Executive Office
444 East Algonquin Road • Arlington Heights, IL 60005-4664
847-228-9900 • Fax: 847-228-9131 • www.plasticsurgery.org

December 12, 2019

The Honorable Mitch McConnell
317 Russell Senate Office Building
Washington, DC 20510

The Honorable Nancy Pelosi
1236 Longworth House Office Building
Washington, DC 20515

The Honorable Charles E. Schumer
322 Hart Senate Office Building
Washington, DC 20510

The Honorable Kevin McCarthy
2468 Rayburn House Office Building
Washington, DC 20515

RE: OPPOSE - Title III of the Lower Health Care Costs Act

Dear Leader McConnell, Leader Schumer, Speaker Pelosi, and Leader McCarthy:

The American Society of Plastic Surgeons (ASPS) opposes the Lower Health Care Costs Act. As outlined, Title III of the proposal will fundamentally change the balance of power within carrier-provider contract negotiations and institute government rate setting for medical services. It will lead to a race to the bottom in network adequacy, and it will decimate access to care, especially in rural settings. Title III is not the comprehensive solution to unanticipated medical bills that patients deserve. We urge you to find a better way.

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 promote public policy that protects patients. We have stayed true to that as Congress has worked to develop comprehensive solutions to this problem, and ASPS has been a committed stakeholder that provided constructive feedback to the various congressional groups that have sought input from the medical community. Because of that good faith support, we are deeply discouraged by the fact that this bill continues to show such overwhelming bias in favor of insurance companies and disregard for the serious concerns raised repeatedly by the provider community.

While not the only areas where the proposal needs improvement, the following are our chief concerns:

Rate-setting at median in-network payments is a financial windfall for insurance companies

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 providers and adjusted down to reflect the increased access to patients, decreased billing disputes, and more timely payment those providers receive. In other words, *quid pro quo* – we get treated decently, and they 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 benefits. This disrupts the contracting environment and is patently unfair. Frankly, this legislation is a gift to the for-profit insurance industry. It does not make sense, and is completely one-sided, to set reimbursement based on unilaterally-controlled rates determined by whatever the insurers want to pay.

Ultimately, 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. This ***has happened*** in California, and network adequacy has suffered.[1]

Any federal solution must, at minimum, 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.[2]

The independent dispute resolution threshold is not fair or accessible

The structure of an independent dispute resolution (IDR) 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 arbitration process is balanced. Having the benchmark considered by the arbiter be the median in-network rate is not balanced, as articulated above, and that says nothing of the inherent bias that is introduced into the arbitration process by using the same rate as the initial payment and the supposedly appropriate reference point the arbiter is going to use to render a decision.

The structure may ultimately be a moot point, though, because the $750 physician threshold to initiate the IDR process is not realistic in many circumstances. In the real world, many physician charges would not reach this threshold, making it unattainable. Any congressional solution must include a lower, real-world threshold; permit bundling of claims to meet the threshold; allow billed amounts to be considered by the independent reviewer; and require the IDR system to reference an independent, conflict-free nonprofit claims database.

This proposal must not pass in its current form. It does not offer the comprehensive solution to unanticipated medical expenses that patients deserve. We strongly encourage Congress to continue the substantial progress that has been made on this issue and work until an equitable solution has been found. 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,

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

cc: Members of the United States Congress

[1] https://www.cmadocs.org/Portals/CMA/files/public/CMA%20Suprise%20Billing%20Survey%20Results%202019.pdf
[2] https://georgetown.app.box.com/s/6onkj1jaiy3f1618iy7j0gpzdoew2zu9