

September 6, 2017

To: Mr. William Melofchik
National Conference of Insurance Legislators (NCOIL)
(Via email wmelofchik@ncoil.org)

From: American Academy of Orthopedic Surgeons (AAOS)
American Association of Oral and Maxillofacial Surgeons (AAOMS)
American College of Emergency Physicians (ACEP)
American College of Radiology (ACR)
American Society of Anesthesiologists (ASA)
American Society of Plastic Surgeons (ASPS)
College of American Pathologists (CAP)
Physicians for Fair Coverage (PFC)

Re: Proposed Amendments (Attached) to Draft NCOIL Out-of-Network Balance Billing Transparency Act

The following are comments that delineate our concerns with the above-entitled Proposed Model Act and explain our proposed amendments. We appreciate the opportunity to provide constructive input into the development of this Model Legislation by the National Conference of Insurance Legislators (NCOIL).

As a preface to the explanation of our specific amendments (see: Redlined Amendments, Coalition of Medical Specialties), we believe the current NCOIL proposal on network adequacy is **flawed** and should be amended in order to ensure that patients are able to purchase and avail health insurance products that can provide the full continuum of health care many may need and that should be covered under the terms and conditions of their particular health plan.

Many medical specialty societies, in coordination with the American Medical Association (AMA), participated in development of the prior version of the NCOIL Model Act (Healthcare Balance Billing Disclosure Model Act- 2011) on out-of-network billing and were pleased with the result. We look forward to again working with NCOIL on updates to the prior version to include requirements for health plan network adequacy that are clearly needed in light of the current health insurance plan market environment.

Section 4 – Definitions:

A definition of “usual and customary rate” (UCR) should be established in the bill in the definition section in order to standardize its use for purposes of the act. In our proposed amendments, we transpose the definition from Section 5 to Section 4 (New definition “N”.) In addition, the terminology should be “rate” and not “cost” in accordance with the traditional and widely understood use of the term by the insurance industry in order to reflect the general market value for the service.

Moreover, the UCR should be calculated by entities that have no legal or financial affiliation with health insurance carriers. Such independence in UCR calculation is critical in light of past improper business practices by the health insurance industry brought to light in New York State. A recent study by National Opinion Research Center (NORC) at the University of Chicago evaluated and confirmed the importance and reliability of calculating UCR data based upon independent sources such as Fair Health Inc.¹

Section 5- Determinations of Network Adequacy

The current draft does not address network adequacy as it relates to in-network physicians at in-network facilities and hospitals. At present, there is a systemic failure by state regulators to ensure network adequacy for facility- and hospital-based physicians at in-network hospitals.

In November 2014, Health Management Associates published a survey of insurance regulators and found that only 14% of state insurance regulators assessed whether insurance plans with in-network hospitals actually include in-network facility- and hospital-based providers. (See: *Ensuring Consumer Access to Care: Network Adequacy Survey, Findings and Recommendations for Regulatory Reforms in a Changing Insurance Market*, Health Management Associates, November 2014, P.25) Similarly, in 2015 public testimony, one state insurance regulator acknowledged certifying insurance plans as “adequate” when in fact the regulator **acknowledged** the plan was in fact “inadequate” for at least one essential facility- and hospital-based physician specialty.

Current American Medical Association (AMA) Policy on Network Adequacy (H-285.908.11) states: “Our AMA advocates that health plans should be required to document to regulators that they have met requisite standards of network adequacy including facility- and hospital-based physician specialties, (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible.”

In order to remedy the problem of inadequate insurance networks, state regulators should be statutorily compelled to assess whether health plan networks with in-network hospitals have actually contracted with facility- and hospital-based physician specialties at that hospital. Health plans should not be legally allowed to claim compliance with State network adequacy standards when the plan represents to regulators that it has an in-network hospital, but does not undertake the obligation to contract with the specialties of emergency medicine, anesthesiology, radiology and radiation oncology, pathology, and other hospitalists at such facility.

¹ “Quantitate Assessment of Databases for Out-of-Network Physician Reimbursement,” Final Report, NORC at the University of Chicago, May 24, 2017

Furthermore, insurance regulators should be statutorily mandated to conduct a comprehensive network adequacy review to include “provider-to-enrollee ratios for primary care and specialty care providers.” Such standards for evaluation should include “geographic accessibility” and maximum distance and wait time standards for patient access.

In sum, state determinations of health plan network adequacy should be sufficiently comprehensive and stringent enough to ensure that all enrollees can have “reasonable and timely access” to in-network health care services at in-network hospitals, facilities and in the community where the enrollee resides. State responsibility in this matter for both the state-based insurance exchanges and the private market is paramount and clearly contemplated by the federal government (Centers for Medicare and Medicaid Services (CMS)) in its most recent rulemaking. (See: 82 FR 18346-18347)

We are also finalizing policies intended to affirm the traditional role of States in overseeing their health insurance markets while reducing the regulatory burden of participating in Exchanges for issuers. The modified approach we are finalizing for network adequacy, which includes deferring to States with sufficient network adequacy review (or relying on accreditation or an access plan), will not only lessen the regulatory burden on issuers, but also **will recognize the primary role of States in regulating this area.**

Absent such state regulatory oversight, health plans have already demonstrated a widely observed and documented business practice proclivity to *shrink and narrow* their insurance networks in order to shift the cost of health care on to their enrollees. As a broad physician coalition, we strongly denounce these deceptive and manipulative business practices by the health insurance industry. We strongly urge that NCOIL’s network adequacy model be a policy basis for protecting patients from these exploitative business practices by the industry.

Section 6 – Coverage Option Mandate

It is important to note at present, many health insurance plans (e.g. United healthcare and Aetna), in fact, do avail the UCR formula for determining payment for out-of-network services. We agree with the proposed draft that the UCR should be established at the 80th percentile benchmark for charges, in the same or similar specialty, based on geography of the service, as determined by an independent database. Use of the UCR is an important public policy incentive for health plans to contract with physicians and to maintain marketplace equilibrium between payers and providers.

In December 2015, the non-partisan National Association of Insurance Commissioners (NAIC) in their annotations on this issue (MDL 74-22) noted that

States should consider a payment formula such as: “a) some percentage of a public, independent database of charges for the same or similar services in the same geographic area, or b) some percentage of usual, customary and reasonable (UCR) charges in the state, if defined in state law or regulation.”

Furthermore, the NAIC noted the imperative need for states to recognize the need for payment equilibrium in the market: “In setting a benchmark or benchmarks state should carefully consider the impact on the market. Setting a rate too high or too low may negatively impact the ability of facility- and hospital-based providers and health carriers to agree on a contract.”

We believe that mandated UCR payment, as is used in New York State for example, should be an economic inducement for both providers and health insurance carriers to undertake contractual arrangements that greatly maximize the ability of the health insurance networks to provide the enrollee or patient with the full continuum of in-network health care.

Section 7- Emergency Services Provided by Out-of-Network Providers

The health insurance industry should be required to pay the UCR, or the physician’s charge, whichever is lesser, for the out-of-network physician service at in-network hospitals and facilities. This standard should include all physicians who provide emergency care. **Emergency physicians, and others who provide emergency care, are performing screening and stabilization for life- or limb-threatening conditions to every patient, as mandated by the federal Emergency Medical Treatment and Labor Act of 1986 (EMTALA).** Accordingly, the provision of their services cannot be contingent upon considerations regarding the patient’s insurance status or their participation in the health plan network. Thus, their services should be subject to UCR payment requirements on health insurance carriers.

Moreover, out-of-network payment to physicians should always be made directly to the provider of the service, and not to the enrollee. The diversion of payment to the enrollee is a frequent business practice of health insurance plans to impede and encumber the collection of payment by the out-of-network physician, thereby driving up the administrative cost of care.

Section 9- Provider Notice to Enrollees

Under the proposed NCOIL requirement for providing notice “prior to providing services,” patient care is substantially impeded and jeopardized by requiring a potential delay in the performance of physician services for a patient. Quite simply, ethical and legal standards of care do not allow for the performance of certain facility- and hospital-based physician services to be delayed by insurance considerations, as such could be detrimental to quality and to the actual performance of the service. Thus, the provision requiring notice to

enrollees should only be applicable to facilities and to providers who have a scheduled appointment with a patient.

Application of the contemplated “notice” requirement to out-of-network physicians, who have both ethical and legal obligations to ensure the well-being of the patient and the expediency of a diagnosis, is a potentially deleterious impediment to the delivery of health care. For some medical specialties, a delay in providing services can be **directly deleterious to the health of the patient, who may be under anesthesia or otherwise incapable of receiving notice, or to the timely accuracy of a diagnosis (e.g. patient specimen degradation for pathological analysis).**

It is for these aforementioned reasons that this requirement was considered and in broad consensus ***rejected*** by both the National Association of Insurance Commissioners (NAIC) in 2015 and, **notably, in 2010 by the National Conference of Insurance Legislators (NCOIL) in consideration of model legislation being developed on this issue at that time.** Accordingly, we urge NCOIL to maintain its well-deliberated, ***prior position*** on this issue and amend the proposed bill to delete this requirement.

In addition, the referring health care provider cannot infer the determination of another health care provider’s insurance status. Thus, enrollees are best positioned to inquire with their own health plans, or to inquire with the actual provider of the service as to what health insurance plans are served as participating providers.

Section 11 – Balance Billing

The proposed NCOIL legislation contravenes conventional medical billing practices by establishing extraordinary, politically improvised additional requirements, exclusively applicable to out-of-network balance bills and that do not provide meaningful or actionable information for the patient.

The proposed requirement for ***itemized bills*** is administratively onerous and illogical since providers, and the health insurance industry, rely upon a largely automated and standardized medical billing and coding system that denotes services for which the health insurance payer or patient are billed and under which claims are processed by the carrier. This delineation of services also appears on an “explanation of benefits (EOB)” the patient receives from the health insurance payer, whether subject to balance billing or billed under deductibles, co-payments or co-insurance.

The requirement for an “itemized listing of non-emergency medical care provided along with the services and supplies provided” is impractical and an unnecessary administrative onus on the health care system. The itemization is not meaningful or actionable when coming from an out-of-network provider. (Such itemization

requirements may have practical purposes if emanating from the hospital or facility for its miscellaneous service and supply charges, but certainly not from physicians to whom such costs are integral to the provision of the service.) It is also unclear to us what policy concern the itemization requirement is intended to remedy.

Equally important, the contemplated disclosure statement *fails* to inform enrollees of options to have charges waived based upon economic necessity, which is a common practice voluntarily undertaken by physicians. The voluntary waiver or adjustment of charges by physicians, based upon patient economic necessity, should be communicated and legally safe harbored under our proposal in order to ensure that it is not legally assailed by the health insurance carrier.

Furthermore, the legislation fails to standardize a payment rate for the provider's charge based upon the lesser of the provider's charge or the "usual and customary rate" (UCR). We think this omission is a disservice to patients. We recommend a clear citation of UCR in the out-of-network physician communication, including an affirmation that provider is billing in accordance with the UCR applicable to the service and the location where the service is provided. This provision will also help to curb any truly egregious physician billing outliers who charges do not conform to UCR.

Accordingly, as a practical and equitable measure, our proposed language helps to ensure that out-of-network physicians bill in accordance with the UCR and health insurance carriers commensurately pay in accordance with the UCR, thereby largely remedying policy concerns over inordinate balance billing of patients who are not financially held harmless by their insurance carriers.

We also recommend that the legislation place clear obligations on health insurance plans. The current draft largely elides over health insurance carriers responsibilities both to their enrollees and to the health care system. Specifically, health insurance plans should be clearly obligated to:

- 1) provide the out-of-network facility- and hospital-based physician with an explanation of benefits;
- 2) make payment directly to the out-of-network provider (not payment to the enrollee) at the usual and customary rate, or the pay the provider's charge, whichever is lower; and
- 3) apply any amount paid by the enrollee that exceeds applicable deductibles, co-payments or co-insurance towards the enrollees annual limitation on cost-sharing.

With respect to our proposed new subdivision 3), under federal rules to take effect on January 1, 2018, a health insurance carrier that fails to provide an

enrollee with written notice on higher costs associated with scheduled facility- and hospital-based out-of-network care must “count the cost sharing paid by an enrollee for an essential health benefit provided by an out-of-network ancillary provider in an in-network setting towards the enrollee's annual limitation on cost sharing.” (See: 45 CFR 156.230 (e) (1)).

We think it is both logical and proper to have states extend this federal patient cost-mitigation measure to situations wherein enrollees cannot access in-network providers at in-network facilities. These situations wherein enrollees have no in-network options at in-network hospitals and facilities should be rare if the Model NCOIL legislation adopts our proposed revisions to ensure specialty physician network adequacy at hospitals and other facilities, including other measures to induce robust health plan network adequacy and health insurance carrier payment for the out-of-network provider in accordance with UCR.

Section 14 – Provider Directories

When health plan enrollees purchase health insurance products that list in-network hospitals and facilities, but such plans have failed to contract with certain essential facility- and hospital-based physician specialties at these locations, the health plan has deceived the enrollee into purchasing an insurance product that is fundamentally deficient. Such deceptive trade practices by health insurance plans should be expressly prohibited and subject to state sanction under this Model legislation.

In addition, the health insurance carrier should be legally responsible for maintaining an accurate and current provider directory so that enrollees can make responsible decisions for accessing in-network health care services. Accordingly, carriers should be required to, at a minimum, conduct a monthly review of each plans network directory for accuracy.

In order to promote accurate directories on an ongoing basis, carriers should be statutorily compelled to contact facilities and providers listed in the carrier's network directory who have not submitted a claim in the last 6 months to determine if the facility or provider intends to remain in the carrier's provider network. Carriers should update information within 15 working days after receiving notice from the participating facility or provider of a change. These requirements will enable enrollees and patients to make informed choices in non-emergency situations. Out-of-network care is likely to be more expensive for the patient as the result of higher co-payments, co-insurance and different deductibles; however, in some cases patients may want to elect such providers for their services. In any case, the patient should be fully enabled to make an informed choice in a non-emergency, elective health care situation.

Furthermore, patients who rely upon inaccurate provider directory information should not be responsible for out-of-network health care costs that would

otherwise exceed in-network care. The health carrier should be financially responsible for any difference in the amount.

New: Section 15- Waiver of Out-of-Network Charges

Some health insurance plan payers construe any physician waiver of co-payments, co-insurance, or deductibles whether occurring up front at the time of medical services or after receipt of payment by the plan, on any patient claim, regardless of the patient's economic status, as a potentially fraudulent activity by the physician. It has been noted in the legal community, "...the practice of out-of-network providers waiving co-payments and deductibles has continued and is occurring with such frequency in the market that one national insurer in particular has resolved to commence a major legal campaign to curtail the billing practice."²

A provider may receive significant legal protection similarly by including a statement on its insurance claim that it will waive the co-payment or deductible, or that it reserves the right to not pursue the patient for these amounts. This disclosure, however, could result in the insurer's denial of the claim, and if the insurer does not agree to the statement, a provider risks displaying the requisite intent for being accused of insurance fraud.³

Nevertheless, according to a recent national survey, approximately 22% of individuals who used out-of-network providers negotiated an out-of-network bill with the insurer or provider, and 58% were successful in reducing their costs for at least one of the bills.⁴

Health insurance plan efforts to legally assail physician authority to waive charges, on a case-by-case basis, based upon a patient's economic condition, creates a hostile legal atmosphere that is designed to deter such benevolent financial actions by physicians for their patients. Accordingly, physicians should have an explicit legal safe harbor in state law to conduct such waivers on out-of-network charges on a case-by-case basis so as to financially benefit economically distressed patients.

Summary

In total, we believe that our proposed amendments to the proposed NCOIL model create a framework for cost efficient health care that minimizes patient cost and that ensures that health insurance carriers cannot circumvent or shirk their legal and financial responsibilities in providing coverage that provides reasonable and timely in-network access to all health care services.

² "Out of Network Referrals and Waiver of Patient Copayments and Deductibles: The Battle Between Payors and Providers Endures and Intensifies," The Health Lawyer, Charles C Dunham, Esq. O'Connell & Assoc. Albany, NY., Volume 25, Number 5, June 2013.

³ Ibid.

⁴ "Patient's Success in Negotiating Out-of-Network Bills," The American Journal of Managed Care, Kelly A. Kyanko, MD, MHS, Susan H. Busch, PhD, Vol, 22, No 10, October 2016.

Thank you for your consideration of these proposed amendments.

Respectfully submitted,

American Academy of Orthopedic Surgeons (AAOS)
American Association of Oral and Maxillofacial Surgeons (AAOMS)
American College of Emergency Physicians (ACEP)
American College of Radiology (ACR)
American Society of Anesthesiologists (ASA)
American Society of Plastic Surgeons (ASPS)
College of American Pathologists (CAP)
Physicians for Fair Coverage (PFC)

cc: Emily Carroll, Senior Legislative Attorney,
American Medical Association

Attached: Proposed Amendments of the Coalition