AMERICAN SOCIETY OF PLASTIC SURGEONS ®
THE PLASTIC SURGERY FOUNDATION ®

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February 15, 2017

Washington House of Representatives
House Health Care and Wellness Committee
Eileen Cody, Chair
Nicole Macri, Vice Chair
257A John L. O'Brien Building
Olympia, WA 98504

RE: HB 2114 – Relating to Health Care Services and Balance Billing

Dear Honorable Committee Members:

On behalf of the American Society of Plastic Surgeons (ASPS), I am writing to request you amend HB 2114. ASPS represents more than 7,000 board-certified plastic surgeons. Because ASPS's mission prioritizes the patient experience, we have serious concerns about this legislative measure.

Following passage of the Affordable Care Act, insurers have created products with narrow, inadequate and non-transparent physician networks. These "narrow networks" often force patients "out-of-network" for needed care. When patients receive care from a provider they did not know was outside their network, they are surprised after the fact that their insurance will not cover that service. We appreciate your effort to address surprise billing, but any such correction must address the issue properly.

Your current legislation considers the situation wherein a patient knowingly seeks an out-of-network provider as a "balance billing" situation, even when a patient has received the required notification from the facility and no in-network provider is available at the time of care. In such a case, the patient is aware the provider is out of network, and therefore the billing is not a "surprise". Surprise balance billing occurs only in those situations in which a patient is not fully informed and has no opportunity to request an in-network provider. The issue to address is transparency: fully informing a patient well in advance that the provider is out-of-network, what the out-of-pocket costs may be, and providing the option to find another in-network provider, as well as demanding that insurers have adequate networks. Thus, HB 2114 should not include non-emergent situations.

Although well-intended, your current language holds physicians unilaterally accountable for the serious issue caused by inadequate insurance networks. As a result, insurance companies will no longer negotiate with doctors, because even with inadequate numbers of in-network doctors, they will only be liable to pay out-of-network providers your legislated discount payment. This is inherently inequitable. The result will be decreased access to care and rationing. When an insurer creates a de facto inadequate network and a patient must be served by an out-of-network physician, the insurer should instead face penalties and be required to pay the out-of-network provider a fair and equitable reimbursement.

As currently written, HB 2114 sets reimbursement at the average contracted rate or 125% of Medicare (whichever is greater). Medicare rates are notoriously low, and will not be rising for the next ten years. Insurers have the unfair power to determine reimbursement for non-contracted, out-of-network providers. We ask you to consider what we feel is the most successful out-of-network policy in place, New York's "*Emergency Medical Services and Surprise Bills*" law. New York's determination of fair reimbursement for out-or-network providers is outlined below:

> (i) "Usual and customary cost" means the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent. The nonprofit organization shall not be affiliated with an insurer, a corporation subject to article forty-three of the insurance law, a municipal cooperative health benefit plans certified pursuant to article forty-seven of the insurance law, or a health maintenance organization certified pursuant to article forty-four of the public health law.[1]
> …

ASPS asks you add this definition for "usual and customary cost" to the definitions section of the legislation, and use this phrase in place of "average contracted rate" wherever the latter is referenced. To ensure fees paid to out-of-network providers are both fair and unbiased, New York utilizes Fair Health, Inc. as its independent nonprofit organization. FAIR Health, Inc. is a repository of the nation's largest collection of privately-billed medical claims data, Medicare claims data, and geographically-organized healthcare cost information. This allows FAIR Health, Inc. to provide relevant region-specific cost information. This non-profit exists solely to provide objective healthcare cost information to providers, patients and insurance companies.

FAIR Health, Inc. was created as part of a $350 million legal settlement in New York over the use of Ingenix, a United Health Group health data subsidiary found to be manipulating usual-and-customary rate information to defraud consumers. Last year in California, there was a $9.5M settlement against another United Healthcare health data subsidiary for continuing the same unlawful practices. Such corrupt data manipulation by private carriers is very concerning, but would be allowed under the current language of HB 2114. We ask you to prevent this.

Utilizing FAIR Health, Inc. will provide fair reimbursement to out-of-network providers and will stop "surprise" bills. However, you must also require insurers to have adequate networks, as well as transparency and notification to patients when in-network providers are not available. ASPS recommends patient notification provisions be included in HB 2114 that requires health insurers, providers, and facilities to better communicate network status to patients. HB 2114 should also require health plans to:

1) Design networks with *adequate numbers of active physicians in each specialty* within a reasonable distance and availability to patients;

2) Provide *accurate and timely directories* of physicians, other providers and facilities;

3) Provide *accurate and timely fee schedules* to patients and physicians for cost transparency;

[1] New York Financial Services Law, art 6, § 603

4) Inform patients with a *clear description of coverage* on an on-going basis (not just at the time of enrollment);

5) *Offer out-of-network options*. This will ensure that patients have choices when their payer network does not have adequate physicians to meet the patient's needs.

ASPS is additionally concerned with your dispute resolution plan for carriers and providers over balance bills. Arbitration is a costly, burdensome solution to billing disputes. Instead, the legislature should utilize an independent third party claims data repository, such as FAIR Health, Inc., described above, as the basis for determining appropriate reimbursement.

Lastly, language should be added to permit a patient to assign benefits to an out-of-network provider. The flexibility to assign benefits allows an out-of-network provider to be reimbursed without additional obstacles. In some cases, when a patient receives a check from an insurer, they may not recognize it is for out-of-network care they received. If the patient does not forward the funds to the intended provider, the patient may be annoyed to receive a balance bill.

For the reasons outlined above, please amend HB 2114. Please do not hesitate to contact Patrick Hermes, ASPS's Senior Manager of Advocacy and Government Affairs, with any questions at Phermes@plasticsurgery.org or (847) 228-3331.

Regards,

Debra Johnson, MD
President, American Society of Plastic Surgeons