



AMERICAN SOCIETY OF
PLASTIC SURGEONS®



THE PLASTIC SURGERY
FOUNDATION®

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February 12, 2020

The Honorable Richard Neal, Chair
House Committee on Ways & Means
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Kevin Brady, Ranking Member
House Committee on Ways & Means
1139 Longworth House Office Building
Washington, DC 20515

RE: Amend the Consumer Protections Against Surprise Medical Bills Act

Dear Chairman Neal, Ranking Member Brady, and members of the Committee on Ways and Means:

The American Society of Plastic Surgeons (ASPS) opposes the *Consumer Protections Against Surprise Medical Bills Act* as introduced and respectfully requests that you amend it during committee markup. In your press release announcing the proposal, Chairman Neal and Ranking Member Brady, you described the proposal as seeking to “create a more balanced negotiation process to encourage all parties to resolve their reimbursement differences before using the streamlined and fair dispute resolution process.” Because your proposal still ultimately relies on the median in-network rate as a benchmark for what is considered a reasonable payment and because it contains a fundamentally imbalanced set of rules about what information should be part of the dispute resolution process, it falls short of that goal.

While your Committee has worked diligently to produce a solution to unanticipated medical bills and while there are a number of positive steps taken in it that do more than other proposals to protect and inform patients, we believe it still falls short of the solution patients deserve. To remedy this, we urge you to amend the bill by:

- changing the structure of the open negotiation and mediated dispute process from their current forms, which are heavily biased toward insurance companies, to one that allows for consideration of all factors that are relevant to each party in the dispute.
- adding true network adequacy standards and real consequences for insurance companies who have poor networks and/or inaccurate network information.

Improve the open negotiation process to prevent the further erosion of physician negotiation power

As proposed, the *Consumer Protections Against Surprise Medical Bills Act* contains an open negotiation period in which payers and providers can resolve a payment dispute prior to the onset of mediation. We support this approach and appreciate your efforts to facilitate a truly market-based payment. That said, we believe (1) the open negotiation process will be rendered ineffectual by the structure of the subsequent mediated dispute process, as detailed in the next section, and (2) the open negotiation process requires physicians to divulge information that is not relevant to the market value of their services and will give insurers even more leverage over providers in their network contracting negotiations.

Specifically, the proposal requires at the start of open negotiation that insurers provide the physician with the median contracted rate for the disputed service and that physicians provide insurers with the median of their contracted rates with all payers for the disputed service. It is totally appropriate for insurers to provide physicians with their median in-network rate because that rate will be the basis by which the payer determines its proposed payment for the disputed service.

However, to require physicians to provide details to an adversarial party on the outcome of its negotiations with other adversarial parties represents a serious erosion of the integrity of future physician/payer negotiations. This provision, located in Section 7, is tantamount to giving insurers information that they would only otherwise be able to acquire through collusive activities with other payers that would certainly represent anti-trust violations if they were to happen without Congress' blessing. Insurers will be able to identify where they can lower their offers to physicians below amounts that those payers might otherwise deem reasonable, and this will lead to a race-to-the-bottom in the quality of insurance networks.

Remove the extensive pro-insurer bias in the mediated dispute process

As noted above, the mediated dispute process will ultimately render the open negotiation process meaningless because payers know that the mediation process is set up to color a mediator's review in a way that will make the median in-network rate appear to be "reasonable." Specifically, the mediator is required to consider the median in-network rate (a data point that one party in the dispute, the payer, views as reasonable) and specifically prohibited from considering any charge-based data points (those that the other party in the dispute, the physician, considers reasonable).

An in-network rate is determined only by the insurance company, with no outside input from the federal government, providers, or patients as to whether the methodology is representative of the cost of care. These amounts are calibrated for in-network physicians and adjusted down to reflect the increased access to patients, decreased billing disputes, and more timely payment those providers receive. In other words, physicians receive non-financial benefits, and in exchange, insurance companies get to pay us a deeply discounted rate.

Basing payments on that rate outside of that contracting environment forces nonparticipating providers who were unable to reach a fair deal to accept a discounted rate with none of the aforementioned benefits. This is coercive contracting, and it disrupts the contracting environment. Because its ultimate endpoint for resolving reimbursement disputes revolves around the median in-network rate, this legislation is a gift to the for-profit insurance industry. It does not make sense, and is one-sided, to set reimbursement based on unilaterally-controlled rates determined by whatever the insurers want to pay. This approach is particularly worrisome when considered in light of the insurance industry's history of data manipulation and restriction of patients' access to care.¹

¹ A sampling of citations of carrier rate manipulation and inappropriately restrictive behavior:

1. http://s3.amazonaws.com/fcmd/documents/documents/000/003/228/original/UnitedHealth_Group_-_NYAG_OON_Investigation_NYAGPR.pdf?1426791839
2. <https://www.managedcaremag.com/archives/2009/5/ingenix-aftermath>
3. <https://www.motleyrice.com/article/cigna-medical-upcharge-claims>
4. <https://khn.org/news/medicare-advantage-overbills-taxpayers-by-billions-a-year-as-feds-struggle-to-stop-it/>
5. <https://www.homecaredaily.com/2017/10/25/cigna-facing-claims-committed-fraudulent-billing-least-one-client/>
6. <https://www.fiercehealthcare.com/payer/cigna-cost-shifting-second-suit-american-specialty-health-lawsuits>
7. <http://www.startribune.com/federal-judge-says-unitedhealthcare-medicare-fraud-case-can-move-forward/473851213/>
8. <https://news.bloomberglaw.com/health-law-and-business/unitedhealth-subsiary-optumrx-sued-for-30-million-in-ohio>
9. <https://www.lawyersandsettlements.com/legal-news/health-insurers-denying-medical-claims-bad-faith/united-healthcare-faces-class-action-lawsuit-arbitrary-therapy-p-23010.html>
10. <https://www.bna.com/unitedhealth-hit-again-n57982082861/>
11. <https://www.cnn.com/2019/03/06/health/unitedhealthcare-ruling-mental-health-treatment/index.html>
12. <http://avym.com/blue-cross-blue-shield-il-sued-for-fraud-robbing-chicago-taxpayers/>

The structure of a dispute resolution system is critically important. It needs to allow appropriate factors to be considered, and it needs to be benchmarked to an appropriate rate so that the review process is balanced. Having the benchmark considered by the mediator be the median in-network rate is not balanced. This imbalance is deepened by the prohibition on the inclusion of any charge-based data.

Ultimately, this dispute resolution structure will completely alter the physician-insurer negotiation process (both inside and *outside* of out-of-network disputes) by removing any incentive for the carrier to negotiate in good faith during contract discussions. This *has happened* in California, and network adequacy has suffered.² Any federal solution must require the carrier to make an initial reasonable payment based on market value, *a la* the New York model. If that is the structure, and a legitimate route to appealing unfair payment is in place, you will see instances of surprise billing plummet and low rates of arbitration. This *has happened* in New York.³

Institute strong network adequacy and transparency provisions

State laws on network adequacy vary greatly in requirements, enforcement, and philosophy. Since the promulgation of 82 FR 18346 in April 2017⁴ – a rule that all but abdicated the federal government’s network adequacy enforcement responsibility to the states and private organizations – there are virtually no federal mechanisms to ensure states appropriately protect patient access to high-quality care through high-quality insurance products. Enforcing network adequacy requirements is essential to protecting American healthcare consumers, and it is essential to reducing patient encounters with out-of-network providers. Network adequacy standards stop insurers from creating even-narrower networks that prevent patients from receiving the necessary specialty and subspecialty care they need when they need it.

To ensure that patients have in-network access to necessary specialty care providers, we ask that the Committee amend the proposal to reverse 82 FR 18346 and incorporate specific, quantitative standards that require insurers to:

- **Design adequate networks** with a specific minimum number of active primary care and specialty physicians available by reasonable time and distance standards, adjusted by appropriate population density and geographically-impacted factors;
- **Promote transparency** by providing accurate and timely fee schedules to patients and physicians;
- **Ensure patient choice** by offering out-of-network options when their network does not offer access to 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, or when insurers fail to maintain accurate and timely physician directories, **insurers should compensate those providers at their full fee.** In these cases, the insurer has created an inadequate network, and they, not the patient, should bear the entire responsibility of ensuring patient access outside what is available in the network.

The *Consumer Protections Against Surprise Medical Bills Act* must not pass in its current form. It does not currently offer the comprehensive solution to unanticipated medical expenses that patients deserve, but we believe it is close. We strongly encourage the Committee to continue the substantial progress that has been made on this issue and incorporate the recommended changes included in this letter. Doing so will finally produce the truly equitable solution that you have worked so hard to find.

² <https://www.cmadoocs.org/Portals/CMA/files/public/CMA%20Suprise%20Billing%20Survey%20Results%202019.pdf>

³ <https://georgetown.app.box.com/s/6onkj1jaiy3f1618iy7j0gpzdoew2zu9>

⁴ <https://www.federalregister.gov/documents/2017/04/18/2017-07712/patient-protection-and-affordable-care-act-market-stabilization>

Thank you for your consideration of our concerns and for your efforts to address this very difficult issue. Please do not hesitate to contact Patrick Hermes, Director of Advocacy and Government Relations, at phermes@plasticsurgery.org or (847) 228-3331 to request any additional information or with any questions.

Sincerely,

A handwritten signature in black ink that reads "Lynn Jeffers". The signature is written in a cursive, flowing style.

Lynn Jeffers, MD, MBA, FACS
President, American Society of Plastic Surgeons

cc: Members of the House Committee on Ways and Means