AMERICAN SOCIETY OF PLASTIC SURGEONS ®
THE PLASTIC SURGERY FOUNDATION ®

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February 13, 2017

Oregon House of Representatives
House Committee on Health Care
Representative Mitch Greenlick, Chairman
Representative Cedric Hayden, Vice-Chair
Representative Rob Nosse, Vice-Chair
900 Court St. NE, H-493
Salem, Oregon 97301

RE: OR HB 2339 – Relating to Claims for Reimbursement of the Cost of Health Care Services

Dear Honorable Committee Members:

On behalf of the American Society of Plastic Surgeons (ASPS), I am writing to request that you amend HB 2339. Founded in 1931, ASPS is the largest association of plastic surgeons in the world, representing more than 7,000 members and 94 percent of all American Board of Plastic Surgery board-certified plastic surgeons in the United States. Because ASPS's mission prioritizes the patient experience, we have serious concerns about this legislative measure.

Since passage of the Affordable Care Act, insurers have created products with narrow, inadequate and non-transparent networks. The rise of "narrow networks" has forced patients to have to go out-of-network to receive the medical care they need. Patients often do not realize that their plan does not cover an adequate number of providers and specialists, and they are shocked when told they are financially responsible for their medical visit. This has become too common a problem and has led to the introduction of HB 2339. We appreciate your effort to address surprise billing, but we believe it can be strengthened.

First, we recommend that the definition of surprise billing be amended to make clear that patients are still free to privately contract with non-participating providers in non-emergency situations. As written, HB 2339 limits the ability of non-participating providers to bill in participating facilities under any circumstances. Section 2. (2) should be revised to read:

> …
> Except for applicable coinsurance, copayments or deductible amounts that apply to services provided by a participating health care facility or a participating provider, a participating health care facility of a facility-based provider who is not a participating provider may not bill an enrollee for emergency services ~~or other inpatient or outpatient services~~ provided to the enrollee at a participating health care facility.
> …

Second, as currently written, HB 2339 uses vague provisions that allows insurers to control processes for settling disputes they have with providers over bills for out of network services. Insurers should not be permitted to unilaterally determine what to pay non-participating providers. This is inequitable, unjust and

can be easily exploited by insurers through the data manipulation process outlined below. A better course for Oregon would be to follow the most successful out of network policy in place, New York's "*Emergency Medical Services and Surprise Bills*" law. We recommend HB 2339 be amended to reimburse out-of-network providers the usual and customary cost for services using the same definition that is working in New York:

> …
> (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]
> …

In order to ensure that fees paid to out-of-network providers are both fair and unbiased, New York utilizes Fair Health, Inc. ASPS recommends that, like New York, you reimburse out-of-network providers utilizing a fee-schedule pegged to a truly independent entity like Fair Health, Inc. FAIR Health, Inc. has the nation's largest collection of privately billed medical claims data, access to Medicare claims data, and geographically organized healthcare cost information, allowing it to provide relevant cost information that is regionally specific. This non-profit exists solely to provide objective healthcare cost information to providers, patients and insurance companies.

It is unaffiliated from all of those parties. In fact, it was created using funds provided by United Healthcare and Aetna, as part of a $350 million legal settlement in New York over the use of Ingenix, a United Health Group health data subsidiary that was found to be manipulating usual and customary rate data to defraud consumers. After the settlement in New York, United Healthcare rebranded Ingenix as Optum. In 2016, ASCs in California also won a $9.5M settlement against Optum and United Healthcare for continuing the same practices. This history of corrupt data manipulation practices by private carriers dictates that leaving insurers to unilaterally determine what to pay out-of-network providers is, quite frankly, not an option.

Utilizing Fair Health will address many of the immediate patient and provider issues with surprise bills. However, a long term solution requires stronger, robustly enforced patient notification and network transparency and adequacy rules that apply to all insurers. To achieve this, ASPS recommends patient notification provisions be included in HB 2339 that require providers, facilities and health insurers to better communicate network status to patients. Much of the surprise billing problem can be addressed by reducing confusion and fully informing patients of network coverage, and by requiring insurers to maintain transparent and adequate networks that provide the care their patients need by:

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

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

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

3) Providing *accurate and timely fee schedules* to patients and physicians, so all parties have more cost transparency;

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

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

Lastly, ASPS requests that language be added to permit a patient to assign benefits to an out-of-network provider. The flexibility to assign benefits directly maintains a patient's ability to receive out-of-network care without overwhelming the patient with additional obstacles. It is also good public policy to allow benefits to be assigned directly from the carrier to the out-of-network provider. In some cases, when patients receive a check from an insurer, they do not immediately recognize it is for out-of-network care. In these scenarios, the funds are frequently never received by the intended provider, and ultimately the patient may receive a balance bill.

For the reasons outlined above, please amend HB 2339. 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