



AMERICAN SOCIETY OF
PLASTIC SURGEONS®



THE PLASTIC SURGERY
FOUNDATION®

Executive Office

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June 24, 2019

The Honorable Lamar Alexander
455 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Patty Murray
154 Russell Senate Office Building
Washington, DC 20510

RE: OPPOSE - Title I: End Surprise Medical Bills Act, within the Lower Health Care Costs Act

Dear Chairman Alexander and Ranking Member Murray:

On behalf of the American Society of Plastic Surgeons (ASPS), we are writing to express our profound concern with the Lower Health Care Costs Act and the subsequent manager's amendment, which was introduced June 24. Title I of each measure will fundamentally change the balance of power within carrier-provider contract negotiations and will institute government rate setting for medical services. Provisions within Title I will negatively affect access to care, especially in rural settings that already face physician workforce shortages. We do not believe that Title I is the comprehensive solution to unanticipated medical bills that patients deserve and urge you to withdraw these provisions and instead work with the provider community to identify pragmatic solutions to this issue.

As 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, it is our responsibility to advance quality care for patients and promote public policy that protects patients. We have stayed true to that as the Senate has worked to develop comprehensive solutions to this problem, and ASPS has been a committed stakeholder that provided constructive feedback to the Senate Working Group, led by Sens. Cassidy and Hassan. Because of that good faith support, we are deeply discouraged by the fact that this bill shows such overwhelming bias in favor of insurance companies and disregard for the serious concerns raised repeatedly by the provider community. We remain highly concerned about the ramifications of the following provisions and therefore must oppose this legislation unless amended:

Oppose the ban on consciously chosen out-of-network elective care

We believe patients should be removed from billing disputes between providers and carriers, and we support policies that require an automatic assignment of benefits for emergency out-of-network care. However, the provider should be able to directly bill the patient for *elective* care in which the patient can fully research their health care options and make informed decisions. The original version of the bill only allows patients to knowingly select out-of-network care once the patient is stabilized following emergency care. This choice must be extended to all patients who seek nonurgent out-of-network care.

ASPS believes that patients should always be fully informed of the provider's network status and should have the opportunity to seek care from an in-network provider if they so chose. Patients who seek elective medical services have the opportunity to consult various providers and select one who best meets their medical needs, regardless of network participation. If the patient knowingly selects an out-of-network provider and agrees to pay the provider's fee, the patient and provider should be able to enter into a direct payment agreement. This practice encourages patient choice by allowing the patient to make informed health care decisions in determining what is best for their medical needs, while also fostering greater access to care. We cannot support any proposal that does not provide this option to patients.

Oppose a fixed out-of-network reimbursement rate set at the median in-network rate

Fixed out-of-network reimbursement at the median in-network rate is, simply put, a windfall for the for-profit insurance industry. It places complete power in the hands of carriers and strangles the provider's ability to competitively negotiate a fair in-network contracted rate. Sixty-one percent of ASPS plastic surgeons are in solo or group practices of between two and five physicians. These are small businesses, Senators, and they already face an uphill battle during contract negotiations with some of America's largest, wealthiest, most profitable, and most politically powerful companies. A predetermined out-of-network payment rate set on in-network amounts would shatter any negotiating power left for these small businesses and virtually all other physicians.

The 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 providers and adjusted down to reflect the increased access to patients, decreased billing disputes, and more timely payment those providers receive. 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 the median of these 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 disrupts the contracting environment and is patently unfair.

Furthermore, this payment 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. These measures are a paradigm shift after which carriers will know that they will only be required to reimburse at the in-network rate, thus removing any incentive to work in good faith to bring a provider in network. This unfairly tips the balance in contract negotiations toward insurance companies and leaves providers in a take-it-or-leave-it situation, where if the provider "leaves it" and choose not to participate in a network, they will be forced to accept that network's rate regardless of whether they treat one of its enrollees.

Instead, we encourage the Committee to require the carrier to make an initial reasonable payment based on market value. This is the best solution to ensure that physicians receive fair reimbursement for their services and are able to engage in level in-network contract negotiations.

In light of the preceding, we must oppose the original legislation and the manager's amendment. Neither of these proposals offer the comprehensive solution to unanticipated medical expenses that patients deserve. We have enclosed our principles on unanticipated medical bills, which offer recommendations on how to appropriately address this issue. We strongly encourage the committee to work with all stakeholders in developing policy that incorporates these principles instead of the provisions offered in the Lower Health Care Costs Act. 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,

Handwritten signature of Alan Matarasso, MD, in black ink. The signature is cursive and includes the initials 'MS' at the end.

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

cc: Members, Senate Committee on Health, Education, Labor and Pensions

Principles to Address Unanticipated Medical Bills

Solutions that remove patients from billing disputes and ensure access to quality specialty care

In recent years, insurers have created products with narrow, inadequate, and non-transparent provider networks. 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.

Many of these plans also offer low monthly premiums in exchange for high annual deductibles. For a healthy individual, this is appealing due to low upfront costs. However, in emergencies or for patients with chronic illnesses, reaching a \$10,000 deductible, for example, will require significant out-of-pocket costs before the patient's insurance plan starts to financially contribute to care. Once patients reach their deductible, many plans still require coinsurance payments.

Unfortunately, patients rarely understand these terms, let alone how they will be charged for their cost-sharing responsibilities. It's no wonder patients are "surprised" when they are directly billed for care that they thought their insurance policy would cover. This is a direct result of the failure by insurance companies to educate patients about the limitations of their policy. The American Society of Plastic Surgeons supports state and federal efforts to protect patients who receive unanticipated medical bills. This can only be achieved through a comprehensive solution that safeguards patient access to necessary specialty care through provisions which:

- **Remove patients from billing disputes** for out-of-network emergency care by automatically assigning the patient's benefits to the physician. Patients should only be responsible for their in-network cost-sharing amount, while allowing the provider and carrier to directly negotiate appropriate reimbursement for the remaining expenses
- **Ensure patient choice** by permitting patients to knowingly select nonurgent out-of-network care, as long as written consent is provided and the patient understands their full financial responsibility
- **Facilitate a fair contract environment** between providers and insurance carriers that encourages both parties to negotiate appropriate payment. This is only possible if the minimum benefits standard for out-of-network services is based on billed charges that reflect the market value of services and not a percentage of Medicare or allowed amounts as dictated by the insurance carrier
- **Provide fair and timely payment** by requiring insurance plans to reimburse providers for unanticipated and/or emergency out-of-network care based on a percentile of physician submitted claims collected by an independent, non-profit database
- **Mandate adequate insurance networks** and **reduce maximum allowable cost-sharing amounts**
- **Address existing state policies** and **ensure coverage of ERISA plans** by establishing a baseline standard that protects patients and providers across all 50 states