



AMERICAN SOCIETY OF
PLASTIC SURGEONS®



THE PLASTIC SURGERY
FOUNDATION®

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May 28, 2019

The Honorable Frank Pallone, Jr.
2107 Rayburn House Office Building
Washington, DC 20515

The Honorable Greg Walden
2185 Rayburn House Office Building
Washington, DC 20515

RE: No Surprises Act – Discussion Draft Response

Dear Chairman Pallone and Ranking Member Walden:

On behalf of the American Society of Plastic Surgeons (ASPS), we thank you for this opportunity to provide greater insight into the ways in which plastic surgeons and their patients are affected by out-of-network care. 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 patients and promote public policy that protects patient safety.

Before we answer specific questions outlined in your May press statement, we would like to first provide insight into why these billing practices occur. In recent years, insurers have created products with narrow, inadequate, and non-transparent provider networks. Many of these plans also offer low monthly premiums in exchange for high annual deductibles. Unfortunately, patients rarely understand these terms, let alone how they will be charged for their cost-sharing responsibilities, causing confusion when the patient is balance billed.

While there is no excuse for the failure of insurance companies to educate patients about the limitations of their policy, we believe that patients deserve to be protected – especially for out-of-network emergency care. With these dynamics in mind, we offer the following solutions to safeguard patients and ensure they have access to the necessary specialty care they require:

Ways to help consumers better understand their health plans and which providers are in their network.

In purchasing their health insurance policy, a patient relies on their health insurance plan for accurate information to help guide their health care decisions. As such, insurers should take the lead in protecting their customers from unanticipated bills by clearly articulating the patient's cost-sharing responsibilities, including any copays, deductibles, and/or coinsurances. Plans should educate patients about the limitations of their policy and whether the plan will cover out-of-network care and, if so, at what percentage. The patient should be explicitly informed that they will be responsible for the remaining expenses, regardless of their monthly premium.

We believe insurers need to make available a truly up-to-date provider directory via the internet and be held accountable for decisions made based on the contents of those 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. This information is essential as providers and patients anticipated out-of-pocket expenses and assess whether to seek in-network and out-of-network care. As such, insurers should

take the lead in protecting their customers from surprise bills by providing enrollees, at every critical juncture, with notice that includes network status information, warns that they might be billed for the balance of the provider's fee, lists all of the plans' participating providers, flags any request for pre-certification of services submitted by an out-of-network provider, details potential enrollee payment responsibilities, and explains the enrollee's right to assign future payments to out-of-network providers.

That said, we believe that facilities and providers should also play a role in ensuring that patients are aware of network participation prior to elective care. Facilities, such as hospitals, are well-positioned to inform patients of potential interactions with out-of-network providers and offer patients an opportunity to adjust their treatment plan. Facilities should provide patients with access to a directory of employed providers and those with privileges, as well as the providers contact information. The facility can easily post information on which plans it participates with, thus offering full transparency to the patient on the facility's network status.

It is incumbent upon all physicians to inform a patient prior to nonemergent treatment if a provider does not participate in the patient's network. In recent years, this has become common practice through the use of a single page informed consent. This initial conversation allows the patient to make an educated decision to receive care from the provider at their own expense or choose to see another provider who participates in their network.

Opportunities to ensure that networks sufficiently meet the needs of patients.

Patients purchase health insurance to ensure that they have access to necessary medical care. While most plans offer access to primary care services, access to specialty care is often limited by the insurer in an effort to drive profit through reduced costs. Limited access to in-network providers requires patients to receive medically necessary care out-of-network. However, this can be alleviated through stronger network adequacy requirements, and we thank you for recognizing the undeniable connection between network adequacy and out-of-network medical care.

Current state-level network adequacy standards differ greatly 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 2017¹ – 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 concerned that specialty and subspecialty physicians were not accurately nor adequately captured in network adequacy standards. Nothing has happened in the last 24 months to address those concerns. Therefore, to be certain that patients have in-network access to necessary specialty care providers, we urge you to reverse 82 FR 18346 and instead incorporate specific, quantitative standards within the *No Surprises Act* that require insurers to:

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

- 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.

Approaches to aid states in developing robust all-payer claims databases.

We appreciate your interest in identifying a fair and comprehensive claims database that can assist the Secretary in determining payment methodology, as mentioned in the *No Surprises Act*. However, we believe that state-run all-payer claims databases (APCDs) are not the appropriate tool to reference and analyze claims, especially because – as highlighted below – state-run APCDs lack uniform data sets and access processes.

Currently, these databases are “all-payer” in name only, as the United States Supreme Court struck down employer-sponsored health plans’ reporting requirements in *Gobeille v. Liberty Mutual*. In *Gobeille*, the Court concluded that, “Preemption is necessary to prevent States from imposing novel, inconsistent and burdensome reporting requirements on plans.”² Therefore, Congress would need to revise the Employee Retirement Income Security Act of 1974 (ERISA) further in order to allow APCDs to capture the necessary information to truly create a database that would reflect fair market value for physician services.

Furthermore, including any APCD that considers CMS payments would not be a fair representation of provider reimbursement, as those rates are politically-derived and notoriously low. For example, Medicare was conceived to provide reliable, quality care for elderly, disabled, and end-stage renal disease patients. 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 (i.e., primary care rather than specialized services). Lastly, Medicare fees are finite, which leads to situations where the program reimburses providers less than cost. As things stand, allowing these rates to be included in APCDs and then using APCD information to determine out-of-network benchmarks would be inappropriate.

As Congress seeks to determine a nationwide standard benchmarking database, it should not promote wasting state and federal governmental resources when reputable nonprofit entities are already doing the work. Rather than using a piecemeal approach, we suggest the utilization of an independent nonprofit

² https://www.supremecourt.gov/opinions/15pdf/14-181_5426.pdf

organization that is not affiliated, supported financially, and/or otherwise supported by the stakeholders that would be affected by this legislation. So far, the only database that we have identified that meets the standard set above is FAIR Health, Inc. (FAIR Health).

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. Moreover, when analyzed vis-à-vis APCDs, FAIR Health was found to have the largest and most geographically widespread database.³ These factors enable FAIR Health to produce relevant, reliable, and regionally-specific cost information. This in turn allows states to avoid using opaque insurer data – a practice that often leads to lawsuit-inducing data manipulation practices on the part of insurers – and protects American citizens from being exposed to potential corruption.

Processes to adequately reimburse providers for out-of-network care through a transparent, non-inflationary mechanism.

We believe that patients need to be protected, especially for emergency care in which the patient was not able to make an informed choice about their healthcare provider. ASPS is a strong advocate for holding patients harmless and does not believe that recipients of out-of-network emergency care should be billed directly for services. Instead, federal law should require an automatic assignment of benefits for all out-of-network emergency care, so physicians can negotiate appropriate reimbursement directly with carriers. Through an assignment of benefits, a patient is completely removed from the billing process – the ultimate goal of this legislation. We thank you for requiring carriers to directly reimburse providers within the *No Surprises Act*.

The 2015 New York surprise billing law has a proven track record of successfully navigating the assignment of benefits, while adequately reimbursing the provider for their services. We encourage you to reference New York as the model for federal policy as recent claims analysis demonstrates a 34 percent decrease in out-of-network billing in New York since the law's implementation.⁴ Furthermore, 57 percent of New York patient calls to the state's consumer help line for unanticipated balanced bills were resolved due to the law's protections.⁵ Similar results nationwide would curb the issue this policy is trying to address.

Another area where the *No Surprises Act* would benefit from an approach closer to the New York model is initial reimbursement to nonparticipating providers for accidental out of network care. Currently, the proposal sets this at the median contracted rate. This is, in fact, a decidedly payer-skewed starting point. It is a rate specifically set below market value because it comes as the product of a negotiation that provides physicians offsetting benefits. This is why "allowed amounts" – contracted rates – are lower than physician charges.

Using that as the initial frame of reference going into the independent dispute resolution process is going to bias that process in favor of payers, making a reasonable physician charge look unnaturally high because

³ NORC at the University of Chicago. "Final Report: Qualitative Assessment of Databases for Out-of-Network Physician Reimbursement." April 18, 2017.

⁴ Cooper Z, Scott Morton F, et al. *Surprise! Out-of-Network Billing for Emergency Care in the United States*. New Haven, CT: Yale University, March 2018, https://isps.yale.edu/sites/default/files/publication/2018/03/20180305_oon_paper2_tables_appendices.pdf

⁵ Benjamin E. "New York Surprise Bill Law: The Consumer Perspective and Ongoing Challenges." (Presentation for NYS Health Foundation, October 29, 2018).

the “recognized amount” is artificially low. Carriers should instead be asked to make an initial reasonable payment based on market value. The New York law encourages appropriate payment without explicitly defining it, and parties only enter into the state’s independent dispute resolution (IDR) system if the payment is not reasonable. However, IDR is generally a deterrent for both parties and therefore reasonable payment is generally offered to avoid arbitration. In point of fact, only 1,571 claims were arbitrated in 2018 through the New York state IDR.

When reasonable payment that reflects market value is not offered, a benchmark is necessary to help an independent arbiter determine adequate reimbursement. ASPS believes the 80th percentile of *billed* amounts is representative of the market rate for out-of-network physicians who have been unable to fairly contract with the carrier. The 80th percentile of a third party, independent charge database, such as FAIR Health Inc., means that 80 percent of all charges are equal to or lower than the presented amount. This results in the outliers – the highest 20 percent of all charges – being removed from consideration.

Many states are already using a percentile of billed amounts collected by FAIR Health, including:

- Connecticut: 80th percentile of billed amounts is utilized as the benchmark for 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” is defined as 85th percentile of billed amounts for in the state’s workers’ compensation program; and
- Alaska: 80th percentile of billed amounts is used as the benchmark for the usual customary standard for emergency services.

Insurance carriers across the U.S. are currently using a percentile – usually 80th – to determine appropriate reimbursement for out-of-network expenses, including Aetna,⁶ Emblem Health,⁷ Oxford Health Plan,⁸ and UnitedHealthcare.⁹ Support for the 80th percentile paradigm has also been adopted by the National Council of Insurance Legislators (NCOIL) within its model legislation, which defines the “usual, customary, and reasonable rate” as the 80th percentile of billed amounts based on an unbiased charge database. Clearly, the 80th percentile is in line with current industry standards.

As noted above, we strongly oppose any reimbursement model that bases physician payment on allowed amounts, including the proposed payment model within the *No Surprises Act*. Allowed amounts are determined only by the insurance company, with no outside input from the federal government, providers, or patients on whether the methodology is representative of the cost of care. Since insurance companies claim that their methodologies are proprietary, we will never know how they determine these allowed amounts. Even if you prescribe a methodology, you’re still relying on payers to assess or provide claims data. They have a long, long history of fraudulently manipulating that.¹⁰

If carriers continue to block access to those methodologies, there will be no way to hold them accountable for the reimbursement they offer. Following the Ingenix investigation in New York, the New York Attorney General “found that having a health insurer determine the ‘usual and customary’ rate – a large portion of

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

7 [https://www.emblemhealth.com/~media/Files/PDF/OON_ReimburseExamples_GHI.pdf](https://www.emblemhealth.com/~/media/Files/PDF/OON_ReimburseExamples_GHI.pdf)

8 <https://www.oxhp.com/secure/policy/OXHPLgGrpEx.pdf>

9 <https://www.uhc.com/legal/information-on-payment-of-out-of-network-benefits>

10 <https://www.nytimes.com/2012/04/24/nyregion/health-insurers-switch-baseline-for-out-of-network-charges.html>

which the insurer then reimburses – creates an incentive for the insurer to manipulate the rate downward.”¹¹ It would be catastrophic if this rate manipulation took place on a national scale.

Furthermore, allowed amounts are only intended to reimburse in-network providers, who receive increased access to patients, decreased billing disputes, and more timely payment in exchange for this agreed upon amount. Keep in mind that the agreed upon amount is different for every physician, even within the same specialty and within the same county, as it takes into account a host of other factors. Utilizing a percentile of allowed charges, which is aggregated among all in-network providers, forces nonparticipating providers who were unable to fairly contract to accept a discounted rate with none of the benefits.

This dynamic leaves the provider at the will of the carrier and removes all incentives for the carrier to offer fair reimbursement, since the carrier ultimately has final say on the reimbursement amount. This is not equitable, especially since 61% of ASPS plastic surgeons are solo or in group practices of between two and five physicians. As small businesses, these practices already face an uphill battle during contract negotiations with the carriers. A predetermined out-of-network payment rate set on allowed amounts would remove much of the negotiating power left for these small businesses and leave many of physicians with limited leverage in contract discussions with large health insurance carriers.

We also want to take this opportunity to thank you for excluding Medicare from consideration as a possible physician reimbursement benchmark. As noted above, utilizing Medicare rates for private payer insurance is structurally unworkable, especially since Medicare does not have rates for certain important areas of care (i.e., pediatrics or obstetrics). Moreover, Medicare often reimburses providers at less than the cost for many services. Providers continue to accept Medicare patients in their commitment to serve their communities. However, they are able to care for these patients, even at a loss, because this loss is balanced by the appropriate reimbursement provided by private insurance. If private insurance is permitted to base reimbursement on Medicare rates, it will be increasingly challenging for physicians to make ends meet.

OTHER RECOMMENDATIONS

Ensure patient choice and retain a balance billing option for elective care.

Balance billing should be permitted for elective care as long as the patient is adequately informed about the provider’s status and the patient’s financial obligation. As we mentioned previously, this information should be offered to the patient within a single page informed consent. This initial conversation allows the patient to make an educated decision to receive care from the provider at their own expense or choose to see another provider who participates in their network. This practice allows patients to make informed health care decisions and fosters greater access to care. We thank you for also recognizing the importance of these patient notifications within the *No Surprises Act*, but encourage you to expand this right to all providers who have direct interactions with the patient, including plastic surgeons.

Clearly address ERISA plans

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.¹² 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

¹¹ <https://ag.ny.gov/press-release/attorney-general-cuomo-announces-historic-nationwide-reform-consumer-reimbursement>

¹² <https://www.kff.org/report-section/ehbs-2017-section-10-plan-funding/>

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. However, if federal policy is to be effective in addressing the instance of unanticipated medical bills, we strongly believe any federally enacted policy must apply to ERISA plans.

We appreciate this opportunity to provide insight and recommendations as you develop legislation that protects patients and fairly affects health care stakeholders. We look forward to working with you throughout this process and providing further guidance, as requested. This is a very important issue for plastic surgery patients and our members nationwide, and we hope we can be a resource to you as you develop policy. 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 "Alan Matarasso, MD". The signature is written in a cursive style with a large initial "A".

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

cc: Members, House Committee on Energy and Commerce