



AMERICAN SOCIETY OF  
PLASTIC SURGEONS®



THE PLASTIC SURGERY  
FOUNDATION®

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# ASPS POSITION STATEMENT

## ASPS PRINCIPLES FOR HEALTH CARE REFORM

While the ACA resulted in a number of desirable reforms, including coverage of pre-existing conditions, removal of lifetime caps, and coverage of children to age 26, the American health care system remains beset by a number of serious problems. Health insurance costs continue to rise, and private insurers draw ever-more-narrow networks, threatening broad access to care. Health system consolidation has exploded, threatening the viability of private practice and increasing costs to patients, taxpayers, and insurers. Well-meaning efforts to use alternative payment methods to reward the value of care, rather than the volume, have resulted in systems ill-equipped to integrate, analyze and reward specialist services. These systems threaten the viability of independent medical practices across the country, while causing physicians to retire early or sell their practices to large corporations and hospitals.

As the 115<sup>th</sup> Congress begins and a new administration takes power, policymakers are poised to again undertake health care reform. The following are key principles that the American Society of Plastic Surgeons believes must accompany such an effort.

### MAKE PATIENT ACCESS TO CARE PRIORITY ONE

Patients should have timely access to high-quality medical care from the appropriate provider. To advance this goal, health care reform must -

- **Maximize the availability of high-quality, affordable coverage.**
- **Prohibit denial or cancellation of coverage for pre-existing conditions.**
- **Prohibit denial or cancellation of policies when a patient becomes sick.**
- **Prohibit annual and lifetime caps.**
- **Maintain medical loss ratio provisions** that require private insurers to spend an adequate percentage of their premium dollar on health care for their customers.
- **Establish and enforce network adequacy and transparency rules.** Insurance companies are creating extremely narrow networks that not only decrease patient choice but also affect patients' access to health care.
  - Payors should be required to design networks to have adequate number of active physicians in each specialty within a reasonable distance and availability to patients.

- Patients may not understand which physicians are in their plan's network, leading to unexpected expenses for patients when insurance will not pay after care is rendered. Payors should provide accurate and timely directories of the physicians, providers, and facilities within their network so that patients and physicians can make informed decisions about their healthcare.
- It is very difficult for patients and even physicians to find out what the insurance will pay for certain procedures and visits. This affects patients' ability to make informed decision about their health and finances. Payors should be required to provide accurate and timely fee schedules to patients and physicians so that patients can be informed about their out-of-pocket expenses.
- Payors must provide patients with a clear description of coverage, not only after enrollment but also at the time of open enrollment, so that patients can choose an insurance plan that is right for their individual health needs.
- Insurers should be required to offer an out-of-network option. This will ensure that patients have choices when their payor network does not have adequate number of physicians to meet patient needs.

## REBUILD THE PHYSICIAN/PATIENT RELATIONSHIP

The ACA and subsequent legislation/regulation have moved the core of American health care delivery from a physician/patient-centric model to one where large-scale systems drive the patient experience. This has had a negative impact on physicians and patients by de-personalizing care and de-emphasizing the preferences of individual patients. To re-center this dynamic, health care reform should -

- **Help physicians spend more time working with and caring for patients, not on regulatory burdens and box-checking.**
  - There are a host of mandated federal reporting programs that in isolation are well-meaning and aimed at positive improvements. Taken together, though, they demand an overwhelming amount of a physician's time.

Consequently, valuable time is allocated away from direct patient care, causing physicians to either see fewer patients or spend an inadequate amount of time with each patient. This dynamic is unacceptable. Federal programs focusing on quality, cost and health IT must be scaled back to a less burdensome level.
- **Give patients more choices** when selecting providers and potential care settings.



- **Evaluate, in a holistic manner, the actual costs of regulatory compliance** and the aggregate impact of the many cuts to physician payments made across the federal policy landscape. These costs make it harder for physicians in small or solo practices to keep their doors open, and it acts as a disincentive to entering medicine for the brightest young minds.
- **Repeal the Independent Payment Advisory Board.** This unelected, unaccountable group of bureaucrats is mandated to, under certain Medicare spending scenarios, add to the already-substantial reductions in Medicare reimbursements facing physicians.
- **Enact common sense medical liability reforms** that do away with the current, high-exposure climate in which physicians practice defensive medicine and patients are subjected to unnecessary screenings, tests and hospital stays.
  - Routinely incorporate mediation as part of the complaint process
  - Employ expert boards to review the merits of medical liability cases
  - Cap non-economic damages.
  - Institute a reasonable statute of limitations on liability claims.
  - Implement standards requiring expert witnesses to have training in the medical field at subject in a lawsuit, be board certified in the specialty of the defendant, and spend at least 50% of their time practicing clinical medicine
- **Seek to reduce the number of uninsured and underinsured patients,** whose care is disproportionately underwritten by providers, taxpayers, and the privately insured.

*Approved by the ASPS Executive Committee - March 2017*