AAPAN

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VIA EMAIL TO: wmelofchik@ncoil.org

Assem. Kevin Cahill
Health, Long-Term Care & Health Retirement Issues Committee
National Conference of Insurance Legislators
Atlantic Corporate Center
2317 Route 34, Suite 2b
Manasquan, NJ 08736

RE: AAPAN Comments Concerning the Draft Out-Of-Network Balance Billing Transparency Model Act

Dear Chairman Cahill, Vice Chair Mulready, and other members of the Committee:

I am writing to submit comments concerning the Draft Out-Of-Network Balance Billing Transparency Model Act sponsored by Senator Seward on behalf of the American Association of Payers Administrators and Networks ("AAPAN"). AAPAN is a national association that represents organizations in the individual group and government health, and workers' compensation markets. AAPAN is an active voice advocating for patient access to appropriate quality health care in these respective markets, and provides a unifying, collaborative forum for member organizations to work in common cause on initiatives for improving healthcare at the federal and state levels.

We appreciate the efforts that Senator Seward and the committee have made to take on this important issue. Our comments are meant to clarify and improve the operability of the draft model.

Proposed Modifications to the Draft Model Act

Section 6. Coverage Option Mandate

While we do not object to the creation of the coverage mandate under Section 6, we believe that this mandate should not in any way prohibit plans from arranging a lower fee or alternative payment methodology with out-of-network providers, if such an amount can be negotiated. Accordingly, we suggest adding language to subsection (A) that states: "Nothing in this section shall prohibit the health benefit plan and provider

reaching mutual agreement to an alternative reimbursement amount or methodology other than the "usual and customary cost".

Section 7. Emergency Services Provided by Out-of-Network Provider

We are concerned that this section, which uses the term "out-of-pocket costs," can be read to require plans to cover any costs beyond those covered for emergency services provided by out-of-network providers. This reading would not only eliminate incentives for providers to join networks, but also to inflate prices charged for emergency care. We suggest that this language be clarified by utilizing the concepts defined in federal guidance, by using the components of the term "cost-sharing" rather than "out-of-pocket costs.[1] Section 7 can then be clarified by adding, after the term "no greater out-of-pocket costs," the following: "(co-insurance, deductibles, co-payments)."

Section 8. Health Benefit Plan Notice to Enrollees

We are concerned with the strict language in subsection (A)(7)(2), which requires that enrollees be provided with a description of the out-of-network reimbursement methodology specifically tied to a usual and customary cost standard. We are concerned that this requirement will not provide the needed transparency for the enrollees of plans that do not use a usual and customary standard methodology.

We agree that the section should require payer transparency for members on out-of-network (and in network) costs. Nevertheless, this section should not dictate how transparency is defined and how costs are calculated and/or expressed in terms of specific methodologies. Payers will know how best to do this based on their plan offerings. A plan that utilizes a Medicare (or other) benchmark would not be able to provide useful out-of-network cost transparency to an enrollee using the usual and customary standard. As currently written we are concerned that these requirements will create an unneeded burden on plans that use a number of options to price out-of-network claims, leading them to drop options that are better for the member.

Accordingly, we request that language in subsection 8(A)(7)(2) be added after "ususal and customary" that allows another "methodology utilized for reimbursement" for use in the out-of-network reimbursement description.

Section 9. Provider Notice to Enrollees

While we support the goals of this section, we believe that there are two components that should be changed to reflect the relative ability of providers to represent accurate information to enrollees. First, the provider should (pursuant to subsection B) identify not only the "health benefit plans" but also the provider networks in which the provider

[1] 2018 Letter to Issuers in the Federally-facilitated Marketplaces, page 46
https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces.pdf

participates. Secondly, we are concerned that the information provided by the provider pursuant to (C)(1) will conflict with estimates the payer required to provide. Accordingly, we believe this requirement on the provider should be removed.

Section 13. Prior Authorization

This section requires that utilization review pre-authorization determinations and provider notification should be made within three days. While we do not object to this specific requirement, we believe that the Model should recognize that states already have these standards in their existing laws and that payers have operations to support those existing standards.

Rather than mandate the specific three day period without comment, we recommend adding language applying the standard in instances when there is not already an existing requirement. This can be done by adding language that the standard will apply "in the absence of an existing state regulation governing authorization response times." In this way, the Model will fill a gap but not replace what may already be well established practice.

Finally, we recommend that notice of the specific amount a plan will pay for out-of-network services required in subsection (A)(3) be identified as an "estimate of the dollar amount." This is appropriate as other factors not known at the time of the notice may change the ultimate reimbursement.

Section 14. Provider Directories

We propose the following clarifications to allow flexibility in the ways plans and networks have structured the systems necessary to produce accurate directories.

In subsection (A), recommend changing "provide" to "make available" as this is more compatible with later language in the section and because it makes clear that the requirement for a printed directory is driven by request.

In subsection (A)(2) we believe it is appropriate for some payers to use the directory websites of their network partners, so long as the links to those networks are specifically labeled and linked by the carrier for transparent access by consumers or enrollees. Smaller payer organizations may use the information technology infrastructure of their networks instead of building their own duplicative directory. So long as the underlying requirements for information is the same, there is no loss of transparency.

In subsection (B)(3)(a) we oppose the inclusion of facility affiliations for providers in the directory unless those facility affiliates are also in the network. Individuals utilizing the online directory will may be misled into assuming that the facility provider is in network.

In subsections (B)(3)(c) and (D)(c) we recommend removing the specific types of services performed as this is not a specific, stable list and not information made readily available by providers. Identifying the facility type will provide useful, stable information
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In subsections (B)(4)(a) and (D)(a) we believe that “contact information” should be changed to “telephone number” for consistency with the requirements for hospitals and facilities is subsections (B)(4)(b), (B)(4)(c), (D)(b), and (D)(c).

Additional Components: Support for a Binding Independent Dispute Resolution Program

AAPAN supports the addition of a binding independent dispute resolution program. States (including California, Delaware, Florida, Illinois, New York and Texas) have already established these programs to address provider/payer disputes. AAPAN supports the inclusion of this mechanism.

Thank you for the opportunity to comments on the draft model. A copy of our proposed amendments are enclosed. We look forward to following up on our comments with the Committee.

Sincerely,

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