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November 14, 2017

The Honorable Kevin Cahill, *Chair*
The Honorable Glen Mulready, *Vice Chair*
Health, Long-Term Care & Health Retirement Issues Committee
National Conference of Insurance Legislators
2317 Route 34, Suite 2B
Manasquan, NJ 08736

RE: The Out-of-Network Balance Billing Transparency Model Act

Dear Assemblyman Cahill and Representative Mulready:

I am writing on behalf of the American Society of Plastic Surgeons (ASPS) regarding the proposed "Out-of-Network Balance Billing Transparency Model Act." ASPS is the largest association of plastic surgeons in the world, representing more than 7,000 members and 94 percent of all board-certified plastic surgeons in the United States. Our mission is to advance quality care for plastic surgery patients and promote public policy that protects patient safety.

Combined with inaccurate network directories, the phenomenon of shrinking insurance networks has contributed to the phenomenon of patients receiving large, unexpected bills at an unacceptable rate. Too often the scrutiny of these bills focuses on physician billing practices and not nearly enough on another crucial part of this problem – insurance companies selling inadequate products and failing to appropriately disclose the realities of the coverage their customers are purchasing. Therefore, we appreciate the opportunity to weigh in on NCOIL's proposed model legislation.

1. Network adequacy language should be as strong as possible in order to protect patients from narrow networks created by health insurers.

The network adequacy section of the model language does not require regulators to assess whether health plans have contracted with in-network physicians at in-network hospitals and facilities. One state that addressed this issue – California – adopted new rules to gauge the capacity of health plan networks for the provision of hospital-based physician providers. Title 10, Section 2240.5(d)(14) of the California Code of Regulations provides that health plans submit prior to approval of the plan:

> *(14) A report describing, for each network hospital, the percentage of physicians in each of the specialties of (A) emergency medicine, (B) anesthesiology, (C) radiology, (D) pathology, and (E) neonatology practicing in a hospital who are in the insurer's network(s).*

Hewing closely to California, Louisiana established a network adequacy requirement that "each health insurance issuer shall maintain a network of providers that includes but is not limited to providers that specialize in mental health and substance abuse services, facility-based physicians, and providers that are

essential community providers." (Louisiana Revised Statutes 22:1019.2.B.(1)) Under this section of Louisiana law, a "facility-based physician" means a physician licensed to practice medicine who is required by the base health care facility to provide services in a base health care facility, including an anesthesiologist, hospitalist, intensivist, neonatologist, pathologist, radiologist, emergency room physician, or other on-call physician, who is required by the base health care facility to provide covered health care services." (Louisiana Revised Statutes 1019.1.)

Elsewhere, the Maryland Attorney General commented on proposed network adequacy rules that are currently under development in the state. The attorney general's office noted that "consumers would be well-served by the express inclusion of the following enumerated hospital-based providers in Proposed 31.10.44.04: anesthesiology, emergency medicine, interhospital transportation services, neonatal-perinatal medicine and pathology."[1] (Radiology services were included in the proposed rule.)

State determinations of health plan network adequacy should be comprehensive and rigorous enough to ensure that all enrollees have reasonable and timely access to in-network health care services – at in-network hospitals and facilities – and in the community where the enrollee resides.

2. Imposing a restraint on the performance of certain physician services is ill-advised.

Section 9(c)(1) would impede a physician from performing timely services for a patient without first providing a cost estimate of services. Myriad scenarios exist in which physician services cannot be delayed without patient harm. For example – the needed substitution of an out-of-network anesthesiologist could occur immediately before the start of a scheduled procedure, or the performance of pathology services may be necessary while a patient is under anesthesia. Ethical and legal obligations prohibit physicians from delaying the provision of medical services based on insurance considerations. Implementing this prior restraint clause would be detrimental to medicine and is extremely likely to harm patient care. Therefore, the proposed requirement for physician written estimates "prior to providing services" should be removed.

As outlined in Section 13, the proposed requirement for a healthcare provider to provide a patient with "an itemized listing of the non-emergency medical care provided along with the dates the services and supplies were provided" is equally concerning. This requirement is inconsistent with coding and billing practices that are largely automated. Physician costs for services submitted to patients and payers are classified under the American Medical Association's Current Procedural Terminology (CPT) that is recognized by the federal government, standardized throughout the healthcare insurance sector, and highly nuanced. The requirement for an itemized listing may have relevance to facility or hospital charges, but unclear applicability to physician services for which these costs are integrally factored into the physician charge.

The American healthcare system already faces sizeable regulatory burdens and increasing costs. Adding more cumbersome obligations for providers would further hinder physicians from delivering the highest quality of care, and would be a slippery slope toward a potentially harmful environment for patients and physicians alike.

3. The use and citation of usual and customary rate (UCR) is a critical component.

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[1] August 21, 2017 Correspondence of Patricia F. O'Connor, Maryland Assistant Attorney General, Deputy Director, Health Education and Advocacy Unit to Lisa Larson, Regulations Manager, Maryland Insurance Administration.

America's Health Insurance Plans (AHIP) opposed the use of the UCR definition currently provided in the proposed model legislation during the October 13 NCOIL stakeholder call, and implied that health plans do not use UCR to determine reimbursement. The idea that health plans do not rely upon the UCR as currently defined in the model legislation is dishonest. Many health plans rely upon the 80th percentile of all charges for the particular healthcare services performed by a provider in the same or similar specialty, and provided in the same geographical area as reported in a benchmarking database (i.e. FAIR Health Inc.). Furthermore, a recent study by the 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.[2]

NCOIL should take every precaution not to utilize an insurer-influenced list of reimbursements in its health-related data and statistics, because **insurers have a storied and documented history of rate manipulation**. In New York, United Healthcare and Aetna were ordered to pay a $350 million legal settlement over the use of Ingenix, a United Health Group health data subsidiary that was found to be manipulating usual and customary rate data to defraud its customers. It was as a result of this settlement that FAIR Health, Inc. was created solely to provide objective healthcare cost information to providers, patients and insurance companies. After the settlement in New York, United Healthcare rebranded Ingenix as Optum. In 2016, ambulatory surgical centers in California won a $9.5M settlement against Optum and United Healthcare for continuing the same corrupt practices.

Consequently, we support the current use and citation of the UCR for determining the market value of services as set forth in the proposed model, and urge that it be also included in the definition section of the bill in order to govern both health plan payment and dispute resolution.

4. **While we prefer a fee schedule based on a well-structured repository – such as FAIR Health Inc. – to settle billing disputes, should an Independent Dispute Resolution (IDR) process be used, we would ultimately support the structure set forth in Section 11.**

As stated above, we believe that an independent, third-party fee schedule should be utilized to resolve billing disputes. FAIR Health Inc. has the nation's largest collection of privately billed medical claims data – and its healthcare cost information is organized geographically, allowing it to provide relevant cost information that is regionally specific. This would allow states to avoid using opaque insurer data and exposing American citizens to potential corruption. However, if NCOIL decides to forego this option, we would ultimately support the IDR process that is modeled after the New York law. Including criteria for dispute resolution is an important step in benchmarking data points for consideration by an independent entity. Section 11 of the model legislation includes the language, "The sole issue to be considered and determined in a IDR proceeding is the reasonable charge for the medical services provided to the individual." Determining the reasonable charge during this proceeding is integral to ensuring fair payment for services rendered. Looking at New York, the state law on independent resolution reads, "Criteria for determining a reasonable fee. In determining the appropriate amount to pay for a health care service, an independent dispute resolution entity shall consider all relevant factors, including: (c) the physician's usual charge for comparable services with regard to patients in health care plans in which the physician is not participating and (f) the usual and customary cost of the service." The usual and customary cost – in New York – is defined as:

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[2] "Quantitate Assessment of Databases for Out-of-Network Physician Reimbursement," Final Report, NORC at the University of Chicago, May 24, 2017.

Usual and customary cost means the eightieth percentile of all 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 in a benchmarking database maintained by a nonprofit organization specified by the superintendent. The nonprofit organization shall not be affiliated with an insurer, a corporation subject to article forty-three of the insurance law, a municipal cooperative health benefit plan certified pursuant to article forty-seven of the insurance law, or a health maintenance organization certified pursuant to article forty-four of the public health law.

We strongly recommend the utilization of a third-party claims data repository to set the fee schedule for billing dispute resolution. However, if this is not the preferred option, we urge you to keep the IDR process modeled after the New York law, and to dismiss any efforts by AHIP – or any other entity – to weaken this resolution process or the criteria used therein.

We look forward to continuing to participate in the NCOIL deliberation process on this important issue. Please do not hesitate to contact Patrick Hermes, Director of Advocacy and Government Relations, at phermes@plasticsurgery.org or (847) 228-3331 with any questions or concerns.

Sincerely,

Jeffrey E. Janis, MD, FACS
President, American Society of Plastic Surgeons

cc: Members, NCOIL Health, Long-Term Care & Health Retirement Issues Committee