**Report to the CMS board of Directors on Out of Network legislation: Accepted for information by the CMS BOD: 1-18-19**

**Report from CMS Work Group on Health Care Costs & Quality**
At the November meeting the CMS board of directors approved a set of bill specifications recommended by the work group. The board also directed the work group to continue working on a minimum benefit standard (MBS). The work group met on December 17 for two hours on this issue and has subsequently continued the discussion on Basecamp. Getting a medical consensus on what that MBS ought to be has not been achieved yet. The opinions within the work group include:

- Those that want the MBS to be based on a percentile of billed charges;
- Those that support some hybrid of contracted rates and billed charges;
- Those that support a percentage of the highest in-network allowed amount for a particular service; and
- Those that support a percentage of the average in-network rate.

Without a medical consensus we can expect all of these opinions to be presented in public hearings.

**Capitol report**
There is a palpable interest from both sides of the aisle to solve the OON issue this session by passing a bill. During her inaugural speech the Speaker of the House referenced that the OON issue will be addressed to protect consumers this year.

There was a meeting at the state capitol with stakeholders on January 8, 2019, to discuss a draft OON bill supported by health plans and consumers. During that meeting several state representatives and senators commented that the meeting was the largest set of participants that they had seen at any stakeholder meeting. The sponsors of this bi-partisan legislation include: Representative Daneya Esgar (D-Pueblo), Senator Bob Gardner (R-Colorado Springs), and, Senator Brittany Pettersen (D-Denver). Senator Rhonda Fields, Chair of Senate Health Committee, attended as an observer.

Stakeholders were asked for comments on the proposed bill and CMS spoke clearly about physician concerns with the legislation as outlined. The main points of a current draft are detailed below.

It is clear that there will be a bill this session and there is political will to pass it from both sides of the aisle. While these bill sponsors will be open to hearing physician concerns, it is also clear that a percentile of billed charges as a minimum benefit standard (MSB) is off the table with these legislators. The bill's benchmark was called to the attention of the board. With this group of bipartisan sponsors, the parameters for adjusting the benchmark appears to be very narrow. Very preliminary conversations suggest CMS could have success by advocating for a reasonable multiplier of an in-network allowable amount tied to arbitration.

CMS is coordinating closely with interested specialty societies and the CPMG Section of CMS in an effort to enact a fair bill.

**Points of the draft bill:**

- Enforcement on health plans – Division of Insurance
- Enforcement on providers - District Attorneys
- Patient disclosures – Nonspecific disclosure left to agencies to develop (EMTALA violations)
- Benchmark - Greatest of: (A) Carrier's average in-network rate; (B) 125% Medicare; (C) 100 % APCD average in-network allowed amount. Taking providers from billed charges to previously rejected in-network amounts.
- Patient protections - Held harmless from balanced billing.
- Mandatory assignment of benefits - Included
- Plan/provider disagreement - Negotiation (independent providers have no negotiating power against a health plan.)
- Rules requirement - DOI/CDPHE/DORA
- Overpayment - 45 days with interest (requires maintenance of two processes)
- Data collection to define problem - Not addressed
- Arbitration - Not included