S.3592, the *No More Surprise Medical Bills 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 program, and the URAC Accreditation for Marketplace Plans – when 82 FR 18346 was finalized and were left

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

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 *No More Surprise Medical Bills 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

While ASPS appreciates the language that requires any payments made by insured individuals to count against their annual deductibles, the bill lacks explicit language that would hold patients harmless and direct carriers to reimburse providers directly. 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 (c) bans balance billing for emergency services. 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 bill unfairly favors insurance companies and forces doctors to accept artificially low reimbursements for their services. Instead, as noted above, 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. Patients must understand their potential to receive care from out-of-network providers, and ASPS believes payers, facilities, and providers are all responsible for communicated network-related information. Therefore, we appreciate that the legislation includes this billing option when a patient has been adequately informed. 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

S.3592 directs carriers and providers to negotiate payment for out-of-network services via an independent dispute resolution (IDR) process. If negotiations do not yield an agreement, the bill directs carriers to offer to pay a healthcare professional the "amount the plan or issuer determines reasonable for the services (less the cost-sharing amount paid by the individual enrolled in the plan and coverage)."

This approach is problematic for several reasons. First, the legislation lacks a clear definition of what would constitute "reasonable reimbursement." Second, the lack of clear parameters for the reasonable reimbursement amount for unanticipated out-of-network care could lead to overreliance on the proposed IDR process.

Using Medicare as a benchmark is problematic because Medicare rates – which are politically-derived and have little or no relation to the cost of providing care – are notoriously low. Medicare was conceived to provide reliable, quality care for elderly, disabled, and end-stage renal disease patients. Shoehorning other patient 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). This is apparent from a lack of the full range of services in the official American Medical Association (AMA) Current Procedural Terminology (CPT) codes, which federal regulation requires be used in billing and record-keeping. Moreover, not only do Medicare rates not include certain segments of the patient population, they also have historically been manipulated to favor and/or encourage specific types of care rather than others (e.g., primary care rather than specialized services). Lastly, Medicare fees are capped, which leads to situations where the program reimburses providers less than cost. As things currently stand, using Medicare rates as benchmarks for fair and timely payment is not a viable solution.

Moreover, 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."[2] It would be catastrophic for providers and facilities if this rate manipulation took place on a national scale.

Instead of using Medicare rates or allowed amounts determined by insurers, 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

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

lower than the presented amount. This eliminates the outliers by removing the upper 20 percent, comprised of providers who charge above the norm.

The following percentiles of billed amounts collected by FAIR Health are currently used in the following states:

- 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,[3] Emblem Health,[4] Oxford Health Plan,[5] and UnitedHealthcare[6] 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.[7] 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, 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.

5. Determining the fee schedule

The legislation also fails to reference the usual, customary, and reasonable charge for a given service. Therefore, 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." 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

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

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

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

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

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

insurers, like what occurred with Ingenix – and protects American citizens from being exposed to potential corruption.

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.

That said – if the use of a third-party fee schedule is not viable, we strongly recommend that the definition of minimum benefit standard is added to the list of factors utilized during the IDR process for determining the base reimbursement. The bill also restricts states who currently use IDR processes to a payment ceiling of 125 percent of Medicare. For the reasons stated above, that provision should be removed from the bill. Furthermore, we urge you to exclude the in-network rate and the Medicare rate as factors that may be used as reimbursement benchmarks.

Equally important to ensuring fair payment is the need for timely resolution of payment disputes. As S.3592 is currently written, the entire arbitration process could last over well over 100 days. Creating a process that would last over 100 days is not viable for physicians who are in small practices. Small practices tend to operate with tighter margins than larger practices and any process that negatively affects cash flow will decimate American solo medical practices. Therefore, we urge you to include specific date benchmarks for physicians to receive fair payment as outlined above. One example that the bill should consider is New York, where an IDR entity is required to make a determination within 30 days of receipt of the dispute. That definitive timeline helps ensure that physicians are reimbursed in a timely manner following payment disputes, thus preventing the bill from adding to the already burdensome practice climate that many small practices deal with daily.

6. Maintain consistent rules across 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 because 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.

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

For these reasons, we urge caution with the pre-emption language under subparagraph (g) of your bill. While we understand that the goal is to allow state laws to continue with the new federal floor, we fear that this process will add an unnecessary layer of complexity and compound the confusion regarding the specific rules and regulations for various plans.

We appreciate the work you are doing to look at the cost of health care in America and specifically on the impact of surprise insurance gaps on patients. We are also aware of the legislation that Senator Shaheen 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 S.3592 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