MASSACHUSETTS

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Vice President
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April 6, 2016

David Seltz, Executive Director
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

RE: *Out-of-Network Billing: Special Informational Meeting*

Dear Director Seltz:

Blue Cross Blue Shield of Massachusetts (BCBSMA) appreciates the opportunity to offer comments as the Health Policy Commission (HPC) considers approaches to address the pressing issues of out-of-network costs and billing. BCBSMA has extensive experience dealing with this problem and we applaud the HPC's consideration of needed solutions through the joint meeting of the Committees on Cost Trends and Market Performance and Quality Improvement and Patient Protection.

Simply put, Massachusetts needs to implement additional safeguards on the receipt of out-of-network care and out-of-network billing so that we can protect patients and control costs. There are three critical elements, each essential to ensuring an effective plan: (A) consumer guidance on surprise billing scenarios; (B) banning patients being balance billed in specific situations; and (C) establishing maximum reasonable provider reimbursements for out-of-network services. All three issues must be tackled in a composite fashion, otherwise negative consumer and cost effects will occur.

A) Consumer Awareness

BCBSMA works hard to educate our members; our Member Service team ensures they are aware of the benefits and risks of out-of-network usage. We educate patients through a wide variety of communications, including benefit material, Explanation of Benefits forms, and other vehicles. BCBSMA is particularly proud of our leading work in Explanation of Benefits, with our recent work setting a market example of "plain English" consumer summaries.

While we continually work to ensure that our members can access a robust and high-quality network of providers to minimize care outside of the network, no network is all-inclusive and leakage results in added costs to the consumer and the system at large. In

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many instances of out-of-network usage, BCBSMA will hold the patient harmless for the cost of care and will then leverage the opportunity to further educate them on out-of-network use.

Additionally, BCBSMA's innovative payment models have established a platform where primary care physicians are engaged and direct patients to seek care from value-based providers, which would include usage of in-network providers. We regularly share reports and data with our provider organizations on the services their patients receive and identify opportunities to redirect care in instances where a patient may be at risk for seeing an out-of-network provider.

BCBSMA would support working with the HPC and other policymakers on further recommendations for additional consumer protections. For example, Massachusetts may wish to consider a recent New York law on insured member protections that sets forth specific "surprise bills" and "non-surprise bills" scenarios, including the reminder that a patient is not "surprise billed" when they choose to "receive services from a non-participating doctor instead of an available participating doctor".

B) Balance Billing

Effective balance billing prohibitions must protect patients. While BCBSMA already goes to great lengths to shield our members from balance billing, there needs to be a standard prohibition against balance billing, coupled with an appropriate payment rate, to truly address this problem.

While the HPC has focused on emergent situations, the same out-of-network issues often also exist in non-emergent scenarios. As the "next generation" of innovation continues in value-based plan designs including limited and tiered products, out-of-network usage and increased costs will continue to be a problem.

This is a complicated area requiring detailed study; in particular, Massachusetts should consider and discuss specific scenarios when effective balance billing protections may already exist or could be further implemented. In its consideration, it should analyze the effect of existing law on the marketplace, including relevant sections of MGL c. 176G and the ACA.

C) Establishing an out-of-network payment rate

Establishing an out-of-network payment rate would address many of the cost considerations for payers, patients, and the Commonwealth --- as both payer and the monitor of health care costs system-wide. For BCBSMA alone, Massachusetts out-of-network services total over $134 Million in 2015. This cost to the system could be dramatically decreased if an equitable rate is set for these services.

In setting a maximum reasonable price for out-of-network services, the HPC should adhere to several key principles. First, the overall impact should result in cost savings to consumers and have minimal additional administrative expense to both providers and payers. There should be a reasonable, transparent, and simple approach to applying a rate. Lastly, any rate should ensure that current network participation levels are at minimum maintained and optimally improved upon.

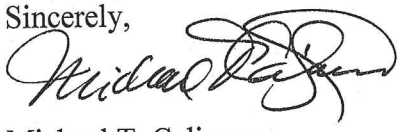
The HPC must ensure that any such rate does not inadvertently entice providers to leave a network. For a variety of reasons the normal insurance levers are not available in many instances of out-of-network services. For example, some out-of-network providers currently receive charges not controlled or regulated and can be set at any level. Incenting providers to further leave a network would cause significant increases in costs to the system and would seriously harm member access.

This protection is particularly critical for the incenting the robust networks necessary for novel insurance products that can offer lower cost options to the market.

We must stress that the cost impact of out-of-network providers affects payers' and the state's ability to meet the statewide benchmark. For some services, in fact, provider charges on average range between three to five times our in-network rate, and we have seen some cases where the charge is as high as one hundred times our in-network rate. When a health plan is forced to pay these levels to prevent balance billing of our members, there are significant cost impacts to the payer and the state as a whole.

These three key features are critical underpinnings of any plan of action. As you can see, they are also market-specific and merit further detailed analysis. We appreciate the opportunity to offer comments, and look forward to this further market-based dialogue. Please contact me if you have any questions in the meantime.

Sincerely,



Michael T. Caljouw

Cc: Dr. David Cutler, Chair of the Cost Trends and Market Performance Committee, Health Policy Commission

Martin Cohen, Chair of the Quality Improvement and Patient Protection Committee, Health Policy Commission