



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

MASSACHUSETTS MEDICAL SOCIETY COMMENTS REGARDING OUT-OF-NETWORK BILLING JUNE 30, 2021

The Massachusetts Medical Society (MMS) is a professional association of over 25,000 physicians, residents, and medical students across all clinical disciplines, organizations, and practice settings. The Medical Society is committed to advocating on behalf of patients, to give them a better health care system, and on behalf of physicians, to help them provide the best care possible. The Medical Society appreciates having the opportunity to participate in the listening sessions convened by the Executive Office of Health and Human Services (EOHHS), the Health Policy Commission (HPC), the Center for Health Information and Analysis (CHIA), and the Division of Insurance (DOI) as part of their charge to issue policy recommendations relative to out-of-network reimbursement.

The Medical Society strongly supports a comprehensive approach to the issue of out-of-network billing that protects patients from surprise out-of-network bills and establishes a fair reimbursement mechanism, which helps to maintain healthy negotiation in the physician-carrier insurance market such that out-of-network bills are reduced and health care costs are minimized. With those goals in mind, the Medical Society recommends that Massachusetts allow the federal No Surprises Act to take effect in the Commonwealth. Accordingly, the Medical Society urges EOHHS and the HPC to recommend the legislature to allow the federal law to take effect as scheduled on January 1, 2022 and to take the time to learn how our Commonwealth can best tailor a solution to fit our health care system's unique needs.

Most importantly, the No Surprises Act holds patients harmless from surprise out-of-network bills, leaving them responsible for only in-network cost-sharing amounts in situations of unanticipated out-of-network care. With patients out of the middle, this law provides a thoughtful process to provide reimbursement by first requiring insurers to pay physicians for their services and then requiring both parties to negotiate a fair price for out-of-network services if the initial payment is not appropriate. Only after 30 days of open negotiation, in cases where the parties are

unable to reach an agreement, either party may initiate an independent dispute resolution (IDR) process to determine the reimbursement rate. Critically, the impartial arbitrators in the IDR process are not permitted to consider usual and customary rates or billed charges in their determination of the reimbursement rate, nor can they consider payment rates of public payors, including Medicare, Medicaid, CHIP, and Tricare. The factors that may be considered help the arbitrator to consider circumstances that are unique to each particular case, such as, the complexity of the case, the training, experience, quality, and outcome measurements for the physicians, the market shares of the parties, and the Qualifying Payment Amount, which is based on the carrier's median in-network contracted rate adjusted over time increases in the Consumer Price Index. It is important to note that the parties may continue to negotiate throughout the IDR process, giving them additional time to come to agreement.

Importantly, this law is expected to save patients money by reducing out-of-network bills, outlying physician payments, and the cost of premiums. The Congressional Budget Office (CBO) has scored this legislation favorably, estimating that it will result in overall savings of greater than \$17 million over the next ten years, leading to a decrease in insurance premiums by 0.5 to 1 percent. While patients will be held harmless from surprise out-of-network bills, these additional cost savings—while not the central intent of the legislation—are all extremely beneficial to the Massachusetts health care system as a whole.

The Medical Society supports the federal law as a reasonable and fair compromise that entirely removes patients from surprise out-of-network billing while maintaining Massachusetts' healthy insurance market. This law is the result of lengthy, thoughtful, bipartisan negotiation, establishing a nationwide agreement on this complex issue. It was contemplated with the benefit of data and experience from various individual states' attempts at legislative fixes. Furthermore, the law accomplishes all that Massachusetts hopes for while providing mechanisms for successful implementation. While arbitration is not without costs, the benefit of payment that accurately reflects the costs appurtenant to health care services delivered under exceptional circumstances cannot be understated. It is for these situations that the IDR process will be most beneficial in determining fair reimbursement.

Attempting a state-level fix at this time would be unnecessarily duplicative and costly at a time when critical resources could be spent addressing other pressing access issues and fundamental inequities in the health care system exacerbated by the COVID-19 pandemic. Significant state

governmental resources would be required to create and administer a state-level system to resolve out-of-network billing disputes, with the potential outcomes of such a program largely speculative and highly debated. Instead, Massachusetts can use the federal law to glean important insight into how our Commonwealth's health care system will respond to various aspects of surprise billing law while dedicating critical time and resources to more pressing issues in our health care system. Our Health Policy Commission is well-suited to collect and analyze data on the impacts of the federal law, while our state is well-positioned to learn from this data and implement appropriate changes if they should eventually be needed.

Importantly, Massachusetts has a long history of high rates of in-network doctors and hospitals. We have a health care market where doctors and insurance companies are incentivized to contract. It is critical to retain that for our patients. A high level of contracting ensures quality reporting, credentialing, timely payments, and less administrative cost. Massachusetts needs a balanced out-of-network billing solution that maintains these beneficial aspects of a healthy insurance market. An inappropriately set benchmark for reimbursement may jeopardize this important equilibrium.

For that reason, it is important to reiterate that the Medical Society is not advocating for any solution that is based on billed charges. It is similarly imprudent to base reimbursement on the Medicare rate, a federal payment schedule that even the federal out-of-network billing law excludes from reimbursement consideration as inapt. Governor Baker issued an Executive Order using Medicare rates as the benchmark for out-of-network billing specific to COVID-19 services, which may have been appropriate for a public health emergency because it was administratively straightforward to implement on short notice for a very narrow portion of clinical care. In the longer term, however, Medicare rates are an inappropriate benchmark for out-of-network reimbursement; they are not a useful metric for the fair market valuation of health care services, as they fluctuate with the political whims of the federal budget. Moreover, Medicare rates have not kept up with inflation – comparing Medicare payments to inflation between the start of the RBRVS system in 1992 and 2016, Medicare payments have actually *decreased* by 53% .

Over time, establishing Medicare rates as the benchmark for out-of-network reimbursement will provide carriers with a ceiling for reimbursement, disrupting the fair market negotiation between physicians and insurers, which would give insurers undue leverage and little incentive to fairly negotiate with physicians. This imbalance may cause increased physician consolidation and

thereby reduce network access and create barriers to care for patients. Critically, such a reimbursement scheme would also financially burden the most susceptible hospitals in the Commonwealth, which are often relied upon most heavily by vulnerable patients. The entire health care system functions better for patients when payers and physicians agree on contracts. The aim of a sustainable out-of-network solution in the long-term is to maintain balance that ensures both sides are incentivized to negotiate and ultimately retain robust access to in-network providers.

Additionally, the No Surprises Act will ensure consistency in out-of-network approaches across all commercially insured plans and all employer, self-funded plans that are exempt from state insurance laws. This aspect is key to administrative simplicity considering that a significant percentage of the health plans in Massachusetts are ERISA plans. Moreover, this consistency will foster effective management of the health care market by promoting consumer protections, cost reductions, and uniform data collection for all health plan participants.

By allowing the thoroughly-considered federal law to govern out-of-network billing disputes in Massachusetts, patients will be protected from surprise medical bills, physicians will have appropriate processes for being fairly reimbursed, and our health care system will benefit from the market dynamics that incentivize carriers and providers to contract in good faith. Additionally, by not duplicating efforts already undertaken on the federal level, Massachusetts will be able to dedicate much-needed resources to more pressing issues for our health care system.

For the above reasons, the Medical Society strongly urges EOHHS, HPC, CHIA, and DOI to recommend that the legislature allow the No Surprises Act to take effect in Massachusetts while taking time to collect data on the impacts of the legislation in order to better tailor the best approach for our Commonwealth in the long term. We thank you for your consideration of our comments on this important issue and look forward to working with you to help craft solutions that best fit the needs of our patients.