AMERICAN SOCIETY OF PLASTIC SURGEONS ®
THE PLASTIC SURGERY FOUNDATION ®

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August 8, 2016

The Honorable Ricardo Lara
Chair, Senate Appropriations Committee
State Capitol Building Room 2206
Sacramento, California, 95814

RE: Opposing A.B. 72 – Relating to Health Care Coverage

On behalf of the American Society of Plastic Surgeons (ASPS) we are writing to respectfully oppose A.B. 72.

ASPS is the world's largest association of plastic surgeons, with over 7,000 members representing 94 percent of Board-Certified Plastic Surgeons in the United States. ASPS promotes not only the highest quality in patient care, but also in professional and ethical standards. Our members are highly skilled surgeons who improve both the functional capacity and quality of life for patients, including treatment of congenital deformities, burn injuries, traumatic injuries, hand conditions and cancer reconstruction.

Combined with inaccurate network directories, the phenomenon of shrinking insurance networks has contributed to increased incidence of patients encountering out-of-network providers while receiving care at in-network facilities or in emergency situations. This has resulted in patients receiving large, unexpected bills at an unacceptable rate. The rise of these "balance bills" and "surprise bills" has led to the introduction of A.B. 72, which will eliminate these surprise bills and remove patients from the center of billing disputes between providers and insurers when out-of-network care is provided at in-network facilities. ASPS commends the California State Legislature for pursuing these common sense patient protections.

We also support A.B. 72's provision allowing patients to consent to care from an out-of-network provider and consent to pay such a provider's charge in addition to said patient's out-of-network benefit. This is a key measure to ensure patient access to specialists of their choice. As previously mentioned, insurance products are increasingly offering narrower and narrower networks of covered providers. Patients deserve the right to access physicians outside of their network when certain specialists are not available or when a non-contracted provider is better equipped to serve a patient's specific care needs, and A.B. 72 preserves that right.

In spite of these and many other positive elements in A.B. 72, the legislation also needs significant refinement in two key areas. First, the right for patients to assign out-of-network benefits to out-of-network providers needs to be strengthened. Too often, patients do not fully understand the obligations they face when they receive their benefits directly, and this can lead to situations where providers must pursue payment from beneficiaries who are not aware that the benefits they received were meant to be remitted as payment for services. This dynamic is in direct conflict with A.B. 72's efforts to remove patients from the middle of provider and insurer disputes. ASPS recommends automatic assignment of benefits in these situations.

Second, and most importantly, the bill imposes a flawed fee schedule for payments for services by an out-of-network provider when they deliver care to a patient at a covered facility. This fee schedule severely disadvantages providers because it is currently set at the greater of the average contracted rate or 125% of the Medicare reimbursement levels. The flaws in the former approach are outlined in the subsequent paragraph, but the flaws in latter do not require that much space to explain. Simply put, Medicare rates are notoriously low and clearly ill-suited for broad application to patient populations outside of those served by Medicare.

Regarding the use of the average contracted rate, it is important to bear in mind what a contracted rate is. Health plan networks are formed through a negotiation between insurers and health care providers who, in order to join the insurer's network, accept rates for their services that are usually deeply-discounted from the actual full charge. The provider concedes a portion of their billed charge in order to gain access to more patients. By using this baseline to dictate payments to non-contracted providers, A.B. 72 makes providers *de facto* network participants without offering them the patient access advantage that comes with being a contracted provider.

This is patently unfair, because it retains everything one party – the provider – forfeits in the negotiation behind contracted rates – specifically, a portion of their charge – without providing that party the benefit that motivated this concession – specifically, access to more customers. If you're skeptical of the imbalance here, I strongly recommend you approach the other party in this matter – the insurers – with the mirror of the current situation. Ask them how they would feel if the fee schedule paid the higher of 125 percent of Medicare or the average of the original billed charge as calculated by data given by providers. I suspect their reaction would be similar to ASPS's reaction to the current proposal.

Fortunately, there is a better, alternative approach. ASPS requests that A.B. 72 instead use an independent third party claims data repository to set the fee schedule. ASPS believes that the track record of using one such repository, FAIR Health, demonstrates that it is an acceptable benchmark for future policy development and warrants inclusion in A.B. 72.

FAIR Health is an independent not-for-profit that provides objective healthcare cost information to all interested stakeholders. It has the nation's largest collection of privately billed medical claims data, and its healthcare cost information is organized geographically, allowing it to provide relevant cost information that is regionally specific. Furthermore – and contrary to claims otherwise by the private for-profit insurance industry – FAIR Health, Inc. collects data on both

amounts billed and *paid*. Lastly, FAIR Health has recently been certified by Medicare as a Qualified Entity to access all Medicare claims data under Parts A, B, and D. In short, FAIR Health is the only entity capable of accessing such a robust and objective set of claims data that is not in any way affiliated with either of the parties – the insurer and the provider – involved in the fee schedule or billing disputes addressed by A.B. 72.

Thank you for your consideration of ASPS's comments regarding out of network billing. Please do not hesitate to contact Patrick Hermes, Senior Manager of Advocacy and Government Affairs, with any questions at Phermes@plasticsurgery.org or (847) 228-3331.

Regards,

David Song, MD, MBA
President, American Society of Plastic Surgeons