CALIFORNIA SOCIETY OF PLASTIC SURGEONS, INC.

August 6, 2012

Peter Lee, Director
California Health Benefit Exchange Board
2535 Capitol Oaks Drive, Suite 120
Sacramento, California 95833

Submitted electronically to info@hbex.ca.gov

RE: Comments and Recommendations on Cap for Out-of-Network Benefits for Qualified Health Plans (QHP)

Dear Mr. Lee and Members of the Board:

On behalf of the California Society of Plastic Surgeons (CSPS) we appreciate the opportunity to provide comments and recommendations regarding the "Standardization of Minimum Out-of-Network Benefits".

In the staff recommendations to the Exchange Board regarding qualified health plan policies, one of the staff recommendations was to "standardize minimum out-of-network benefits", which could include a maximum fee that can be charged by a provider for out-of-network care. The staff provided some background on this recommendation stating unless capped, a member can be faced with unexpected large bills from providers when the member chooses to go out-of-network. The Exchange further clarified on the webinar it held on July 24th this requirement relates to PPO products and not HMO products.

CSPS opposes the Exchange requiring a health plan or health insurer to cap what a physician may charge for out-of-network care for PPO products. PPO products are specifically designed to allow individuals the flexibility to go out-of-network if they choose. The problem of the individual receiving unexpected large out-of-network bills stem from a lack of information being available for the individual to make a decision. The solution to this problem is not to simply place a cap on what the physician can charge rather the individual should be placed in a position to have as much information they need to make the best decision for their specific circumstances.

There is an understanding by the individual purchasing a PPO product they will be responsible for a higher portion of the cost of care when they choose to seek care from an out-of-network physician. If the individual does not want to pay those out-of-network costs, they may choose a physician within their network or a different out-of-network physician who charges less.

If the problem is the patient was not aware of the costs of the care from the out-of-network physician this seems to suggest two possible problems; 1) the patient was not aware of how much of the out of network care their PPO will pay for and/or 2) the patient was not aware of how much the out-of-network physician charges.

We are aware at times patients are confused with the amount the PPO will pay for when it comes to out-of-network care. Individuals seeking PPO products generally accept up front that they will be paying more out of pocket if they opt to see out-of-network physicians. Plan documents often state the insurer will reimburse for somewhere between 70-80% of the out-of-network provider's charge, with enrollees being responsible for the remainder. What patients do not often understand is that the insurer may not, in fact, be reimbursing 70-80% of the physician's actual fee, but for 70-80% of some arbitrarily determined "usual and customary/reasonable" (UCR) charge the insurer has deemed appropriate for a given service. For example, for a $700 charge for an out-of-network physician's service, an enrollee might expect to be responsible for $210, or 30% of that charge. However, if the insurer has deemed the UCR fee for that service is really $350, it may only pay 70% of that charge, or $245. So, the patient really ends up owing the out-of-network physician a balance of more than double what slhe expected, or $455. Due to this flawed methodology, patients who pay more to insurance companies for a "richer" benefits package end up with unexpectedly high medical bills due to artificially low out-of-network reimbursement.

It would seem the Exchange should require the plan to use clearer terminology to explain exactly how much the PPO product will pay for with out-of-network care. CSPS recommends the Exchange require the health plans or health insurers include tools for individuals to use related to out-of-network care including:

- An "out-of-network guide" developed by the PPO to walk the individual through what they need to be aware of when pursuing out-of-network care. This detailed information will place the individual in a better position to make an informed decision when considering going out-of-network.
- A calculator which will help the individual determine when obtaining out-of-network care how much they will be responsible for as compared to seeing an in-network provider.

If the individual is not aware of how much the physician charges they need to be responsible for speaking with the physician to better understand the physician charges and how much they would be responsible to pay. Many times physicians are open to discounting their fees when patients explain to them their situation. Once again, if the patient understands how much the physician charges they will have a better understanding of what they are responsible for paying and can then make the best decision for themselves. If the out-of-network physician's charges are too high the individual can negotiate with the physician for lower charges, or they can choose to see a different physician.

In addition the individual could also use the FAIR Health database which has tools for individuals to look up the costs of procedures in specific zip codes. This will give the individual a basis for understanding the cost of the care they are seeking in their own geographic area. After this research is done the individual will be better able to make an informed decision on the care they want and from which physician.

If the Exchange were to require the cap, this could lead to physicians leaving networks all together, which would have a significant impact consumer choices for physicians available in Exchange products.

CSPS respectfully requests the Exchange to not place a cap on out-of-network charges and instead work on improving access to the information an individual needs to make an informed decision when considering out-of-network care.

Respectfully,

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