MASSACHUSETTS Health & Hospital ASSOCIATION

Out of Network Payment Rates for Health Services
June 2021

The Massachusetts Health & Hospital Association (MHA) appreciates the opportunity to provide input to the Executive Office of Health and Human Services (EOHHS) regarding the establishment of commercial rates for out-of-network emergency and non-emergency services. MHA supports many aspects of both the state and federal laws that protect patients from receiving surprise bills. Surprise billing is a contracting issue that catches patients in the middle of a payment dispute between a payer and an out-of-network provider, often leaving the patient with an unexpected bill for services. Among other remedies, one way to address this problem is by developing reimbursement processes that neither encourage plans to take unfair advantage of providers nor encourage providers to leave the network. MHA believes that the best way to accomplish this is not to establish benchmark default rates, but to allow payers and providers to use independent dispute resolution (IDR) as a remedy when the two parties cannot reach agreement. The federal government in its No Surprises Act has already carefully considered and included a mechanism for IDR that creates a fair process for both payers and providers. MHA urges the state to reject any sort of default rate. Instead, the state should embrace and support the federal legislation that will be implemented on January 1, 2022, and take steps to minimize any divergence.

As always, MHA appreciates the opportunity to work with the Executive Office of Health and Human Services, the Division of Insurance, the Health Policy Commission, and the Center for Health Information and Analysis as these agencies begin their work on developing recommendations as directed by Chapter 260 of the Acts of 2021..

In determining next steps, consider these principles that are critical to addressing the out-of-network problem.

MHA agrees that protecting the patient from surprise bills is paramount. However, there are additional principles as outlined by the American Hospital Association that should help guide policy makers in developing solutions to surprise billing. These include:

- Ensure patients have access to and coverage for emergency care;
- Preserve the role of private negotiation by ensuring that providers are able to negotiate appropriate payment rates with health plans;
- Educate patients to understand the scope of their health coverage; and
- Ensure adequate provider networks and health plan transparency around who is in and out of networks.

Establish and enforce network adequacy standards and restrict plans from selling products that do not provide sufficient access to all types of care.

According to the National Association of Insurance Commissioners (NAIC), a trend in the health insurance industry toward “narrow network” health plans, which offer a limited choice of providers, caught the attention of state insurance regulators. As a result, in 2015 the NAIC adopted a revised

model act titled the *Health Benefit Plan Network Access and Adequacy Model Act*. The purpose of this act is to establish standards for the creation and maintenance of networks by health carriers; and assure the adequacy, accessibility, transparency, and quality of healthcare services offered under a network plan. Notably, that act states:

- A health carrier providing a network plan shall maintain a network that is sufficient in numbers and appropriate types of providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults, will be accessible without unreasonable travel or delay.
- Covered persons shall have access to emergency services twenty-four (24) hours per day, seven (7) days per week.

While Massachusetts insurance laws include network adequacy standards, it's unclear how well these standards are enforced, particularly for self-funded plans that are not under the jurisdiction of the Division of Insurance. In addition, as plans create new benefit restrictions such as prohibiting certain services from being delivered in a hospital or retroactively denying emergency room coverage, surprise bills are likely to increase.

Look to other states where independent dispute resolution has been successful before recommending commercial rates that could disrupt the marketplace and interfere with private contract negotiations between plans and payers.

MHA has consistently opposed setting rates in statute because it interferes with the private negotiation process and can have significant unintended consequences, including the ability for health plans to reimburse at a low out-of-network rate, diminishing any incentive for them to contract with providers. Likewise, rates that are set higher than what some currently contracted providers receive can also encourage providers to leave the network. Instead, MHA supports the national standard Congress adopted, which protects patients yet maintains the ability for providers and health plans to negotiate with a baseball-style arbitration process for making a final decision if the two are unable to come to agreement. This would keep patients out of the middle, allow clinicians and payers to negotiate independently, and does not create network adequacy issues or winners and losers among providers. It would also afford the opportunity to collect meaningful data on these types of situations before imposing government price-setting that could unfairly tip the scale of private market negotiations. Perhaps most importantly, it would ensure a common standard for patients in all types of plans, thereby eliminating confusion and establishing a predictable approach for all.

The health insurers assert that IDR actually raises costs, referencing both New York and New Jersey state laws as examples. However, there is no documentation that premiums have gone up as a result of IDR. In fact, the New Jersey Department of Banking and Insurance, in its January 2021 report noted that "*As part of the Department's rate review process, carriers were asked to provide data on out-of-network claims spending. All carriers from which the Department obtained data have experienced a reduction in involuntary out-of-network claim costs since the Act has taken effect. The change in the law likely contributed to reduced costs associated with claims for involuntary (i.e. emergency and inadvertent) out-of-network services paid by carriers."*[i]

In New York, insurers are required to file their rates with the DFS on an annual basis. Since the surprise billing law has been in effect, higher out-of-network costs and IDR have never been cited as a reason for increasing premiums. A September 2019 report by the New York Department of

Financial Services (DFS) found that from its implementation in March 2015, through the end of 2018, the Out-of-Network (OON) Law has saved consumers more than $400,000,000.

The Massachusetts Association of Health Plans (MAHP) and Blue Cross Blue Shield of Massachusetts have also criticized the New York and New Jersey laws for payments that were significantly higher than in-network rates. In both states, the arbiters must consider, but are not bound to, the usual and customary rate (UCR), which is defined as the 80th percentile of all charges for the particular healthcare 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. In contrast, the federal law does not have any such requirements. *In fact, the federal law allows payers to bring to the table the median in-network rate for consideration and prohibits an IDR entity from considering a provider's billed charges or public payer rate as part of the arbitration process.*

Another fact that both MAHP and BCBSMA omit is that payers prevail in a significant number of cases. In New Jersey, as of January 2021, 36% of the 4,173 eligible cases were resolved in favor of the carrier. In New York between 2015-2018, with respect to emergency services, 43% of decisions were in favor of the health plan, 24% were in favor of the provider, and 33% were split between the health plan and provider due to multiple CPT codes. Not only do payers often prevail, but the number of cases that end up in the dispute resolution process is a tiny fraction of the overall number of claims insurers processed.

The federal No Surprises Act should be fully implemented and evaluated before any consideration of further steps in Massachusetts.

After years of careful consideration, the federal government has recognized the benefits of IDR as a balanced solution to OON billing. The dispute resolution process established in the No Surprises Act prevents artificially low payment rates that would incentivize insurance companies to keep providers out of their networks. Providers and insurers are able to bring to the table relevant information, including:

- Median in-network rates;
- Provider training and quality of outcomes;
- Market share of parties;
- Patient acuity or complexity of services;
- Teaching status, case mix, and scope of services of the facility;
- Demonstrations of previous good faith efforts to negotiate in-network rates; and
- Prior contract history between the two parties over the previous four years

The No Surprises Act is set to go into effect on January 1, 2022. This law provides a comprehensive federal solution that covers both fully insured as well as self-insured plans and their members. Under the No Surprises Act, patients are fully protected from surprise bills; health plans and providers have the ability to seek an independent resolution if they are unable to reach an agreement on a fair price. The federal government has established specific factors that payers and providers can bring to the table and at the same time prohibits both from using billed charges or public charges in an arbitration. We have seen the success of IDR in other states that have implemented similar IDR processes. MHA strongly supports the federal law and and is closely following federal rulemaking necessary for implementation.

The establishment of any default rate in the commonwealth could result in differing standards based on the patient's insurance plan. Instead, allowing the federal law to prevail will create a uniform playing field for payers, providers, and patients regardless of the type of insurance coverage.

Massachusetts has much lower rates of out-of-network billing than other states. Don't create a system that will do more harm than good over the long term to address a very small percentage of out-of-network cases.

According to the Peterson-KFF Health System tracker (February 10, 2020), the rate of out-of-network billing in emergency settings and inpatient settings for people with large employer coverage out of network for both inpatient and emergency room visits is far lower in Massachusetts than in most of the country. This does not mean that we should not address this serious problem here, but it does mean that the solution should be commensurate with the magnitude of the problem. Establishing benchmark rates in Massachusetts would be disruptive to private contract negotiations and would have negative consequences on network adequacy, which is the very problem that these laws are attempting to address.

QUESTIONS POSED BY EOHHS FOR LISTENING SESSIONS

In evaluating potential OON commercial rates for emergency and non-emergency services, what are key considerations with respect to the impact of those rates on patient access to healthcare services by geographic location?

We do not believe that establishing OON commercial rates will benefit patients in terms of access to care. In fact, default rates could make it more difficult to attract certain specialties to economically challenged communities, rural areas, geographically isolated hospitals, and gateway cities, resulting in shrinking networks. In many of these communities, hospitals actually subsidize hospital-based physician salaries. Establishing artificially low rates for these physicians will simply shift costs to hospitals, endangering the services these hospitals are able to provide. Instead, providing incentives to negotiate and enter into meaningful contracts through private negotiation will help to attract and retain providers and mitigate the negative effects inherent in establishing benchmark rates.

In evaluating methodologies for establishing an OON commercial rate for emergency and non-emergency services, what potential implications would the establishment of a default benchmark rate have on member cost sharing for in- vs out-of-network services?

MHA supports mechanisms that protect patients from surprising billing situations without any penalty. Member cost sharing won't be affected by an independent dispute resolution process – technically it probably wouldn't be through a benchmark either. Member cost sharing shouldn't be affected since patients will only be paying what they would have paid for in-network services; in addition, the No Surprises Act is creating a qualified payment amount that will be used as the basis for patient liability. The qualifying payment amount is defined as the median of contracted rates for a given service in the same geographic region within the same insurance market (i.e., nongroup, fully insured large group, fully insured small group, or self-insured group) across all of an issuer's health plans as of January 31, 2019, inflated forward in perpetuity by the Consumer Price Index for All Urban Consumers (CPI-U). Patient cost-sharing limits for surprise out-of-

network services are based on this metric and public reporting of arbitration awards is required to be presented as a percentage of this amount.

In evaluating potential OON commercial rates for emergency and non-emergency services, what are key considerations with respect to the impact of those rates on the delivery of care by providers who predominantly serve communities that experience health disparities as a result of race, ethnicity, or socioeconomic status?

Establishing commercial rates could make it more difficult to attract providers to practice in these settings and could affect network adequacy when providers choose to go elsewhere. See response to first question.

What are key considerations for potential OON commercial rates for emergency and non-emergency services given the forthcoming implementation of the federal No Surprises Act, including with respect to the potential impact on the Massachusetts healthcare market?

The federal government is just beginning the rulemaking process for implementation of the No Surprises Act. This involves U.S. HHS, the Department of Labor, and the Treasury. At this point in time, much is still unknown and there is great risk that state laws or regulations in Massachusetts could conflict with federal law, adding to the confusion among patients, providers, and health insurance companies. Regardless, the federal law has an independent dispute resolution process, which the state law does not contain. As previously stated, and based on the experience of other states, an IDR process is the best way to ensure that payers and providers have an opportunity for an independent, criteria-based decision that won't disrupt the marketplace the way benchmark rates will. Additionally, the federal law will protect all patients regardless of the type of insurance coverage they have, and all providers will have the same access to independent dispute resolution. This is not true for the state law.

Some states' out-of-network billing laws allow self-insured health plans to opt into certain protections. What are your organization's perspectives of such laws, given that the No Surprises Act applies to self-insured health plans? Do you have any comments with respect to the anticipated impact of implementation for self-insured health plans and the self-insured commercial market in Massachusetts?

Given that the federal law will incorporate self-funded plans, those patients who have this coverage will be able to access the same protections as those in fully funded plans, making it a more comprehensive solution, particularly given the percentage of Massachusetts residents with self-funded plan coverage. Massachusetts law allows self-funded plans to opt into the state law, but this is unlikely if the plans do not believe it is in their own financial interest to do so. In terms of administrative simplification and reducing consumer confusion, we strongly support having one standard for all types of health plans. This can only be achieved through the No Surprises Act.

In evaluating potential OON commercial rates for emergency and non-emergency services, what are key considerations with respect to the impact of those rates on the financial stability of providers and healthcare systems, including but not limited to community hospitals?

Hospitals must be able to appropriately staff emergency departments and provide necessary clinical services for inpatients as well. Setting benchmark rates will diminish incentives for fair negotiation, encourage narrow networks, and could make it harder for these hospitals to attract staff, resulting in lengthy waits in emergency departments, reduced capacity for inpatient care,

and limited patient access. In addition, hospitals often subsidize the salaries of hospital-based physicians. Artificially low default rates will shift costs onto hospitals to make those physicians whole and will compromise the ability to negotiate fair reimbursement rates through private negotiations, as health plans will have no incentives to do so. Ultimately the financial stability of these hospitals will be affected either through the cost shift or if emergency room physicians, anesthesiologists, radiologists, and others decide to practice elsewhere.

What are your perspectives on the relationship between recommended OON commercial rates for emergency and non-emergency services and incentives to contract with providers or health plans (as applicable)? Do your perspectives differ at all depending on the method utilized for rate determination (i.e., payment benchmark versus a dispute resolution process)?

We continue to advocate for an independent dispute resolution process for situations where payers and providers cannot come to terms. We believe that any statutory commercial rates will disrupt the market, compromise the ability of private negotiations, and are unnecessary in Massachusetts. It is important to note, that after years of analysis and careful consideration of existing state laws from around the country, Congress explicitly rejected the establishment of any sort of default rate in the No Surprises Act.

Can you describe your organization's perspectives on and, as applicable, any impact of the default OON commercial reimbursement rate of 135% of Medicare established pursuant to Governor Baker's COVID Orders No. 25 and 61 (and the Division of Insurance's Bulletins 2020-13 and 2021-03)?

This time-limited default that applied to a limited universe of services made sense for the public health emergency so that patients could receive necessary care for COVID-19 and providers would be reimbursed – but it's not a long-term, sustainable solution. In addition, out-of-network billing was generally not an issue during the pandemic because the CARES Act prohibited balance billing for any providers who received Provider Relief Funds. State requirements also required that carriers forego any cost sharing for COVID testing and treatment for both in- and out-of-network providers.

Thank you for the opportunity to provide feedback on this important topic. Both the state and federal law accomplish the most important goal of taking the patient out of the middle of surprise billing disputes. We hope that the state will agree that adopting the federal IDR process will allow providers and payers to continue to negotiate contracts in good faith and minimize the number of out-of-network providers while allowing an IDR process to resolve disputes in outlier cases.

Please don't hesitate to contact Karen Granoff, MHA's Sr. Director Managed Care at KGranoff@mhalink.org if you need additional information .

[i] Out-of-network Consumer Protections - Data Reporting as of January 31, 2020 (state.nj.us)