AMERICAN SOCIETY OF PLASTIC SURGEONS ®
THE PLASTIC SURGERY FOUNDATION ®

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February 11, 2019

The Honorable S. Chris Jones
Chairman, Committee on Appropriations
Virginia House of Delegates
900 East Main Street
Richmond, VA 23219

The Honorable R. Steven Landes
Vice Chairman, Committee on Appropriations
Virginia House of Delegates
900 East Main Street
Richmond, VA 23219

RE: In support of S.B. 1763

Dear Chairman Jones and Vice Chairman Landes:

I am writing on behalf of the American Society of Plastic Surgeons (ASPS) urging you to support S.B. 1763. ASPS is the largest association of plastic surgeons in the world, representing more than 93 percent of all board-certified plastic surgeons in the United States – including 205 board-certified plastic surgeons in Virginia. 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.

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.

1. Remove patients from billing disputes

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. Therefore, we appreciate that the legislation removes patients from billing disputes and requires insurers to pay providers directly.

2. Provide appropriate reimbursement for emergency care

We understand that concessions must be made to ensure that patients do not bear the burden of excessive emergency department expenses and appreciate the legislation's efforts to adequately reimburse providers for their service through the "regional average of commercial payers," which is defined as paid and accepted claims data by an independent non-profit. We thank the legislature for removing Medicare, TRICARE, and Medicaid data from this repository as reimbursement for these services are not based on market indicators and are instead derived based on budgetary and regulatory constraints. Finally, we support the use of 2017 data adjusted based on CPI so that the information remains unbiased and cannot be manipulated.

3. Retain a balance billing option for non-emergent conditions

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. Ensure adequate insurance networks

While this legislation does not address insurance network adequacy, we encourage the legislature to consider addressing this issue in future measures in an effort to wholistically address this issue. To be certain that patients have in-network access to necessary specialty care providers, though, we urge Virginia 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.

While we strongly recommend that Virginia adopt stricter network adequacy standards, we support the legislation as it is currently written. S.B. 1763 will help protect patients while also ensuring that physicians are reimbursed fairly.

Thank you for your consideration of our comments. Please do not hesitate to contact Patrick Hermes, Director of Advocacy and Relations, at phermes@plasticsurgery.org or (847) 228-3331 with any questions.

Sincerely,

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

cc: Members, Committee on Appropriations