



SENT VIA EMAIL

August 31, 2017

The Honorable Kevin Cahill
Chair, Health, Long-Term Care & Health Retirement Issues Committee
National Conference of Insurance Legislators
2317 Route 34, Suite 2B
Manasquan, NJ 08736

Dear Assemblyman Cahill:

On behalf of the 9,000 fellows and members of the American Association of Oral and Maxillofacial Surgeons (AAOMS), we commend the committee's leadership in the development of NCOIL's Out-of-Network Balance Billing Transparency Model Act by seeking a balanced approach to this complex issue.

Oral and maxillofacial surgeons (OMSs) are surgically and medically trained doctors of dental medicine (DMD) or dental surgery (DDS) who treat patients suffering from an array of dental, medical and surgical conditions that include facial trauma, temporomandibular joint disorders, third molar and other dental extractions and reconstructive procedures. Unlike most dentists, who are primarily office-based providers, OMSs are an integral part of trauma teams throughout the country and many perform complex procedures at hospitals. In addition, all OMS residents complete a minimum four-year hospital based residency.

As the committee moves towards finalizing this model act, AAOMS respectfully offers the following comments for consideration:

Section 4

The draft defines a "health care facility" as a "hospital, emergency clinic, outpatient clinic, birthing center, ambulatory surgical center, or other facility providing medical care, and which is licensed by [Insert appropriate state agency]." We understand the intent of this Act is to focus on larger surgical facilities, such as an ASC or hospital, where unexpected out-of-network bills are most likely to occur and that private practitioner offices are not intended to be included within this definition. However, in some states, individual OMS practices are licensed by the state and could unintentionally be included in this definition depending on how the model Act is implemented by the states. To avoid any undue burden on provider practices, which we specify later in this document, we request the committee amend this definition specifically to exclude private provider practices.

Also in this section, the Act defines "provider" as "an individual who is licensed to provide and provides medical care." As previously mentioned OMSs provide both medical and dental care services to patients. While dental insurance plans, as excepted benefits, are not included in the requirements of this Act, it is possible for OMSs to provide dental treatment that will be covered by medical insurance, especially in a trauma situation. To ensure that patients receiving medical care provided by OMSs is covered under this model Act, we suggest the phrase "medical care" be replaced by "healthcare services."

Section 5

Many of the issues related to out-of-network/surprise billing are the result of health benefit plans' attempts to narrow their provider networks. We commend the committee for empowering state commissioners to ensure health benefit plans maintain adequate provider networks. The method provided through this Act also allows each state to determine what is considered an adequate network for their individual state rather than utilizing a one-size-fits-all approach.

Section 6

We commend the committee for providing a method for out-of-network providers to be reimbursed at a reasonable rate. By providing reimbursement for 80 percent of a provider's usual and customary fee, the patient will only have to pay a reasonable amount, which is common for cost sharing in some insurance plans. We ask that the definition of "usual and customary rate" be amended to require a database such as FAIR Health be utilized for this benchmarking and that insurers only compare providers of the same specialty in the geographical area when determining the average rate of a service.

We are concerned with paragraph B, which allows a health benefit plan to waive this requirement if "it would pose an undue hardship upon a carrier." We request the committee clarify this statement and provide greater specificity as to what would constitute an undue hardship. As you can imagine, this vague statement could lead to significant confusion among all involved ultimately denying appropriate coverage for patients.

Section 7

While we appreciate the committee's intent to protect patients during emergencies, we request the committee consider additions that will add more clarity to this section. We request the committee specify the payment out-of-network providers should receive from health benefit plans in these emergencies. We would argue providers should receive their stated fee or at a minimum 80 percent of the usual and customary fee as outlined in Section 6.

Section 9

We appreciate the intent of paragraph C.2., which requires providers to present an enrollee with a written amount or estimated amount the provider anticipates billing the enrollee for non-emergency planned services. Many OMSs currently provide patients a pre-estimate of benefits or advance beneficiary notice; however, each case is unique. Despite prior planning and consultation, providers cannot know what treatment will be provided to a patient until the procedure is complete. Because of this, providers are not able to anticipate the final cost, as they have no way of knowing what will or will not be covered by insurers prior to the adjudication of a claim. Discussing this verbally with every patient also takes up valuable time in a patient's appointment. Instead, we recommend this be discussed only when requested by the patient.

We also have serious concerns with the disclosures required under paragraphs D and E of this section, as this information is not always available to the provider until the day a service is being provided. While an OMS may be able to provide information about any anesthesia, laboratory, radiology, pathology or assistant surgical providers that will be involved in a patient's treatment at a provider's office, OMSs are unable to provide this information for services provided at a hospital or ambulatory surgical center until the day of surgery and may even at that point be unaware of any additional treatment professionals (such as a pathologist) involved in the patient's care if they are not physically present in the operatory. As such, it is impossible to require a provider to disclose the names of these providers providing treatment at the time of scheduling. We recognize it is difficult for patients to ascertain this information as well, but it is unfair to place the notification burden on the treating practitioner. Instead, we recommend the committee consider requiring healthcare facilities to provide this notification.

Section 10

As previously mentioned, because the Act as currently drafted uses a broad definition of “health care facility,” services provided in a state-licensed private practitioner’s office could be affected by this section, which requires a number of onerous disclosure statements for an individual practitioner. Disclosures regarding facility charges and facility versus provider participation in a plan do not apply to a private practice. As such, private practitioner offices specifically should be excluded from the requirements of this section.

Section 11

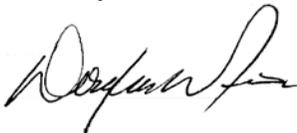
OMSs are licensed by the state Dental Boards. In addition, other providers such as CRNAs, may be licensed by someone other than the state Medical Board. As such, we suggest the committee amend Paragraph 5 to indicate that complaints may be filed with the “appropriate licensing board.”

Section 14

Accurate provider directories are essential for an enrollee to make informed decisions when selecting a provider. Without an accurate provider directory, enrollees are unable to determine correctly which providers are participating in their network plan and are not able to make informed decisions regarding the anticipated costs of treatment. We commend the committee for requiring provider directories to be provided in both print and electronic formats and that the electronic format is updated on a monthly basis. To insure the most accurate information is provided to an enrollee, we recommend the committee provide more specificity as to the frequency a carrier should audit its provider directories and that at a minimum all provider records are audited at least once in a calendar year.

Thank you for your committee’s thoughtful and thorough approach to addressing this important issue. We look forward to our continued efforts with NCOIL on this and future issues. Please contact Ms. Sandy Guenther of the AAOMS Governmental Affairs Department at 847-678-6200 or sguenther@aaoms.org if we can be of any assistance.

Sincerely,



Douglas W. Fain, D.D.S., M.D., F.A.C.S.
President