AMERICAN SOCIETY OF PLASTIC SURGEONS ®
THE PLASTIC SURGERY FOUNDATION ®

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August 30, 2016

The Honorable Anthony Rendon
Speaker of the Assembly
California State Assembly
State Capitol, Room 219
Sacramento, CA 95814

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

On behalf of the American Society of Plastic Surgeons (ASPS) and the California Society of Plastic Surgeons (CSPS) we are writing to respectfully oppose A.B. 72 as currently amended.

Combined with inaccurate network directories, the phenomenon of shrinking insurance networks has contributed to more patients encountering out-of-network providers while receiving care at in-network facilities. 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 and CSPS commend the California State Legislature for pursuing these common sense patient protections. Unfortunately, A.B. 72 will also unjustly enrich insurance companies, and that reality compels our organizations to oppose it.

The legislation tips the scales in favor of payers at the expense of providers through a flawed fee schedule that sets reimbursement at the greater of the average contracted rate or 125% of the Medicare reimbursement levels. Simply put, Medicare rates are notoriously low and are clearly ill-suited for non-Medicare patients.

It is also 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, we 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. We suspect their reaction would be similar to our reaction to the current proposal.

Fortunately, there is a better, alternative approach that, if included in A.B. 72 would allow ASPS and CSPS to support the bill. The legislature should utilize an independent third party claims data repository, such as FAIR Health, Inc., as the basis for determining what fee schedule rates are the most equitable. 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 private payers, as part of a legal settlement, who were found to be manipulating usual and customary rate data to defraud consumers. FAIR Health was created specifically as a conflict-of-interest-free solution to the problem A.B. 72 is trying to solve with its fee schedule.

FAIR Health 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. 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.

Patients should be removed from the center of billing disputes, but insurers should also not be allowed to unilaterally determine what healthcare costs. Therefore, I respectfully urge you to vote to oppose this legislation until an independent non-profit third-party claims database is incorporated to determine appropriate fee schedule rates. 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; or Tim Madden, Legislative Advocate, California Society of Plastic Surgeons at madden@rnmlobby.com or 916-498-3352.

Regards,

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

Jane Weston, MD
President, California Society of Plastic Surgeons

Cc. Members of the California State Assembly