AMA
AMERICAN MEDICAL ASSOCIATION

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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

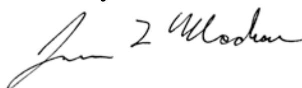
We are pleased to see a section devoted to improving the accuracy of provider directories in the draft model act. The AMA has advocated to your committee for several years about the need to adopt strong standards on provider directories to ensure that patients are able to make informed decisions about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