



Michael D. Maves, MD, MBA, Executive Vice President, CEO

August 27, 2010

The Honorable Kathleen Sebelius
U.S. Secretary of Health and Human Services
c/o Office of Consumer Information and Insurance Oversight
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: OCIO-9994-IFC, Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions and Patient Protections

Dear Secretary Sebelius:

The American Medical Association (AMA) appreciates the opportunity to comment on the Interim Final Rule and Proposed Rule (Rule) (75 FR 37187 et seq) concerning Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections. The AMA generally supports the Rule's approach in interpreting the provisions in the Affordable Care Act (ACA) that are critical to successful implementation of the health insurance market reforms in the ACA. These reforms (e.g., banning preexisting condition exclusions or denials, lifetime dollar limits on benefits, and rescissions except in clear cases of fraud, along with patient protections with respect to choice of health care professionals and no prior authorization requirements for emergency care, including services provided out-of-network) will improve health insurance coverage for millions of patients. Our comments will focus specifically on the emergency care services and claims language.

The AMA supports Congress' intent to reduce the economic burden of emergency services for patients and to ensure that any cost-sharing requirement for a patient is fair and reasonable. We agree with the conclusion in the Rule that a health plan should be required to pay a "reasonable amount" to a physician or other provider of emergency services before a patient becomes responsible for paying that health care provider the difference between the provider's billed charge and the amount the health plan has paid. We have significant concern, however, with how the criteria for a "reasonable amount" is calculated in the Rule. We urge the Department of Health and Human Services (HHS) to consider our suggestions when developing a transparent and fair method that guarantees affordable cost-sharing for patients and appropriate payment for physicians and other providers of emergency services.

We suggest that the standard in the Rule be revised to reflect a fair and “reasonable amount” for payment. Specifically, we urge HHS to revise the current three criteria listed under Sec. 54.9815-2719AT, “Patient protections (temporary); (b) Coverage of emergency services; (3) Cost sharing requirements,” be revised as follows:

A group health plan or health insurance issuer complies with the requirements of this paragraph (b) (3) if it provides benefits with respect to an emergency service equal to the lowest of the three amounts specified in paragraphs (b) (3) (i) A); (b)(3) (i) (B), and (b) (3) (i) (C) of this section: (A) the billed charge; (B) the 80th percentile of the accurate UCR charge (see discussion of requisites for an accurate UCR database and methodology below); or (C) the rate negotiated with and agreed to by the non-contracted provider for the emergency services provided.

Transparency in Patient Cost Sharing and Reasonable Payment

The AMA opposes the Rule draft standard allowing for payment in an amount equal to the greater of: (1) the amount negotiated with in-network providers for the emergency services furnished; (2) the amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services, such as usual, customary and reasonable (UCR); or (3) the amount that would be paid under Medicare because all of these standards will significantly understate the value of the emergency services provided by non-contracted physicians or other health care providers. This will both leave patients with significant personal financial liability for these services and undermine the incentive health plans have to negotiate fair contracts with physicians and other health care providers for these services. Patients who go to an emergency department for emergency medical care rarely have the ability to ensure that they see an in-network provider for emergency services. Thus, to meet patients’ reasonable expectations, health plans that cover emergency services should provide a benefit that ensures a reasonable level of indemnification for out-of-network emergency care.

The AMA believes that the best default standard for the reasonable value of emergency services provided by non-contracted health care professionals is that professional’s billed charge, reflecting the health care professional’s current schedule of retail fees for emergency medical services. Paying a physician or other health care professional the billed charge ensures that the “reasonable amount” reflects the current market value of the service provided and that the patient is receiving the value of the benefit paid for. Physicians consider many market factors when setting their charges just as other professionals, including their costs of doing business, the amount of work and risk involved, and the necessity to remain competitive in the region.

In the emergency department context the AMA believes it is particularly critical that payers are held to a standard of reimbursement that reflects the unique costs assumed by providers of emergency care. Specifically, the mandates set forth in EMTALA (Emergency Medical Treatment and Active Labor Act) require hospitals, emergency department physicians and physician specialists providing back-up to the emergency department to provide emergency care to patients who come to emergency departments without regard for payment of such care. One

undeniable consequence of EMTALA is that providers of emergency services provide billions of dollars in uncompensated emergency care each year. In 2000, *physicians incurred nearly \$4.2 billion dollars in bad debt related to EMTALA alone*. This, coupled with payers' unilateral decisions to under-compensate non-contracted physicians who have provided emergency services, endangers the emergency care system in this country.

To protect against the potential that there may be excessively high charges in particular cases, we recommend that HHS allow health plans to pay less than the billed charge in those circumstances where the billed charge exceeds the 80th percentile of the charges for the same service in the same geographic area. By requiring that health plans pay the lesser of the billed charge, or the 80th percentile of the UCR charge for the emergency services provided, health plans will be protected against unreasonably high charges, and patients will be protected against unreasonably high personal financial liability for emergency services received from non-contracted providers.

Finally, we believe health plans that negotiate a rate with an out-of-network provider in a particular case should be able to pay that rate.

The AMA model bill, "Truth in Out-of-Network Healthcare Benefits Act" provides legislative language that ensures patients, insurers, physicians and other health care providers have accessible and complete information regarding out-of-network benefits, networks, contract status and charges. We have attached a copy of the model bill for your consideration. Many solutions proposed in the model bill are reflected in this letter.

UCR Standard Must Use Charged Based Methodology and Database

To the extent UCR is used as a payment standard, it must be based on an accurate methodology. We recognize that the Rule proposes that one of the payment standards for out-of-network emergency care is (2) above: "the same method the plan generally uses to determine payments for out-of-network services, such as usual, customary and reasonable (UCR.)" As a practical matter, only a UCR standard based on the billed charges for emergency services in the relevant geographic location is relevant to the personal financial liability that patients will face when they receive emergency services from out of network providers. Other standards that health plans may use to pay for out-of-network services typically have no relationship to these market rates, and are generally dramatically lower than market rates. Provided that the health plan clearly describes what the out-of-network rate is, and accurately calculates and pays that rate, patients generally can make knowledgeable decisions as to whether to pay for an out-of-network benefit, and whether, assuming they have purchased such a benefit, to use the services of an out-of-network provider in any particular circumstance. However, patients are not in the same position with respect to emergency services, as they typically will go to the closest emergency department, regardless of the contracting status of the hospital or the physicians on the medical staff.

While historically health insurers defined the out-of-network benefit as a stated percentile of the UCR charge for health care services provided by an out-of-network physician or other health

care provider, more recently health insurers have used various iterations of this language or other standards which have no relationship to the fees typically charged by health care professionals for emergency services. This ambiguity should be eliminated, particularly in the context of emergency services where patients typically have no control over the contracting status of the health care providers from whom they receive emergency services.

To ensure that the health plan uses a UCR charge which reasonably reflects that market rate patients will likely be billed for out-of-network emergency services, the following definitions should be mandated:

- “Usual charge” means a charge for a given service that the physician usually charges to his/her private patients.
- “Customary charge” means a charge that is within a range of usual fees currently charged by physicians of similar training and experience, for the same service within the same specific and limited geographic area.
- “Reasonable charge” means a charge that is usual and customary, and is justifiable considering the special circumstances of the particular case in question, without regard to payments that have been discounted under governmental or non-governmental health insurance plans or policies.

Moreover, before payment should be based on the 80th percentile of the UCR charge rather than the billed charge, the database to be used to calculate UCR must be accurate. The recent findings of the New York Attorney General’s (AG) January 13, 2009 report: “Health Care Report: The Consumer Reimbursement System is Code Blue” discusses the findings of New York AG Andrew Cuomo’s year long investigation of insurers’ claim settlement of out-of-network coverage. The Code Blue report arrived at the same time as the groundbreaking \$350 million settlement between the AMA, along with the Medical Society of the State of New York and the Missouri State Medical Association, and United Health Group. This is the largest monetary settlement of a class action lawsuit against a single health insurer in U.S. history. The lawsuit, pending since 2000, challenged the validity of the United Health Group-owned Ingenix database to determine settlement rates for out-of-network care. The Ingenix database is used to compile billing data from the largest health insurers in the country. After compiling data, the system sends billing schedules back to those health insurers and others. That data is then used as benchmarks for reimbursement rate setting.

The New York AG report concludes that the “consumer reimbursement system needs dramatic reform to protect consumers” and blames insurers for inappropriately reimbursing physicians and ultimately, increasing costs for consumers and physicians. The report findings include the following:

- Insurers profited by using flawed Ingenix database to determine UCR. Cuomo noted that by using a flawed database to determine reimbursement rates for out-of-network care,

insurers have increased profits at the expense of patients and physicians. One example in the report showed that for ordinary doctors' visits, the Ingenix database understated the market rate by up to 28 percent across the state of New York, resulting in "at least hundreds of millions of losses for consumers over the past ten years across the country."

- The report blames insurers for manipulating beneficiaries. Understanding that consumers want out-of-network benefits, insurers charge higher premiums for this type of plan, and "unfairly stick consumers with the bill." The report concludes that some insurers pay the same rates for in-network and out-of-network care, despite charging different premiums.
- The report identifies a number of steps towards solving these problems, the most significant being the need for much greater transparency system-wide. The report bemoans payers' failure to disclose how "UCR" is determined. It calls for payers to disclose "accurately and clearly what they would pay or how they would determine payment for out-of-network care."
- Because Ingenix is owned by United Health Group, AG Cuomo concluded that an inherent conflict of interest existed.
- To correct the fundamental problems underlying the Ingenix methodology and this conflict of interest, the report calls for development of a non-profit "independent and fair database and transparent pricing information" that would be an industry-wide solution to the systemic problems identified in the report.

The AG's conclusions are reiterated in the June 24, 2009 report by the staff of the United States Senate Committee on Commerce, Science, and Transportation. This report concludes that as a result of the use of the corrupt insurance industry database "American consumers have paid billions of dollars for health care services that their insurance companies should have paid."

In light of this history, it is critical that any database used to calculate UCR rates address these problems. Any UCR database must avoid all conflicts of interest. The database must exclude charges that reflect payments discounted under governmental or non-governmental health insurance plans;. UCR rates must be calculated based on either 100 percent of the retail charges from all legally separate and distinct physician practices in the same geographic area and specialty or subspecialty or data from a random sample of no less than ten legally separate and distinct physician practices in the same geographic area and specialty or subspecialty, and exclude charges which are outdated. In determining a charge, the data must account for physician experience and expertise, and cannot include physician charges that reflect discounted payments. Data cannot exclude valid high charges, exclude charges accompanied by modifiers that include procedures and complications or pool data from physicians and non-physician providers. Any database must use data sources drawn from a diversity of health insurers and health care providers. All calculations should be based on a single database that is updated regularly, audited, certified and approved as statistically relevant by an independent auditor.

For more details about how a UCR database should be structured, please see the attached model bill. The AMA understands that the UCR database being developed by FAIRHealth, the nonprofit entity established by AG Cuomo to implement his UCR settlements, is intended to meet these standards. Of course, evaluation of this new database will be necessary to ensure that it achieves its aspirational goal.

Neither Medicare Rates, Nor Negotiated Rates with Contracted Physicians Are Acceptable Payment Standards for Emergency Services Provided by Non-Contracted Physicians

The Rule suggests that the Medicare rate or “the amount negotiated with in-network providers for the emergency service furnished” be used as alternative “reasonable amount” standards. We urge HHS not to use either of these amounts.

Medicare reimbursement rates are significantly lower than the cost to provide medical services. If these rates were to be used as an acceptable standard for reimbursement, physicians would not be able to cover their costs of providing emergency services. Although this fact alone is sufficient, there are numerous additional reasons why Medicare payment rates are not an appropriate basis for determining out-of-network physician payment. First, Medicare rates are subject to budgetary adjustments that have nothing to do with the objective value of physician services, and may differentially impact different physician specialties. Second, Medicare rates have little relationship to the commercial market realities that determine the factors that underlie physicians’ out-of-network charges and, in fact, are not intended to reflect those realities. Third, Medicare rates do not provide a basis for determining the reasonableness of charges for physician emergency services provided out-of-network, which health insurers are required to fully indemnify in several states. Fourth, basing out-of-network reimbursement on Medicare payment rates would create a perverse political incentive for health insurance companies to oppose the increases to Medicare rates that are essential to ensure access to care by the elderly.

The volatility of the Medicare Sustainable Growth Rate (SGR) formula is yet another reason why out-of-network physician payments should not be based on Medicare payments. The manner by which the formula determines Medicare payment rates is complicated, but the SGR formula basically calculates Medicare physician payment rates by comparing Medicare spending for physician services relative to the U.S. Gross Domestic Product. Because the SGR formula is tied to the performance of the U.S. economy and not to the value of physician services, the SGR formula has, since 2002, repeatedly called for significant—if not drastic—reductions in Medicare physician payment rates that have been staved off only by last-second Congressional action. Basing out-of-network payments on such a volatile payment methodology hardly provides the stability, equity, and transparency that the ACA was intended to effect.

Using broad criteria linked to a negotiated contract rate is also an unreasonable basis for the payment of emergency services provided by non-contracted physicians or other health care professionals because a negotiated rate is a discounted rate that the physician has agreed to in exchange for increased patient volume, prompt payment or other services. It is thus, by definition, lower than the “reasonable retail charge.” In addition to not reflecting a reasonable

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substitute for the market rate, negotiated rates are not verifiable. Negotiated rates are typically confidential contract terms. How would patients be able to validate the accuracy of payments made for emergency services, when neither the non-contracted provider of those services nor the patient have any access to the health plan's contracted rates?

However, as noted above, many health plans contract with companies which negotiate rates on a case-by-case basis with non-contracted providers. We believe a health plan should be able to pay this negotiated rate as an alternative to either the billed charge or the 80th percentile of the UCR charge, as, by definition, the physicians or other health care provider has agreed to accept this payment.

The AMA understands that many health insurers have changed the basis on which they reimburse for out-of-network benefits to methodologies based on Medicare or their negotiated rates with contracted providers. As discussed above and provided for in the attached model bill, provided these "non-UCR charge" based methodologies are clearly communicated to the health plan's enrollees and fairly applied, the AMA has no objection to them. However, in the context of emergency services, where patients typically have no choice as to the contracting status of the physician or other health care provider, only a payment standard based on the billed charge, UCR or a rate negotiated for the specific services with the non-contracted provider will protect patients from unfairly large financial liability. Moreover, if health plans are free to pay these lower rates to physicians and other health care professionals providing emergency services, they will have little incentive to negotiate fair contracts with emergency services providers, thus undermining the emergency safety net and increasing the likelihood patients will face increased financial liability for these services.

Conclusion

The AMA appreciates the opportunity to provide its views on the transparency of health benefit information and ensuring health plans pay fairly for emergency services provided by non-contracted physicians and other health care professionals. We look forward to working further with HHS on this important matter. Should you have any questions regarding these comments, please contact Carol Vargo at 202-789-7492 or carol.vargo@ama-assn.org.

Sincerely,



Michael D. Maves, MD, MBA

Enclosure



IN THE GENERAL ASSEMBLY STATE OF _____

“Truth in Out of Network Healthcare Benefits Act”

1 Be it enacted by the People of the State of _____, represented in the General
2 Assembly:

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4 **Section I. Title.** This Act shall be known and may be cited as the “Truth in Out of
5 Network Healthcare Benefits.”

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7 **Section II. Purpose.** The Legislature hereby finds and declares that:

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9 (a) 70 percent of privately insured Americans choose more expensive health insurance
10 coverage that offers access to both in-network and out-of-network physicians.¹
11 Consumers typically pay more for the right to have the health insurer cover a portion
12 of the cost of accessing an out-of network physician because the choice of physician
13 is such a critical decision. Unfortunately, consumers have not always received the
14 benefit of higher premiums that they have been charged for insurance products
15 offering out-of-network coverage;

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17 (b) Health insurers have traditionally defined the out-of-network benefit as a stated
18 percentage of the “usual, customary and reasonable (UCR) charge” for health care
19 services provided by an out-of-network physician or other health care provider.

20 While health insurers have in recent years used various iterations of this language,

¹ 2008 Kaiser/HRET Employer Health Benefits Survey
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Advocacy Resource Center

1 the words “usual charge,” “customary charge,” and “reasonable charge” commonly
2 have the meanings given to them under Section II of this Act. Because physicians
3 generally bill at a rate which is typical for their specialty, consumers purchasing
4 health insurance coverage with an out-of-network benefit have reasonably expected
5 their health insurance to cover the percentage of the out-of-network bill promised in
6 the health insurance policy;

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8 (c) Recent events have shown that the health insurance industry has manipulated UCR
9 criteria to underpay amounts due out-of-network physicians and unlawfully shift
10 financial responsibility from health insurers to consumers. Numerous health
11 insurers utilize defective databases to pay out-of-network physicians substantially
12 less than the amount physicians would be entitled to receive under properly applied,
13 accurate UCR data;

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15 (d) As a result of private litigation and investigations by the New York Attorney
16 General Andrew Cuomo, a significant number of health insurers entered into
17 settlements under which they agreed to discontinue utilizing a flawed database to
18 determine UCR, and to pay more than 90 million dollars to finance the creation of a
19 new and accurate database to determine the UCR charges for medical care provided
20 by out-of-network physicians;

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22 (e) Many health insurers are now replacing “UCR charges” as the basis for calculating
23 out-of-network physician payments with language referencing the Medicare fee
24 schedule or other terminology. These emerging, “non-UCR charge” methods of
25 determining out-of-network physician payment typically give consumers no clear
26 idea of how much of the out-of-network physician’s bill the health insurer will pay,
27 and how much of that bill will remain the subscriber’s financial responsibility; and

1 (f) Consumers must be armed with full knowledge of the facts to make informed
2 decisions concerning the health insurance coverage they purchase and where, and
3 from which providers, they seek health care services. Central to making an
4 informed decision is understanding the amount that an out-of-network physician will
5 charge for providing a medical service. Physicians should, therefore, volunteer fee
6 information to patients and to discuss their out-of-network fees in advance of
7 services. Additionally, only when health insurers clearly disclose the scope and
8 limitations of any out-of-network benefit they purport to provide, in language that is
9 meaningful to the average consumer, will consumers (1) be able to shop intelligently
10 for health insurance, and (2) be assured that the higher premiums they pay to make
11 affordable access to out-of-network physicians reasonably reflect the actuarial value
12 of the out-of-network benefit actually provided.

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14 **Section III. Definitions.**

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16 (a) “Customary charge” means a charge that is within a range of usual fees currently
17 charged by physicians of similar training and experience, for the same service
18 within the same specific and limited geographic area.

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20 (b) “Health Insurer” means any person that offers or administers a health insurance
21 plan.

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23 (c) “Out-of-network physician charge” means the usual, customary and reasonable
24 charge (UCR charge) a non-contracted physician bills a patient for medical
25 services, as “usual charge,” “customary charge,” and “reasonable charge” are
26 defined in this Section II.

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1 (d) “Reasonable charge” means a charge that is usual and customary, and is justifiable
2 considering the special circumstances of the particular case in question, without
3 regard to payments that have been discounted under governmental or non-
4 governmental health insurance plans or policies.

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6 (e) “Retail charge” means the charge that the physician bills on those claims where the
7 physician is not billing a charge that reflects a payment discounted under
8 governmental or non-governmental health insurance plans or policies.

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10 (f) “Usual charge” means a charge for a given service that the physician usually
11 charges to his or her private patients.

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13 **Section IV. Standardized definition of “out-of-network physician charge.”** Any
14 insurer offering health insurance coverage with an out-of-network benefit that calculates
15 payment amounts for services provided by out-of-network physicians using a physician
16 charge-based methodology must do so based on the out-of-network physician charge as
17 “out-of-network physician charge” and “usual charge,” “customary charge,” and
18 “reasonable charge” are defined in Section II of this Act, and may not add or subtract
19 language from those definitions.

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21 **Section V. Requirements concerning the data on which charge-based methodologies**
22 **to determine payments to out-of-network physicians can be based.**

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24 (a) Conflict of interest. A health insurer shall not use any person or entity as the
25 source of the database from which payments to out-of-network physicians are
26 calculated if that person or entity owns or controls, or is owned or controlled by, or
27 is an affiliate of, any person or entity with a pecuniary interest in the development
28 or use of the database. The person or entity who is the source of the database must

1 also be granted tax-exempt status by the Internal Revenue Service under 26 U.S.C.
2 § 501(c)(3) of the United States Internal Revenue Code. An insurer, health
3 maintenance organization, medical association, or health care provider shall not be
4 prohibited from nominating an individual to serve on the board of the tax-exempt
5 person or entity, although no such individual may receive compensation from the
6 tax-exempt person or entity beyond reimbursement for reasonable expenses
7 associated with that service.

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9 (b) **Data integrity.**

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11 i) **Data analytics.** Any health insurer using a charge-based methodology for
12 determining payments to out-of-network physicians must ensure that the
13 database from upon which payments to out-of-network physicians are
14 calculated satisfies the following criteria:

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16 1. The health insurer must calculate an out-of-network physician's charge
17 based on either: (a) 100% of the available retail charge data from all
18 legally separate and distinct physician practices in the relevant
19 geographic area and specialty or subspecialty (if applicable); or (b) data
20 from a random sample of no less than (10) legally separate and distinct
21 physician practices in the relevant geographic area and specialty or
22 subspecialty (if applicable). "Random sample" means that every separate
23 and distinct physician practice within the relevant geographic area and
24 specialty or subspecialty (if applicable) has an equal opportunity to be
25 included in the sample upon which the out-of-network physician's usual,
26 customary, and reasonable charge is calculated;

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2. In determining an out-of-network physician’s charge, the data in the database must consistently account for factors reflecting the physician’s experience and expertise, including but not limited to, the date of the physician’s graduation from medical school, any board certifications held by the physician, any of the physician’s academic appointments, and the site where the physician provides the service;

3. The data in the database cannot include physician charges that reflect payments discounted under governmental or non-governmental health insurance plans; and

4. The data in the database cannot:

- (1) Exclude valid high charges;
- (2) Exclude charges accompanied by modifiers that indicate procedures with complications; and
- (3) Pool data from physicians and nonphysician providers.

ii) Data sources. The health insurer must ensure that the data upon which a charge-based methodology is based is both drawn from a sufficient number and diversity of health insurers and health care providers, and supported by independent research by the person or entity that is the source of the data, to ensure compliance with the requirements of Section V(b)(i) of this Act.

iii) Single database. Regardless of the charge-based methodology used to calculate out-of-network physician payment amounts, all such calculations

1 must be based on a single database that complies with the requirements of this
2 Section V.

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4 iv) Updating. The health insurer is obligated to ensure that the data in the database
5 from which payments to out-of-network physicians are calculated is updated
6 regularly to reflect accurately current physician retail charges. This obligation
7 to update includes, but is not limited to, an obligation to remove data from the
8 database that contains charge information satisfying the earlier of the
9 following: when the charge data is older than three years from the current
10 year, or when the medical expense index applicable to prior charge data is 15
11 percent less than the current year's medical expense index.

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13 v) Audits and certifications. Annually, the health insurer will obtain a
14 certification from an independent auditor certifying that:

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16 1. The data in the database, and the charge-based methodology used to
17 calculate out-of-network physician payments satisfy the requirements of
18 this Act; and
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20 2. The sources of the data used to create and update the data in the single
21 database from which payments to out-of-network physicians are
22 calculated comply with Section V(b) 1 (b), (d), (e) and (f).

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24 vi) Approval and statistical analyses by the department.

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26 1. A health insurer shall not utilize a database or methodology for
27 determining an out-of-network physician's charge unless the Department
28 determines that the health insurer, database and methodology from which

1 payment to out-of-network physicians are calculated satisfy the
2 requirements of Section V of this Act.

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- 4 2. The Department shall annually perform a statistical analysis to ensure
5 that the sample error of the sample size specified in Section V (b) 1 (b) is
6 not greater than 5.5 percent. The Department will perform other
7 appropriate statistical analyses to determine the validity of the
8 methodology described in Section V (b) 1 (b) and to ascertain whether
9 adjustments need to be made to that methodology to ensure that
10 calculations based on that methodology accurately reflect the usual,
11 customary, and reasonable charge of out-of-network physicians.

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13 **Section VI. Restrictions concerning non-charge-based methodologies.** A health
14 insurer shall not utilize a non-charge based methodology for determining the amount of
15 payments due out-of-network physicians unless the Department annually approves the
16 use of that methodology. The Department must on an annual basis approve the use of the
17 non-charge-based methodology.

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19 **Section VII. Disclosure concerning how payment amounts to out-of-network**
20 **physicians are calculated.**

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- 22 (a) Disclosures concerning charge-based methodologies to subscribers and prospective
23 purchasers. A health insurer utilizing a charge-based methodology to calculate
24 payment amounts for services provided by out-of-network physicians must disclose
25 in the summary plan description and to a prospective purchaser of out-of-network
26 coverage the following information:

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- 28 i) The definition of “usual,” “customary,” and “reasonable,” as defined under
29 Section II of this Act;

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- ii) The source of the database from which payment amounts due out-of-network physicians are calculated;

- iii) The name of the entity, if any, from which payments due out-of-network physicians are calculated;

- iv) The Web site address at which a subscriber or prospective purchaser may access the database from which payments due out-of-network physicians are calculated;

- v) A description of how the charge-based methodology is used to calculate amounts due out-of-network physicians, including but not limited to the percentile of UCR-charges that the health insurer will be obligated to pay under the out-of-network benefit; and

- vi) That the payment due pursuant to the out-of-network benefit may be lower than the out-of-network physician's retail charges, and that the subscriber may be responsible to pay the physician the difference between the physician's retail charges and the amount that the health insurer is obligated to pay the physician, in addition to any other cost sharing imposed under the subscriber's benefit plan.

(b) Disclosures concerning non-charge-based methodologies to subscribers and prospective purchasers. A health insurer utilizing a non-charge based methodology to calculate payment amounts for services provided by out-of-network physicians must disclose in the summary plan description and to a prospective purchaser of out-of-network coverage the following information:

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- i) The health insurer’s description of the data source upon which the payment amounts for services provided by out-of-network physicians are calculated;
- ii) The Web site address at which a subscriber or prospective purchaser may access that data source;
- iii) The name of the entity, if any, that the health insurer relies on to calculate the non-charge-based payments due out-of-network physicians;
- iv) The methodology the health insurer uses to calculate payment amounts for services provided by out-of-network physicians using the data source described above, including instructions on how to calculate the amount of the out-of network benefit which will be paid for any physician service using that Web site;
- v) A description of the average percentage of an out-of-network physician’s usual, customary, and reasonable charge the consumer will likely still owe even after the physician receives the out-of-network benefit payment, so that the consumer will understand what his or her payment obligation will likely be as a percentage of usual, customary, and reasonable charges, in addition to any non-charge based description provided to the consumer. The usual, customary, and reasonable charges must be calculated as provided in this Section VII for charge-based methodologies; and
- vi) That the payment due the out-of-network provider by the health insurer may be lower than the out-of-network physician’s retail charges, and that the subscriber may be responsible to pay the physician the difference between

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(c) Disclosure of estimated payment. A health insurer must make the following information available to the general public in order to ensure that the subscriber or physician with an objective good faith estimate of: (1) the amount of the out-of-network benefit the health insurer would expect to pay for a particular elective medical service or services provided by the out-of-network physician to the subscriber, and (2) the amount for which the subscriber would still be financially responsible, assuming the health insurer paid the expected benefit amount. The health insurer must permit subscribers and physicians to request these estimates by e-mail or other electronic means. This disclosure must be provided in writing not later than one (1) business day after the health insurer receives the subscriber's or physician's request.

(d) Required Web site disclosure. A health insurer utilizing either a charge-based or non-charge based methodology to determine payment due an out-of-network physician must establish a Web site that can perform the following functions:

- i) Allow subscribers, prospective purchasers, and physicians to select medical services by CPT Code, physician specialty, and the zip codes for the areas where the services are sought;
- ii) The search result must clearly indicate the UCR charge amount at least the 50th, 80th, and 90th percentile in a given geographic area for a physician specialty;

- 1 iii) The Web site must advise users of the Web site to refer to applicable benefit
2 plan documents or the respective plan administrator for further information
3 concerning the applicable benefit plan, including, with respect to charge-based
4 out-of-network methodologies the percentile of the UCR that will be applied to
5 determine the applicable out-of-network benefit amount;
6
- 7 iv) The search result must also remind users of the Web site that they may be
8 financially responsible for the balance of the out-of-network physician’s retail
9 charges that exceed the amount paid by the health insurer;
10
- 11 v) The Web site must describe in a transparent manner the purpose of the website,
12 and its search function; and
13
- 14 vi) A description of the average percentage of an out-of-network physician’s
15 charge the user of the Web site will likely still owe even after the physician
16 receives the out-of-network benefit payment, so that the user will understand
17 what the user’s payment obligation will likely be as a percentage of usual,
18 customary, and reasonable charges. The usual, customary, and reasonable
19 charges must be calculated as provided in this Section VII for charge-based
20 methodologies.

21

22 (e) Manner of disclosures. The disclosure obligations required under A through D of
23 Section VII of this Act must be:

- 24
- 25 i) Made in easily understood language by subscribers and prospective
26 purchasers;
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- 28 ii) Made in a uniform, clearly organized manner;

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iii) Of sufficient detail and comprehensiveness as to provide for full and fair disclosure; and

iv) Updated as necessary to ensure that all disclosures required by this Act remain accurate.

(f) Required annual disclosures to the Department. Health insurers must annually disclose to the Department the information described in Section VII, (a) (1) through (5) and Section VII, (b) (1) through (5).

Section VIII. Physician fee schedule disclosure.

(a) A physician practice must maintain a current schedule of retail fees for the medical services that it typically provides;

(b) Prior to providing elective services to a subscriber, a physician practice that is not contracted with the subscriber’s health insurer must provide the subscriber with a copy of the physician practice’s most current fee schedule as it applies to the elective services that the physician practice expects to furnish to the subscriber; and

(c) A physician practice must disclose to any patient or prospective patient a copy of the practice’s retail fee schedule applicable to at least its one hundred (100) most commonly provided services by CPT code. The practice may make the required disclosure publicly available via hard copy, electronically or via a Web site.

1 **Section IX. Subscriber and physician appeal rights.**

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3 (a) Any subscriber or physician who disagrees with the information disclosed pursuant
4 to Section VII, (a) through (d) of this Act may appeal the health insurer's
5 determination.

6
7 (b) Any subscriber or physician that submits an appeal to the health insurer as provided
8 under this Section IX may request in writing from the health insurer any and all
9 information that was used to determine the information required to be disclosed
10 under Section VII (a) through (d) of this Act. The health insurer is responsible under
11 this Act for ensuring that the subscriber or physician receives the requested
12 information within 2 (two) business days of receiving the written request.

13
14 (c) A health insurer may not prohibit or in any way interfere with a physician's or
15 subscriber's ability to assist one another in making an appeal described in this
16 Section IX.

17
18 **Section X. Actuarial certification.**

19
20 (a) Any health insurer that offers a health insurance product purporting to provide in-
21 network and out-of-network coverage must disclose to the Insurance Commissioner
22 a written certification by an independent, professional actuary stating:

23
24 i) The difference in value for the purchaser between (a) the in-network coverage
25 without the out-of-network coverage, and (b) the in-network and out-of-
26 network coverage combined; and
27

1 ii) That the difference between (a) the premium that the purchaser will be
2 charged for in-network coverage without the out-of-network coverage, and (b)
3 the premium that the purchaser will be charged for in-network and out-of-
4 network coverage combined, reasonably reflects the difference in value
5 certified pursuant to Section X (a) (1).

6
7 (b) The certifications required by Section X (a) must be made in easily understood
8 language, in a uniform, clearly organized manner, and be of sufficient detail and
9 comprehensiveness as to provide for full and fair disclosure to an average
10 consumer. The difference between the value of the in-network benefit coverage
11 and the combined in-network/out-of-network coverage must be expressed terms of
12 a percentage, although use of a percentage alone will not be sufficient to satisfy the
13 obligations required by this Section X.

14
15 (c) The certifications required by this Section X must be made by a professional
16 actuary currently licensed in [*the state in which the insurance product is being*
17 *offered*] and currently certified [*by a nationally-recognized actuarial certification*
18 *organization*] who is not affiliated with the health insurer or any of its subsidiaries.

19
20 (d) The certifications required by this Section X must be updated annually and made
21 readily available to the general public.

22
23 **Section XI. Enforcement and remedies.**

24
25 (a) Investigation. Where the Department has reason to believe that a health insurer is
26 not compliant with the requirements of this Act, the Department shall:

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- 1 i) Require the health insurer to conduct a statistically valid survey of a sample of
2 physicians approved by the Department, within the same specialty or
3 subspecialty within the same five digit zip code with respect to services
4 identified by the Department using the services' CPT Codes;
5
- 6 ii) Require the health insurer to conduct a statistically valid survey of a sample of
7 subscribers who have received services within the prior three months from an
8 out-of-network physician;
9
- 10 iii) Interview the health insurer, subscribers, prospective purchasers, and
11 physicians; and
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- 13 iv) Any other requirements that the Department determines is necessary to ensure
14 compliance with the requirements of this Act.
15
- 16 (b) Remedies. A violation of this Act constitutes an unfair and deceptive act or
17 practice in the business of insurance. Where the Department has found or it is
18 otherwise determined that a health insurer has failed to meet any of the Act's
19 requirements, the Department shall perform the following:
20
- 21 i) Institute all appropriate corrective action and use any of its other enforcement
22 powers to obtain the health insurer's compliance; and
23
- 24 ii) Where the violation results in a subscriber's use of an out-of-network
25 physician, the health insurer must pay the out-of network physician's retail
26 charge(s) as indicated on the applicable claim form(s).

1 (c) Independent jurisdiction of the Attorney General. The Attorney General has
2 jurisdiction independent of the Department of Insurance to bring actions to enforce
3 the provisions of this Act.

4

5 **Section XII. Severability.** If any provision of this Act or the application thereof to any
6 person or circumstance is held invalid, such invalidity shall not affect other provisions of
7 applications of the Act which can be given effect without the invalid provision or
8 application, and to this end the provisions of this Act are declared to be severable.

9

10 *[Drafting Note: The Advocacy Resource Center (ARC) strongly advises that this model*
11 *bill be introduced in conjunction with the ARC's model bill requiring covered entities to*
12 *honor valid assignments of benefits].*