



AMERICAN SOCIETY OF
PLASTIC SURGEONS®



THE PLASTIC SURGERY
FOUNDATION®

Executive Office

444 East Algonquin Road • Arlington Heights, IL 60005-4664

847-228-9900 • Fax: 847-228-9131 • www.plasticsurgery.org

July 10, 2019

The Honorable Frank Pallone, Jr.
2107 Rayburn House Office Building
Washington, DC 20510

The Honorable Greg Walden
2185 Rayburn House Office Building
Washington, DC 20510

RE: H.R.3630 – No Surprises Act

Dear Chairman Pallone and Ranking Member Walden:

On behalf of the American Society of Plastic Surgeons (ASPS), we are writing to reiterate our request to amend the No Surprises Act, which would currently alter the balance of power within carrier-provider contract negotiations and amount to government rate setting for medical services. Provisions within the bill will result in less access to care, especially in rural settings that already face physician workforce shortages. We do not believe that the current version of the No Surprises Act is the comprehensive solution to unanticipated medical bills that patients deserve. Therefore, we urge you to 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 Congress has worked to develop comprehensive solutions to this problem, and ASPS has been a committed stakeholder that provided constructive feedback to the House and Senate. 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 to:

Remove provisions setting out-of-network reimbursement 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 doctors' 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 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.

In-network amounts are calibrated for in-network providers, which means they are 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.

Moreover, the median in-network rate is calculated based on “the negotiated rates recognized by the plan,” not based on an aggregate of all allowed amounts paid by all plans in the geographic area. This minimizes the dataset available and will further drive down the final payment to providers because the carrier may operate in a vacuum without any market competition. This is yet another give-away to the insurance industry at the expense of small businesses.

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.

Establish an independent dispute resolution (IDR) process that allows parties to challenge inadequate payments

The independent dispute resolution (IDR) system in New York has been tremendously successful.¹ During the New York IDR process, reviewers who have experience in healthcare billing, reimbursement, and usual and customary charges consult with a licensed physician in active practice in the same or similar specialty as the physician in question. Through this best and final offer approach, the IDR entity selects either the amount submitted by the carrier or the amount submitted by the physician as the prevailing amount. That’s the extent of the process. There is no lengthy battle, no “windfall for trial attorneys.” Most physicians go through IDR entirely on their own, with no legal fees and only a minimal processing fee (typically under \$300). For disputes between a patient and a provider, the IDR entity determines a reasonable fee. This system has led to a decrease in the frequency of out-of-network balance bills by 34 percent.

However, the success of the New York model is made possible through the utilization of *all* of the necessary characteristics of a comprehensive solution to surprise billing: (1) an initial reasonable payment; (2) unbiased data about market rates; and (3) an independent dispute resolution system with appropriate benchmarks. Without one of those criteria, the legislation would fail to truly and effectively protect patients and physicians.

Require the use of an independent, third party database to develop reimbursement benchmarks

We strongly encourage inclusion of a database *of charges* in the legislation to ensure that reimbursement rates are determined in an appropriate and fair manner. While we recognize the impartiality of the Secretary, who is currently assigned to determine the methodology used by the plans, the data offered by the plan may be selectively offered or manipulated in determining the median contracted rate. Instead, we urge you to

¹ <https://georgetown.app.box.com/s/6onkj1jaiy3f1618iy7j0gpzdoew2zu9>

require the use of an independent database that will provide transparency in data collection and the methodologies utilized to determine the benchmark.

Specifically, the nonprofit organization must not be affiliated, financially supported, and/or otherwise supported by the stakeholders who would be affected by this legislation. This is important because there are a number of such databases that appear to be unaffiliated with payers but are *de facto* subsidiaries. So far, the only database we have identified that meets the standard set above is FAIR Health, Inc.

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. This produces 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.

Remove the ban on out-of-network care chosen by patients with informed consent

We believe patients should be removed from billing disputes between providers and carriers, and we support the portion of the bill that holds patients harmless for emergency out-of-network care. Moreover, we support the provision that allows a provider to bill a patient directly for *elective* care in which the patient can fully research their healthcare options and make informed decisions. That said, the No Surprises Act bans balance billing by, and uses a vague definition of, facility-based providers. Specifically, that ambiguity has the potential to force certain physicians – who have the opportunity to interact with the patient directly – to adhere to the balance billing ban when they should not be required to do so. Punishing providers who have the opportunity to ensure that a patient is informed before they receive out-of-network services, even if they are rendered at an in-network facility, is inappropriate. Therefore, we cannot support the definition of “facility-based provider” and its blanket ban under the current version of the legislation.

Furthermore, the provision that bans balance billing if there are no available participating providers is an egregious concession to the insurance industry. Since the passage of the Affordable Care Act, insurers have created products with narrow, inadequate, and non-transparent networks. These products have been created specifically because their narrow networks make them highly-profitable and relatively inexpensive for consumers. Your constituents who purchase these products are – unwittingly – subjected to those narrow networks, not realizing that the substandard networks are driving the cost of the insurance product lower. This creates the problem of more physicians being forced out-of-network by the insurance companies, and not enough in-network physicians for patients to see. As noted previously, insurers cannot be trusted to act in good faith during contract negotiations if they know they can fall back on a set rate for out-of-network services. Rather than placing the responsibility of ensuring adequate networks on the backs of physicians, Congress should charge the carriers with this responsibility and place the financial burden on the health plan if they do not contract with sufficient providers. Congress must take steps to ensure that patients have in-network access to necessary primary and specialty care physicians, however the proposed provision is not the solution.

In light of the preceding, we must oppose the original No Surprises Act and respectfully request that you amend the bill as noted above. This problem demands a federal solution that properly protects patients, ensures adequate and fair reimbursement of physician services, and reins in bad actors in the physician and insurance sectors. The No Surprises Act falls far short of providing that solution.

Thank you for your consideration of our requests, and 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