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Texas House Insurance Committee - Balance Billing and Out-of-Network Charges
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Comments from America's Health Insurance Plans
Presented by
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Thank you for the opportunity to be part of this discussion to provide some additional information on scenarios consumers and insurers are facing, and the actions being taken in the states. My name is Mara Osman and I represent America's Health Insurance Plans, a national trade association representing the health insurance community. AHIP's members, including those who provide coverage to Texans, offer health and supplemental benefits through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.

We've been invited to speak today on behalf of our member plans in Texas, which include most, if not all, of the insurers offering health insurance here. And we're here because the focus of today's hearing is something we are seeing become a greater issue nationwide, and thus of importance to all of us.

We'll start by outlining some **key considerations:**

- Hospitals as inpatient or outpatient facilities provide services to consumers, and consumers going to hospitals that participate in their health plans' networks expect the services provided during those stays or visits to be part of that participating providers services.

- Some hospital-based physicians are employees of the hospital, and some are not. Some may be independent contractors that work *at* the hospital, but not *for* the hospital. In fact, as that trend increases, both hospitals and insurers are finding some hospital-based physicians choosing to remain out of insurance networks.

- Out-of-network providers at hospitals are a key concern due to the fact that core services are provided during a hospital stay or visit. For example, by radiologists who read X-rays, scans and other tests, by pathologists who interpret lab results, and by

anesthesiologists or even emergency rooms physicians. These situations represent most of the "surprise billing" cases seen nationwide, because so often a patient who arrives at a hospital is in no condition to "shop around" for providers at the hospital who are part of their health plan network, and a majority of the time the patients do not even realize that certain services are being performed as part of their treatment.

- Heath insurers contract with facilities, physicians and other professional providers to assure consumers have access to coverage for more affordable health services, and protection from the unknown costs of balance-billing. And the costs of balance-billing by out-of-network providers can be unpredictable and sometimes extreme.

- **AHIP released a report in October 2015** – *Charges Billed by Out-of-Network Providers: Implications for Affordability* – that reviewed billed charges for 100 procedures using a national data base of charges, FAIR Health Inc.'s National Private Insurance Claims database. The report examined average out-of network billed charges and overall distribution of these data. I'll cite just a few procedures for you to think about:

    - In Texas, patients that underwent knee arthroscopy/surgery saw potential charges averaging more than 500 percent of the Medicare fee.
    - Some patients seeking emergency care faced potential excess charges averaging more than 600 percent of the Medicare fee.
    - And patients that underwent low back disk surgery incurred charges averaging more than 700 percent of the Medicare fee.
    - Most worrisome, potential charges for cervical/thoracic spinal injections averaged more than 1200 percent of the Medicare fee for the same procedure.

- The results of our out-of-network study underscore the importance of the need for consumer protections, and a consumer disclosure, if there are out-of-networks providers operating at a network facility.

- Consumers and employer groups benefit if hospitals and other facilities engage in good-faith efforts to ensure their hospital-based providers contract with the same networks that the hospital contracts with. This reduces, and can even prevent, the problem of surprise balance bills sent to consumers after discharge.

- Insurers depend on providers and other stakeholders to help protect consumers in these situations, and share the common interest of making coverage available and affordable to consumers. This is a multi-faceted problem that requires the engagement and commitment of multiple stakeholders to resolve it.

- **Any solution that would require insurers to pay charges would be ill-conceived**, and harmful to the overall health system, to hospitals, to consumers when premiums go up, and would provide the wrong incentive to those providers to not negotiate on charges, or contract with hospitals or insurers.

The out-of-network balance billing issues and costs facing patients, health plans and health care providers in Texas are not unique, and require thoughtful and balanced solutions.

Approaches to Resolving the Issue

We believe in a balanced approach that accomplishes three goals:

1. **Protect patients from bills they are not responsible for paying;**
2. **Provide for fair and reasonable payment to a non-contracted providers; and**
3. **Provide for a dispute process when providers feel they have not been accurately or adequately paid.**

- State approaches *should begin to address out-of-network balance billing issues by focusing on hospital-based non-contracting providers.*

- Out-of-network hospital-based providers' contract status should be disclosed to consumers. Providing more disclosure and education to the patient when they plan to utilize a facility will assist them in making decisions.

- States should consider several options to protect the consumers:

    - **Balance billing prohibition**:
      One avenue is through statute or regulation to provide options to out-of-network providers.
        A. Out-of-network providers can accept assignment of benefits from the consumer for the services supplied by the provider and agree not to balance bill the patients. The provider can then get a prompt payment of an in-network provider payment amount from the health plan. And consumers would be responsible for their co- payments. Again, here a provider should not be able to balance bill the patient.
        B. If out-of-network providers choose not to accept the assignment of benefits, then they also should not be able to balance bill the patient. These providers could receive the patient's co-payment and they could only charge patients an amount aligned with a benchmark payment amount set by the state.

      This is not unprecedented: 14 states have explicit prohibitions preventing non-contracted providers from balance billing enrollees in certain circumstances.

    - **Advanced Notice and Consent to OON Charges and Care**: This option would require providers to supply notice to patients - and signature received to ensure understanding - prior to a provider performing those out-of-network services, indicating that the providers may not be participating providers with the patient's health plan network and that the patient could be responsible for

any amount the provider decides to bill the patient over an amount a health insurance plan reimburses the provider for covered services.

- **Provide regulatory oversight for unfair billing patterns**. Another approach that could be taken to protect consumers would be to review patterns of balance billing or charges beyond copayments, coinsurance or deductibles when consumer protections have been enacted, and make a determination if there are excessive or unfair billing patterns that could prompt action by a state agency with jurisdiction.

- States could, and have also considered, establishing a binding independent dispute resolution process for providers and insurers to resolve disagreements in these cases, and it should be a process that takes the consumer out of the middle.

- With respect to fair and reasonable payment, states should consider benchmarks for payment to non-contracted providers, such as average contract rates or a percentage of the Medicare rate. For example, for emergency services, the rate of payment to hospital-based non-contracted professionals should be the greater of these three possible amounts, excluding any in-network copayment or coinsurance imposed with respect to the enrollee:
    1. The amount negotiated with in-network provider for the emergency services furnished;
    2. The amount for the emergency service calculated using the same method the plan generally uses to determine the usual, customary, and reasonable payments for out-of-network services; or
    3. The amount that would be paid under Medicare for such services (Part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.).

Other States' Experiences:

There are various models that are being tried around the nation to address out-of-network services and payment:

- In Illinois and Florida, the state has tried to institute a provider dispute process that has had limited and varied success. This year, Florida expanded its law to cover PPOs as well as HMOs.

- New York passed a law that went into effect in April 2015 that requires a provider dispute process through binding arbitration for certain "surprise" bills.

- New Jersey previously had a requirement to have insurers pay billed charges in these scenarios, but is currently working on legislation to address that unsustainable approach. We note that New Jersey's health insurance premiums are some of the highest in the United States, in part due to this problem.

- In 2016, Connecticut enacted an omnibus health care bill that requires carriers to reimburse out-of-network services at the in-network rate under the plan as payment in

full, unless the carrier and provider agree otherwise. The bill also defines a "surprise bill" for non-emergency services by an out-of-network provider at an in-network facility when the insured did not knowingly elect to receive the services from the out-of-network provider.

These models are an attempt to resolve the issues and indicate that this issue is important, and that hospitals, too, are also concerned about their ability to manage these provider scenarios. In 2016, at least 20 states (CA, CO, FL, GA, CT, HI, LA, MD, MA, MN, MS, MO, NH, NJ, NY, OK, PA, RI, SC, and TN) have considered legislation regarding out-of-network reimbursement.

The National Association of Insurance Commissioners (NAIC) Has Also Focused on this Issue

In November of 2015 an update to the NAIC model on network adequacy was unanimously adopted. The update contains an approach to address the issue of out-of-network charges, which was developed in coordination with stakeholders across the healthcare industry.

It can be found in "Section 7. Requirements for Participating Facility Providers with Out-of-Network Facility-Based Providers" and it includes:

- A notice provision required of both the participating facility, and out -of-network providers working at that facility to disclose that health professionals involved in the care delivered at the facility may be performed by non-contracted providers;

- A requirement that if an out-of-network facility-based provider bills a patient, that provider must notify the patient of their right to:
    - Co-pays and cost-sharing as if in-network,
    - Choose to pay the balance billing, or
    - (if the amount is over $500) send the bill to their health care plan for processing using the benchmarked payment process, or
    - Request a provider mediation process, or
    - Exercise their right to appeals available in the state

- A limitation on balance billing the patient in the above scenarios;

- A process where the states establish a benchmark for insurer payments;

- A provider mediation process that is established in accordance with one of the national mediation standards; and

- An enforcement provision.

This new language was supported by consumer groups, insurers and regulators. And we note that the American Hospital Association (AHA) supported the new language in a comment letter (dated September 22, 2015) stating, *"The AHA supports the proposed revisions, which would*

create a balanced solution amongst providers, health plans and hospitals to better protect the consumer from unexpected bills."[1] We agree.

Since adoption, multiple states have begun looking into enacting provisions of the NAIC Model Act.

Closing

As you continue these important discussions, it will be critical to identify what the key problem is in Texas, how widespread it is, and to develop solutions to prevent and handle it so consumers are not put in the middle of payment disputes.

As noted previously, any solutions will have to carefully provide protection for consumers without creating increased care costs, avoid creating disincentives for providers to participate in networks, unreasonable paperwork for providers and insurers, or one-sided solutions.

Thank you for considering our views today. I'm happy to answer any questions you may have.

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1 *http://www.naic.org/documents/committees_b_rftf_namr_sg_related_aha_cover_letter_and_suggested_model_revisions_09_22_15.pdf*