Murdo, Patricia

From: Bob Olsen <bob.olsen@mtha.org>
Sent: Tuesday, August 09, 2016 4:33 PM
To: Mazanec, Nick; Laslovich, Jesse
Subject: Comments on the draft arbitration legislation

Nick
MHA appreciates your efforts to establish a voluntary approach for arbitration of out-of-network balance bills. Please accept my comments on the proposal. After listening to the discussion at Monday's meeting I wonder if the payers and air transportation council members support this approach. Nonetheless, there are some areas that warrant comment. On page 1 there is a statement noting the balance bill problem is compounded by deficiencies in insurer networks with respect to air ambulances. I believe this continues to be the biggest problem for consumers. Montana hospitals with air companies all participate in insurer networks, and those without such services appear to be making reasonable efforts to call on network services when time allows. I continue to believe that insureds suffer from fully understanding the limitations they face when purchasing insurance products that they may face a problem having reasonable access to a network provider for transportation. It seems that a 'maybe they'll be available in time, or maybe not at all' is not adequate network presence.

As I testified earlier, national ERISA guidance provides for consumer protection when it is determined that the insured did not have reasonable access to a network provider. In those cases, the insured is protected from balance bills by limiting their financial exposure to the out of pocket caps, and the payer is responsible for the balance. I recommend that this determination of reasonable access to a network provider be included in Section 1 as a hold harmless for the beneficiary – even if the case does not go to arbitration. It should also be included as a factor for consideration by an arbitrator.

In Section 1, part 3 the air ambulance should not be barred from collecting, reporting or placing a lien on property for the deductible, coinsurance or copayments due outside of the balance bill. The language should reflect that those amounts can continue aside from balance bill amounts.
Section 1, part 4 falls short of providing a payment consistent with the ERISA guidance. This is important since the proposed language seems to say the payer must only offer its contract rate. As the payers noted they want to pay the 'market value' of the service, not the usual and customary amounts charged. The difference being the 'market value' described by payer is simply the amounts they've negotiated within network agreements. This is a departure from insurance practice, no doubt, but also seems to load the dice against the out-of-network service.

Part 6 defines emergency medical condition. The draft should include "(including severe pain)" to complete the definition.

New Section 2 part 1 states that the procedure shall be used to determine the 'usual, customary, and reasonable value of services'. Payers objected to this language, preferring to use the terminology "market value". As noted earlier, MHA does not support using network contracts as the definitive source of usual and customary, reasonable value. MHA supports retaining the language as proposed. Providers not holding network agreements do not also hold the benefits of network status, not stand in the same circumstances as those providers who have agreed to network pricing. In deference to payer concerns about the disparity of charges for services the language might reasonably include percentiles or some other limit to suggest a reasonable amount within the usual and customary charge by a provider.

In Part 3 I suggest you add language to allow the independent reviewer to determine whether the insured had reasonable access to a network provider. This should matter in the process to differentiate an insured who could have used a network provider, but chose not to do so, from one who did not have a reasonable chance to use a network provider.

We agree with other comment that public payers such as Medicare and Medicaid should be excluded from the determination of amounts accepted by air ambulance services.

At the end of Section 3 you reference 33-17-317. Is this a typo?

MHA heard the concerns insurers stated about ERISA-exempt plans not being subject to the proposed statute. We believe insureds covered by such plans do have recourse in that the out-of-pocket costs are limited when the insured did not have reasonable access to network providers. A referral to the US Department of Labor might be helpful for such insureds caught with balance bills. I believe the federal review would protect the insured in those cases.

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