AMERICAN SOCIETY OF PLASTIC SURGEONS ®
THE PLASTIC SURGERY FOUNDATION ®

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December 14, 2020

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

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

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

The Honorable Charles Schumer
Senate Minority Leader
322 Hart Senate Office Building
Washington, DC 20510

RE: Out-of-Network Proposals in COVID-19 Relief Efforts

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

On behalf of the American Society of Plastic Surgeons (ASPS), I am writing to state our opposition to the out-of-network billing provisions in the discussion draft released Friday, December 11. While we recognize that all of the committee leaders and individual congressional stakeholders who worked on this package made concessions in an effort to make this bill more palatable to physicians, it is still, on balance, largely skewed in favor of payers over physicians, particularly those in small and rural practices. This bill is unquestionably better than recent rumored deals that included an up-front payment benchmarked to the median in-network rate, but we request the following additional refinements to make it truly fair and truly balanced.

As you continue to finalize an out-of-network billing solution, we encourage you to at-minimum make the following adjustments:

- *Ensure fair and timely physician reimbursement.* We are concerned that the proposal currently does not clearly require insurers to pay an out-of-network provider for emergency or inadvertent out-of-network care, instead seemingly only requiring a response to a provider-submitted bill, even if that payer response is a refusal to pay. We request that you **add language clarifying that payers are required to make payments for their customers' out of network care at a non-specified, non-zero commercially reasonable amount**.

  Further, we strongly recommend additional language to the Independent Dispute Resolution (IDR) provisions to **ensure that an insurer's initial payment made carries forward and serves as that insurer's submission to the IDR process**. This will guarantee that they will not send very low payments to providers, a significant concern for small and rural private practices that may not have the means to pursue arbitration. This letter is accompanied by a red-lined version of the IDR provisions to show how this and our subsequent recommendations can be incorporated.

- *Adjust the IDR process so that it is not heavily skewed in favor of payers.* ASPS supports the baseball-style arbitration process included in the bill, but is concerned with the following aspects of the current structure:

- The median in-network rate is given prominence, which will result in a payer-dominated arbitration environment. As we've previously expressed, in-network rates are inappropriate measures of the market value of physician services, and requiring the arbiter to review the parties' IDR submissions in light of an in-network rate will result in payers' submissions at the in-network rate artificially appearing more reasonable.

  What we've learned from state out-of-network policies and from previous CBO assessments of certain federal proposals is that, in arbitration, the context provided to the arbiter heavily influences the decision rendered. Therefore, we are concerned that the **elevation of the median in-network rate as the baseline from which disputes are to be evaluated has a de facto rate-setting effect**.

  When CBO scores of out-of-network proposals to project savings, it is a result of payments for in-network and out-of-network services converging at the median in-network rate. We can quibble about whether that constitutes rate-setting, but there is no disputing that it translates into a tens-of-billions of dollars per-year cut to physician reimbursement from private payers.

- While ASPS disagrees that usual and customary charges for services should be prohibited from consideration in IDR – it has worked very well in New York – we understand it's a non-starter in federal legislation. The given rationale for excluding charge data is that it is not related to the actual cost of care because providers can set it where they like. For the same reason, we recommend that you **add a prohibition on the consideration of data from Medicare, Medicaid and Workers Compensation**. Those rates are also not related to the actual cost of care. They are instead determined through largely political processes that are heavily influenced by federal and state budgetary realities, and they are notoriously low.

  Because we know that, in arbitration, the context provided to the arbiter heavily influences the decision rendered, allowing these artificially low rates to be added to the context and thus be given the appearance of reasonableness will further skew the IDR process toward payers.

- The 90-day cooling off period creates a tremendous cash flow problem for smaller practices, even if out-of-network care is a small part of their practice profile, because they operate on such small margins. For new and early-career plastic surgeons, the bulk of the emergency care they provide could be out-of-network as they work to establish network contracts. Plastic surgeons in smaller practices with a limited reconstructive surgery profile and insurer relationships limited to those areas, have surgical privileges at hospitals and are required to take emergency cases, the bulk of which could be out-of-network. A 90-day cooling off period produces a five-month gap before payment for these services. We recommend that you **add an exception from this provision for small and medium- sized practices**.

  Practices owned by private equity interests will have no problem floating that five-month gap before payment, but independent private practices will not be able to survive that long. This will force even more independent practices to close, which – as you no doubt understand – now often means that they join existing private equity-owned practice groups.

- Similar to the 90-day cooling off period, the requirement that individual providers in group practices enter IDR separately, as opposed to under one practice tax identification number, is a massive barrier for small practices. **Businesses should be able to aggregate their disputed payments from the same payer for the same services within established claim bundling**

windows. Forcing them to do it on a provider-by-provider basis will dramatically increase individual instances of arbitration, which dramatically increases the time and cost for practices. That will be bad, as will the other possible outcome of this hurdle: that smaller groups will just accept very low reimbursement instead of even contemplating utilizing IDR.

If there are concerns about certain types of provider groups exploiting the ability to aggregate claims, we would ask that you consider a targeted response to address that. A blanket prohibition that impacts small and medium practices will force smaller practices to consolidate with private equity or more expensive hospital-owned groups.

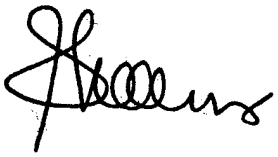
- The two-day window to initiate arbitration after negotiations have failed is too short. We recommend you amend the window to five days and clarify that those are business days.

We appreciate the tremendous efforts made by Congress to support physicians during the current public health emergency, but we urge you to recognize the likelihood that an imbalanced out-of-network proposal will undermine that work. Look to the CBO projections for legislation that pressures payments toward the median in-network rate – there are several -- and remember that a $15-20 billion savings to the federal government requires a roughly $500 billion reduction in private payer reimbursement to physicians over the life of the score. That will be devastating.

We believe the adjustments noted above and the red-lined edits that accompany this message will result in this being a substantially fairer package. We are concerned that last Friday's discussion draft will further strain the viability of private practices. That presents a possible future of expensive consolidation and an ever-growing private equity presence in our health system. Please stand with physicians in not allowing that to happen.

Thank you again for your work. Even if this is not currently satisfactory, you all deserve credit for your continued efforts to compromise and your willingness to entertain and make concessions and changes. As you continue that work, 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. Thank you for your consideration.

Sincerely,



Joseph E. Losee, MD, FAACS, FAAP
President, American Society of Plastic Surgeons