AMERICAN SOCIETY OF PLASTIC SURGEONS
THE PLASTIC SURGERY FOUNDATION
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WSPS
WASHINGTON SOCIETY of PLASTIC SURGEONS

Northwest Society of Plastic Surgeons

February 28, 2018

The Honorable Cyrus Habib, *President*
The Honorable Karen Keiser, *President Pro Tempore*
Washington State Senate
Olympia, WA 98504

RE: H.B. 2114

Dear President Habib and President Pro Tempore Keiser:

On behalf of the Washington Society of Plastic Surgeons (WSPS), the Northwest Society of Plastic Surgeons (NWSPS) and the American Society of Plastic Surgeons (ASPS), we are writing in opposition to H.B. 2114. The Washington Society of Plastic Surgeons is the largest association of plastic surgeons in the state, and in conjunction with our regional and national affiliates – the NWSPS and ASPS, represent 141 board-certified plastic surgeons in Washington. 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' official Position Statement on Out of Network Billing. This detailed analysis focuses on ways to ensure that patients are: (1) properly informed about the costs associated with their medical care; and (2) removed from patient disputes.

1. The measure does not ensure 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 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 Washington 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.

2. The measure does not allow patients to choose to see out-of-network providers

NEW SECTION. Sec. 5 provides that:

> *(1) An out-of-network provider or facility may not balance bill a covered person for the following healthcare services:*
> *(a) Emergency services provided to an enrollee; and*
> *(b) Nonemergency health care services provided to an enroleee at an in-network hospital licensed under chapter 70.41 RCW or an in-network ambulatory surgical facility licensed under chapter 70.230 RCW if the services:*
> *(i) Involve surgical or ancillary services; and*
> *(ii) Are provided by an out-of-network provider.*

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.

3. The measure does not allow for assignment of benefits

We urge the legislature to include language that requires payments for out-of-network services to be paid directly from insurers to providers. In some cases, when patients receive a check from an insurer, they do not immediately recognize it is 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.

4. The measure will be a financial windfall for insurance companies

NEW SECTION. Section 6 would force physicians to accept the greater of: (1) the median allowed in-network rate; (2) the median paid out-of-network rate; or (3) 175 percent of Medicare. These approaches are all flawed methodologies as they (1) discount an already-discounted in-network rate, (2) rely on the carriers to determine the "average" which is subject to manipulation, (3) would utilize an all-payer claims database that does not yet exist, and (4) Medicare rates – which are politically-derived and have little or no relation to the cost of providing care – are notoriously low. Furthermore, we are concerned with the recent addition of language that would allow carriers to reimburse for a "similar service" to the service that was provided by a physician, as this creates the potential for further rate manipulation by insurers.

NEW SECTION. Section 7 establishes an arbitration process, which is a costly and burdensome solution to resolving billing disputes.

In both of these sections, we believe that an independent, third-party fee schedule should be utilized. 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 ask that Washington state adopt this definition for "usual and customary cost" to set the fee schedule for resolving billing disuputes as an alternative to arbitration.

For the reasons listed above, we strongly urge you to oppose H.B. 2114. Thank you for your consideration of our comments. Please do not hesitate to contact Patrick Hermes, ASPS' Director of Advocacy and Relations, with any questions at phermes@plasticsurgery.org or (847) 228-3331.

Sincerely,

Washington Society of Plastic Surgeons
Northwest Society of Plastic Surgeons
American Society of Plastic Surgeons

cc: Members, Washington State Senate

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