Statement
of the
American Medical Association

Health, Long-Term Care and Health Retirement Issues Committee
of the
National Conference of Insurance Legislators

Draft Out-of-Network Balance Billing Transparency Model Act
November 18, 2017

Chairman Cahill and members of the Health, Long-Term Care and Health Retirement Issues Committee (Committee), thank you for the opportunity to submit this testimony on your draft Out-of-Network Balance Billing Transparency Model Act (Model Act). The AMA appreciates the opportunities the Committee has provided the AMA to engage with you throughout the development of the Model Act.

The AMA shares the Committee's interest in developing patient-centered solutions to unanticipated out-of-network care and addressing the financial burden patients may face when they incur unexpected expenses for out-of-network charges not covered by their health insurance company.

We believe that these problems have to be addressed through a multi-pronged approach that not only protects patients from unanticipated out-of-network billing, but also helps solve the larger set of problems that cause these bills, including the way that some health insurers price their products to consumers, organize their provider networks and interact with physicians who are not under contract, or out-of-network.

These problems are interconnected, and all have contributed to patients' assuming increasingly disproportionate responsibility for out-of-network health care expenses not assumed by their health insurance plans. If unaddressed, these practices will continue to create significant access issues and financial problems for patients. Fortunately, your draft Model Act aims to address many of these issues and represents a good starting point for legislation to protect patients.

In October, the AMA submitted detailed comments on the draft Model Act and those comments are attached for your reference. Addressed below are particular points the AMA would like to reiterate as you continue to move toward final consideration of the Model Act.

Essential Component of Model Act

As you move forward with this Model Act, we urge you to address unanticipated out-of-network billing in a way that ensures patients have access to adequate and comprehensive networks and are financially protected when unanticipated out-of-network care is received. Additionally, we ask that you do this in a way that also encourages fair contract negotiations between physicians and health insurance plans. Specifically:

- The AMA urges the Committee to incorporate into the Model Act requirements for active state regulation of networks using quantitative, measurable standards that promote geographic accessibility to in-network physicians. Such standards should include patient-physician ratios, time and distance standards and wait-time maximums. Especially critical, these standards should ensure access to both primary and specialty care, including access to hospital-based specialty

physicians (e.g., anesthesiologists, pathologists, radiologists, emergency physicians, hospitalists) at in-network hospitals.

- The AMA also urges the Committee to protect patients from unanticipated out-of-network costs. When patients receive out-of-network emergency care or unanticipated out-of-network services during scheduled hospital care, patients should not be responsible for more than in-network co-pays, coinsurance or deductible payments. Moreover, any cost-sharing should count toward the patient's out-of-pocket maximum under their health insurance plan.

- Health insurers' out-of-network payments should reflect the cost of providing care in order to incent insurers and physicians to enter into fair contracts. As such, we strongly agree with the draft Model Act's use of the 80th percentile of charge data from an independent source as the basis for "usual and customary costs." We urge you to move this definition of "usual and customary costs" to Section 4 of the model bill and to require that insurers' set their out-of-network payments at the "usual and customary costs," as defined.

All three of these components are critical to the success of legislation addressing unanticipated out-of-network care, creating a three-pronged balancing act of patient and market protections. The AMA urges you to incorporate all three into your model legislation.

Incentives to Fairly Contract

We understand that some concerns have been expressed regarding the use of charge-based data from an independent source as basis for out-of-network payments. While we appreciate these concerns, we urge the Committee to maintain its current definition of usual and customary costs.

The Model Act's current definition reflects on the success of the 2014 New York law addressing balance billing and provider networks. As you know, New York legislators, after years of working with stakeholders, established that independent charge data was the best benchmark to ensure comprehensive coverage for patients and incent health insurance companies and physicians to fairly contract with each other so that in-network providers are available to patients. We urge you to build on New York's success with this model.

AMA supports the use of FAIR Health data for out-of-network payments

The FAIR Health database is often identified as the most comprehensive source for independent charge-based data. The AMA strongly supports the use of FAIR Health data for these purposes for a number of reasons including:

- FAIR Health was established after private litigation and a 2009 investigation by the New York Attorney General determined that many health insurance companies were using faulty, manipulated data to establish usual and customary rates, thereby resulting in overcharges to patients and underpayments to physicians. A number of health insurance companies entered into settlements under which they agreed to discontinue utilizing the flawed database to determine out-of-network payments, and to pay more than $90 million to finance the creation of a new and accurate database to determine the charges for medical care provided by out-of-network physicians. Since its creation, FAIR Health has established itself as a conflict-free and reliable source of health care data, and the AMA supports using the database to solve the problem it was created to solve.

- When FAIR Health compiles it data, it automatically employs an outlier methodology to detect and remove data entries that represent invalid charge data. Your proposal targets outlier charges even further by removing those in the top 20th percentile of the geographic area. As a result, the data that would be used to establish these out-of-network payments are very representative of the costs of providing the care and outliers would have no effect on the resulting data.

- Many health insurance plans currently use FAIR Health data to establish their payments, and many states use FAIR Health data for workers compensation fee schedules and other programs. As such, there is nothing novel about using the data from FAIR Health as benchmarks for physician payments, and in fact, precedent and trust in many states already exists.

- The FAIR Health database is an extremely robust database, capturing approximately 75 percent of the privately insured population and providing stakeholders with the ability to drill down by procedure code and "geozip." They have nearly 500 geozip regions in their database reflecting local billing patters, making FAIR Health suited to determine these payments in every community across the country.

AMA opposes in-network rates as a benchmark for out-of-network payments

Some health insurance plans have suggested that using their negotiated, discounted rates as the basis for out-of-network payments is appropriate. The AMA strongly opposes such a proposal for several reasons, including:

- In-network rates are payments rates that are negotiated by physicians and insurance plans during the contracting process. Physician agree to discount their fees in exchange for contracted benefits such as increased patient volume, being listed in the plan's provider directory, and prompt payment of claims. However, setting out-of-network payments at those discounted rates removes health plans' incentives to negotiate in good faith. It also further disrupts the increasing market imbalance tilted toward health insurers—an undesirable outcome for any state.

- The AMA is also concerned that allowing insurers to unilaterally determine out-of-network physicians' payment is a massive step backwards in efforts to promote fairness and transparency in the health care system, especially in health care costs. Such a standard would be reminiscent of pre-2009, when out-of-network payments were based on manipulated data and patients and physicians were financially harmed by a lack of transparency.

- Additionally, undercutting physician's ability to negotiate a fair contract not only impacts the stability of physician practices and the ability of physicians to invest in innovation for their practices, but impacts the financial health of our communities. Data show that each physician, on average, supports 13.84 jobs and contributes to a total of 10 million jobs nationwide. In New York, for example, $5.6 billion in local and state tax revenue is generated by physicians, while physicians generate $93.3 million in local and state tax revenue in Vermont. In Oklahoma, $5.2 billion in wages and benefits are supported by physicians, while that number is $10.6 billion in Indiana. In North Dakota, 13,038 jobs are supported by physicians, while physicians support 85,137 jobs in Kentucky. [1] Ensuring that physician practices are able to negotiate fair contracts has far reaching benefits in every state.

[1] The State Level Economic Impact of Physicians Report (IMS Health, March 2014)

AMA opposes Medicare rates as a benchmark for out-of-network payments

Health insurance companies have also suggested that Medicare rates, or a percentage of Medicare rates, are an acceptable benchmark for out-of-network payments to physicians. Again, the AMA strongly disagrees.

Medicare uses the sophisticated resource-based relative value scale (RBRVS) system to establish physician payments, determined by the resource costs associated with the total amount of physician resources required to provide a specific service. The total amount of physician resources is referred to as the service's "relative value." A service's relative value is measured by determining the "relative value units" (RVUs) with respect to the following three factors: (1) physician work; (2) practice expense; and (3) professional liability insurance. However, before Medicare rates are finalized, they go through adjustment and conversion processes to meet federal budgetary requirements.

These adjustments are done in a budget neutral manner, meaning that if an adjustment increases the payment for one service, it must account for this increase by decreasing the Medicare conversion factor. This establishes artificial decreases in payment for many physician services ever year.

Additionally, before the final Medicare payment is set, the geographically adjusted RVU is multiplied by a conversion factor that determines the final Medicare payment. The conversion factor is a monetary payment determined by Medicare each year. Adjustments to the conversion factor are typically based on the Medicare economic index, adjustments pertaining to budget neutrality and other adjustments stipulated by legislation. After everything is complete, the resulting payment rates are not generally reflective of markets rates for physician services.

Physicians are able to accept Medicare rate for the same reasons they negotiate discounted contracted rates with private health plans, including the high volume of Medicare patients associated with being a Medicare provider. But using Medicare to establish out-of-network payments in the private market will have the same results as using the in-network discounted rates, including undermining fair contracting efforts between physicians and insurers, as well as undercutting the financial stability of physician practices.

Conclusion

The AMA is committed to solving provider network problems and is grateful to the Committee for addressing these critical issues through model legislation. We look forward to continuing to work with you on this model bill and other efforts that will support network adequacy, fair payment standards and patient protections from unanticipated out-of-network bills.

Thank you for the opportunity to submit this testimony and for the continued opportunity to work with NCOIL. Please contact Emily Carroll, JD, Senior Legislative Attorney, AMA Advocacy Resource Center, at emily.carroll@ama-assn.org or (312) 464-4967 with any questions.

AMA
AMERICAN MEDICAL ASSOCIATION

JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

ama-assn.org
t (312) 464-5000

September 11, 2017

The Honorable Kevin Cahill
Chair
Health, Long-Term Care
and Health Retirement Issues Committee
NCOIL National Office
2317 Route 34, Suite 2B
Manasquan, NJ 08736

Re: AMA Comments, NCOIL's Draft Out-of-Network Balance Billing Transparency Model Act

Dear Chair Cahill:

On behalf of the American Medical Association (AMA) and our physician and student members, thank you for the opportunity to submit comments on the National Conference of Insurance Legislators' (NCOIL) Draft Out-of-Network Balance Billing Transparency Model Act (draft model act). Additionally, I would like to extend the AMA's appreciation to the Health, Long-Term Care and Health Retirement Issues Committee for addressing this important issue. The draft model act offered for public comment is a strong starting point. Below, the AMA suggests several revisions that we believe will further strengthen and improve the draft model act.

Out-of-Network Protections

I would first like to bring to your attention new AMA policy adopted at our Annual Meeting this past June (see attached). This policy was generated by many of the hospital-based national medical specialty societies, as well as several state medical associations, that have been actively developing solutions to unanticipated out-of-network care.

Adoption of this policy signifies physicians' strong commitment to creating patient-centered solutions to unanticipated balance bills in the hospital setting. As you can see, the new AMA policy supports the protection of patients from specific out-of-network bills and requires that strong network adequacy requirements and fair benefits standard are put in place. With this policy in mind, we urge you to consider the following for inclusion in NCOIL's draft model act:

- Patients should not be financially penalized for receiving unanticipated out-of-network care. When these specific situations arise, patients should not be responsible for more than their co-pays, coinsurance or deductible payments and any cost-sharing should count toward the patient's out-of-pocket maximum under their health insurance plan.

- The best way to prevent out-of-network costs to patients is by ensuring adequate networks. The AMA urges NCOIL to incorporate into its model bill requirements for active state regulation of networks using quantitative, measurable standards that promote geographic accessibility to in-network providers. Such standards should include patient-provider ratios, time and distance standards and wait-time maximums. And especially critical, these standards should ensure access to both primary and specialty care, including access to hospital-based specialty physicians (e.g., anesthesiologists, pathologists, radiologists, emergency physicians) at in-network hospitals. When a provider network is determined not to meet such standards, it is imperative that it not be approved by state regulators.

- Health insurers' out-of-network allowables should reflect the cost of providing care in order to incent insurers and physicians to enter into fair contracts. As such, we strongly agree with NCOIL's draft model bill's use of the 80th percentile of charge data from an independent source as the basis for "usual and customary" costs. We urge you to move this definition of "usual and customary" costs to Section 4 of the model bill and to require that insurers' set their out-of-network allowables at the "usual and customary" costs as defined. Additionally, it is critical that insurers recognize patients' assignment of benefits to out-of-network physicians. Without this requirement, the patient and the physician spend unnecessary time and money attempting to secure payment for care.

This multi-pronged solution is designed to apply to both emergent and non-emergent care. Patients receiving emergency care and the physicians providing it should be subject to the protections and requirements outlined above. Additionally, this approach would negate the need for many of the other costly and administratively burdensome provisions proposed in NCOIL's draft model act. For example, many of the billing requirements outlined in Section 11 would be superfluous if the physician received the required payment at the "usual and customary" rate as defined in your current draft and the patient was only responsible for applicable co-pays, coinsurance and deductible payments.

Notice and Disclosure

NCOIL's draft model act aptly considers the importance of transparency and disclosure in patient care. The AMA has policy that encourages physicians to communicate information about the cost of their services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible. However, we have serious concerns about some of the disclosure requirements included in the current draft model act, as some physicians will be unable to meet the outlined standards.

Most importantly, requirements to disclose fees to patients should never come at the price of delayed patient care. However, we fear some of your requirements might put physicians and patients in such a situation while hard-to-obtain information is located and insurers are consulted. For example, physicians who are not in the patient's provider network will be unfamiliar with the health insurer's out-of-network payment rates, the level of coverage the patient's products provides for out-of-network care and other factors specific to the patient's coverage. As such, a physician will be unable to estimate the amount for which a patient will be responsible.

Finally, the AMA strongly supports NCOIL's Healthcare Balance Billing Disclosure Model Act (2011 Model Act), adopted in 2011. The disclosure provisions outlined in the 2011 Model Act strike an important balance, which is why it garnered such widespread support. The AMA supports re-adoption of the 2011 Model Act and/or inclusion of its provisions in NCOIL's new draft model act.

Prior Authorization

The AMA continues to advocate for improvements to the prior authorization process and an overall reduction in its burden on patients and physicians. We agree that the information outlined in Section 13 of your draft model act is critical information for a patient to receive prior to care and the prior authorization determination, if needed, is a logical way for that information to be communicated. As you finalize this draft, we ask that you consider shortening the required response time for a prior authorization request to 48 hours from submission and 24 hours for urgent care. Too often care is delayed because a prior authorization determination has not been received. It is the AMA's position that three business days is often too long to wait to determine if services will be covered that are already covered under the patient's benefit plan and the physician has already determined to be medically necessary.

Provider Directories

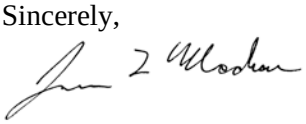
We are pleased to see a section devoted to improving the accuracy of provider directories in the draft model act. The AMA has advocated to your committee for several years about the need to adopt strong standards on provider directories to ensure that patients are able to make informed decisions about their health care and health insurance.

As NCOIL moves forward with efforts to improve provider directories, we ask that you require:

- Health insurers conduct a monthly review of their provider directories to ensure accuracy.
- Health insurers provide and promote in the online directory a toll-free number for patients to report inaccuracies within directories.
- State insurance regulators conduct yearly audits of provider directories and provide a toll-free number for patients to report inaccuracies.
- Patients be held harmless when they inadvertently receive out-of-network care from a provider listed as being in the network in the directory.

In conclusion, the AMA greatly appreciates the opportunity to comment on this draft model act. We look forward to further engagement with you on this important issue. If you have any questions, please contact Emily Carroll, JD, Senior Legislative Attorney, AMA Advocacy Resource Center, at emily.carroll@ama-assn.org or (312) 464-4967.

Sincerely,



James L. Madara, MD

Attachment

AMA Policy

Out-of-Network Care H-285.904

Topic: Managed Care
Meeting Type: Annual
Action: NA
Council & Committees: NA

Policy Subtopic: NA
Year Last Modified: 2017
Type: Health Policies

Our AMA adopts the following principles related to unanticipated out-of-network care:

1. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.

2. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.

3. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.

4. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.

5. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.

6. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.

7. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network 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 by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.

8. Mediation should be permitted in those instances where a physician’s unique background or skills (e.g. the Gould Criteria) are not accounted for within a minimum coverage standard.