June 29, 2021

Secretary Marylou Sudders
Massachusetts Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

RE: ***Section 71, Ch. 260 of the Acts of 2020***

Dear Secretary Sudders:

On behalf of Blue Cross and Blue Shield of Massachusetts (BCBSMA), I offer comments on the establishment of an out-of-network commercial payment rate for emergency and non-emergency health care services pursuant to Section 71 of Chapter 260 of the Acts of 2020.

Our state is emerging from a once-in-a-century pandemic that has challenged us all, especially our health care system. Our hospitals and clinicians have done superb and heroic work, saving countless lives, often putting themselves at risk. We take pride in our support and partnership with our state's extraordinary health care providers.

While we continue to work together to promote public health and recover from the pandemic, we must not lose sight of another urgent issue: the affordability of health care in the Commonwealth. Many Bay State companies are still struggling to recover economically and many of our neighbors remain unemployed or under economic strain. The cost of health care is an increasingly heavy burden. We appreciate the current focus on out-of-network billing since it is a critical consideration in this environment.

In 2017, the Special Commission on Provider Price Variation's final report strongly recommended:

> Comprehensive out-of-network billing laws require a three-pronged approach. First, there must be a fair default rate for out-of-network services. Second, there must be consumer education, notice to patients, and provider price transparency, so that consumers only receive out-of-network bills when they affirmatively choose to visit an out-of-network provider. Third, where the health plan pays the provider the appropriate default rate, that provider must be prohibited from balance-billing the patient.

See Special Commission on Provider Price Variation Report, March 15, 2017, 69.

We agreed with the conclusion of this multi-stakeholder Commission and are pleased that consumer awareness and balance billing prohibitions have been addressed. With those protections in place, the third prong, a fair default rate for out-of-network services, becomes more critical for a composite solution.

Much analysis has occurred on this topic since the Special Commission's report. The Health Policy Commission (HPC) released a DataPoints in August 2019 that reviewed variation in out-of-network payment benchmarks, including percentile of charges, percentage of median allowed amount, and percentage of Medicare. The HPC's analysis found that paying out-of-network providers at a percent of charges are typically two to three times higher than those based on actual negotiated allowed amounts or Medicare rates. In many instances, 125% of Medicare was comparable to the median allowed amount for the codes examined.

More recently, a May 2020 HPC chartpack found that many of the negative consequences of out-of-network billing have intensified, including lack of consumer awareness, potential balance billing, and an increase in the amounts charged by out-of-network providers. Many hospitals continue to outsource certain specialty providers, including ED doctors, anesthesiologists, pathologists and radiologists, a practice associated with higher rates of out-of-network claims. BCBSMA has seen instances where emergency services claims were between 20 and 50 times the Medicare rate. This is not a sustainable environment.

Setting an out-of-network rate is essential – it would directly decrease costs for the health care system, patients and the Commonwealth --- both directly at MassHealth and as it impacts our collective work system-wide. We would note the important voices of the consumer and employer-purchaser in this discussion as well, since these stakeholders have expressed support for setting a reasonable default rate.

The current costs of out-of-network services impedes Massachusetts' ability to meet the statewide health care cost benchmark. For some services, in fact, charges range between three to five times our in-network rate, on average, and we have seen some cases where the charge is as high as one hundred times our in-network rate. When we (or the state) is forced to pay these levels, there are significant costs. More importantly, the current system impacts members who may have cost sharing as part of their plan design. The higher the out-of-network payment, the more a member will have to pay out-of-pocket.

Section 71 of Chapter 260 tasks the Secretary with making recommendations for establishing a default rate for noncontracted, out-of-network commercial payment rate for emergency and non-emergency health care services in the commonwealth. In setting this standard, we encourage you to consider several key principles:

- The overall impact should result in cost savings and have minimal additional administrative expense to providers and payers;
- There should be a reasonable, transparent, and simple approach to applying a rate;

- Any rate should ensure that current network participation levels are improved upon.

It is important to ensure that any rate does not inadvertently entice providers to leave a network. Currently, some out-of-network providers receive charges not controlled or regulated at any level. Incenting providers to further leave a network would cause significantly increased costs to the system and would seriously harm member access to vital health care services. This protection is particularly critical for the next generation of robust tiered and limited network designs, historically providing significant premium relief to the market. Since it was mentioned in the listening sessions by other participants, I want to reiterate BCBSMA's commitment to ensuring robust networks for our members in addition to the strong network protections for consumers that already exist in Massachusetts. The Division of Insurance regulates and monitors network adequacy for the market, so there are system checks to monitor changes.

Other states have taken varied approaches to address out-of-network billing and their experience is useful for the Administration as they consider a reasonable reimbursement rate. USC-Brookings Schaeffer Initiative for Health Policy (USC-Brookings) examined New York's experience with the arbitration process utilizing data released by the New York Department of Financial Services[1]. The data indicates that the state's arbitration process is substantially increasing what New Yorkers pay for health care. Additionally, a report from the New York Department of Financial Services found that arbitration decisions averaged 8% higher than the 80th percentile of charges. USC-Brookings found that it was likely that the very high out-of-network reimbursement attainable through arbitration will increase emergency and ancillary physician leverage in negotiations with commercial insurers, leading either to providers dropping out of networks to obtain the higher payment or extracting higher in-network rates, or some combination of the two, which in turn will increase premiums.

USC-Brookings also examined California's out-of-network law which requires fully insured plans to pay out-of-network physicians at in-network hospitals the greater of the insurer's local average contracted rate of 125% of Medicare[2]. They found a 17% decline in the share of services delivered out-of-network at inpatient hospitals and ASCs. While the California Medical Association expressed concerns that California's law would impact networks, such as narrower networks and adversely affect patients' access to in-network care, USC-Brookings did not see evidence of diminishing network breadth.

An analysis published in January 2021 in Health Affairs examined the impact of arbitration in New Jersey[3]. The researchers found that arbitrators seemed to anchor their decisions to the 80th percentile of charges which ultimately resulted in increases in health care costs. While relatively few cases resulted in arbitration, the award amounts were

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[1] https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/10/24/experience-with-new-yorks-arbitration-process-for-surprise-out-of-network-bills/

[2] https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/09/26/california-saw-reduction-in-out-of-network-care-from-affected-specialties-after-2017-surprise-billing-law/

[3] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.00217

considerably high than typical in-network payment awards. The mean arbitration amount was nine times higher than the median in-network price for the same services. Compared to Medicare prices, the mean and median arbitration awards were found to be 12.8 and 8.5 times higher, respectively.

The Commonwealth Fund examined the question of health care spending in an April 26, 2021 post entitled, *Are Surprise Billing Payments Likely to Lead to Inflation in Health Spending?*[4] They examined experiences in other states, including New York and New Jersey, and found that establishing payment boundaries is essential because an upward trend in payments for out-of-network care could lead to higher in-network contract rates. These costs, in turn, could push premium costs higher for employers and consumers.

During the Public Health Emergency, COVID-19 Orders No. 25 and No. 61 required that carriers reimburse non-contracted acute care hospital providers at 135% Medicare for medically necessary emergency department and inpatient services. These payments were considered payment in full and balance billing was not allowed by the provider. This is also consistent with the Governor's recent legislation that is currently under consideration by the legislature. We would strongly encourage consideration of this process and rate since it was implemented across the market already and met the key principles listed above. Utilizing the Medicare index has benefits, including allowing for natural annual adjustments and regional differences. Additionally, there is over a year of practical experience by both payers and providers which allows for consistency within the market.

As was the case under the Executive Orders, we would caution the Administration against allowing exemptions from the set default rate. The mandated approach should be system-wide and cover all services to appropriately address the identified issues. Similarly, consistency will benefit both payers and providers, so BCBSMA would suggest that once a default rate is set, it is reviewed every three to five years.

While we were pleased to see the passage of the federal No Surprises Act and additional protections in Massachusetts, BCBSMA believes that more work remains. As we have seen in other states, arbitration can lead to higher costs for members and the system. It adds additional layers of administrative complexity and lacks the transparency and simplicity that a set out-of-network rate would address. Massachusetts has the opportunity to enact a comprehensive solution to the out-of-network issue, and lower costs for members and the whole health care system.

BCBSMA remains committed to work with the Administration on this issue and are happy to provide additional information about our experience.

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[4] https://www.commonwealthfund.org/blog/2021/are-surprise-billing-payments-likely-lead-inflation-health-spending

Sincerely,

Michael T. Caljouw

cc: Gary Anderson, Commissioner of Insurance
Kevin Beagan, Deputy Commissioner, Division of Insurance
Stuart Altman, Chair, Health Policy Commission
David Seltz, Executive Director, Health Policy Commission
Ray Campbell, Executive Director, Center for Health Information and Analysis
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