



Out-of Network

Background

The debate over controlling rising out-of-network costs to the healthcare system is occurring across the country. Over the past decade, New Jersey has attempted to address the issue through piecemeal regulations and guidance documents. Examples of these actions taken by the Department of Banking and Insurance (DOBI) include:

- *Effective May 1, 2000: N.J.A.C 11:24-9.1 (d)(9)* requires that an HMO must include in a patient's statement of rights the right to be free from balance billing by providers for medically necessary services that were authorized or covered by the HMO except as permitted for copayments, coinsurance and deductibles by contract;
- *Effective March 17, 2008: N.J.A.C. 11 :24-5.3(B)* requires that HMOs limit a member's liability for emergency care rendered by non-participating providers, including ambulances, to the network copayment, deductible or co-insurance;
- *Effective May 1, 2000: N.J.A.C. 11:24-5.1 (a)* requires that an HMO that refers a member to a non-participating provider is fully responsible for payment to the provider and the member's responsibility is limited to the network copayment, coinsurance or deductible.¹

The out-of-network issue was brought back to the forefront with the signing of an “assignment of benefits” (AOB) law (P.L. 2009, Chapter 209) by Gov. Jon Corzine on one of his last days in office. This NJHA initiative, later amended to address some of the concerns of the insurance industry, requires insurance companies to issue checks paying for services rendered to both the out-of-network provider and the patient when the patient seeks services outside of a carrier’s network. The law helps to remedy a common practice of insurance companies remitting their share of the payments directly to the patient and requiring the provider to seek the full payment from the patient.

During tense debates over this bill, Assemblyman Gary Schaer, chairman of the Assembly Financial Institutions and Insurance Committee, explicitly acknowledged that the AOB issue is only part of the problem of out-of-network costs and attempted to address it in the 2010 – 2011 legislative session. NJHA participated in a series of roundtable discussions comprised of various stakeholders in the healthcare community to seek a common ground on the issue.

¹ DOBI has interpreted these regulations to mean that in cases of emergency care rendered by an out-of network provider, or where the HMO has referred a member to an out-of-network provider, it must pay the out-of-network provider a benefit large enough to ensure that the provider does not balance bill a member for the difference between billed charges and the payment to the provider by the insurer. Thus, in such circumstances, payers have been required to reimburse out-of-network providers up to their actual charges.

After NJHA successfully stopped the bill in the Assembly Financial Institutions and Insurance Committee last year, Assemblyman Schaer introduced A-2751 in May 2012 to remedy the out-of-network problem.

NJHA was successful in mitigating the impact of the legislation by removing any language of a fee schedule, or any onerous disclosure requirements. A-2751 was reported out of the Financial Institutions and Insurance Committee with amendments and is currently on second reading in the Assembly. Currently there is no Senate sponsor on the bill.

In addition to the Legislature's desire to act on the issue of out-of-network payments, the newly elected Christie Administration also expressed a need to address this issue. When testifying in opposition to the AOB legislation, DOBI stated that "The cost of-out-of network (OON) claims has been one of the main drivers of recent increases in premiums," and urged the committee to "refrain from releasing this bill until it seriously considers simultaneously implementing some cost containments such as a fee schedule or other limitations on both emergency and non-emergency OON claims."² Furthermore, the Subcommittee on Health of the Christie transition team recommended that the Administration "should explore placing a cap on OON charges and should prohibit the waiver of member liability."³ The subcommittee for DOBI echoed these sentiments by noting that the state must take a strong look at ways to contain the "burgeoning issue" of out-of-network insurance costs. According to the subcommittee report, possible solutions that should be examined are:

- Imposing a fee schedule for out-of-network costs;
- Setting up a dispute resolution system outside of the current arbitration system to impose a greater degree of cost effectiveness; and/or
- Re-examining how carrier and providers negotiate contracts to find a method that will encourage greater in-network participation while providing adequate compensation for services.⁴

As it became apparent that either the Administration or the Legislature would work to limit the payments to OON providers in the 2010 – 2011 legislative session, NJHA staff provided informative updates on the issue to both the NJHA Board of Trustees and Policy Development Committee throughout 2011. At a recent meeting, the Board advised staff to re-examine the nationwide landscape regarding OON payments to present and analyze trends throughout the country. Below are our findings:

Trends

Some states have decided to take the issue of out-of-payments head on. Although from the initial research it appears that a majority of states do not have firm policies regulating OON payments, there are growing trends throughout the country that must be examined. Some states (particularly California and Texas) overlap in various categories through omnibus pieces of

² Jan. 2009 Linda Schwimmer DOBI Summary of Department of Banking and Insurance Position on A.132

³ David Knowlton Governor-Elect Christopher Christie Transition Memorandum – Sub-Committee on Health Jan. 5 2009

⁴ DOBI Transition report Jan. 5, 2010 Edward Deutsch

legislation. It is also worth noting that much has been written and enacted regarding Medicaid HMO requirements, as well as emergency balance billing requirements. However, the following trends are focused on OON hospitals and OON hospital-based providers as it applies to the commercial market and non-emergent balance billing practices.

Caps and Balance Billing Practices

Some states have proposed placing a cap on the reimbursement levels for OON charges. For example, in Maryland, where rate-setting exists, hospitals are subject to the rate requirements established by the Health Services Cost Review Commission (HSCRC). Other providers are paid at a capped rate as a percentage of Medicare. California has attempted rate-setting, but instead follows a very complicated triggering system for payments.

- Maryland – Since 1971, hospitals have been paid by rate setting under the authority of the HSCRC. Recent legislation (§Health General §19-710) clarified that hospitals should be paid based on the HSCRC, and physicians should be reimbursed for OON services at 125 percent of the Medicare level. As an exception, trauma physicians are paid at 140 percent of the Medicare rate.⁵
- California (*AB 1455*⁶) – Over the past 10 years, California has been on a rollercoaster ride with its own healthcare reform efforts. Although there have been many attempts to establish an OON fee schedule based on various levels of the Medicare rate, there is still no rate-setting in California. However, a guidance letter that followed AB 1455 in 2005 has served as a de facto way of addressing out-of-network payments. Commonly known as the *Gould* criteria, the guidance document sent to payers stated that they will not enforce punitive actions against payers for certain OON practices so long as the state they meet the following criteria when reimbursing OON providers. Payments must be:
 - ✓ Determined by a methodology based on the 50th percentile or higher of an aggregated billed charge database;
 - ✓ At least 110 – 120 percent of the payer’s in-network rate for similar services;
 - ✓ Equal to or greater than the Medicare rate for that service.⁷

Other states have taken a consumer-based approach by ensuring that consumers are held harmless from balance billing practices by OON providers within in-network facilities. In New Jersey, patients are protected from balance billing by these providers for emergency situations, thereby putting the onus on carriers to ensure that they pay a “fair” rate to the providers for

⁵ <http://law.justia.com/codes/maryland/2005/ghg/19-710.1.html>

⁶Regulations see: CA Code of Regulations Section 1300.71(a)(3)(B) of Title 28

Guidance Document see: Department of Managed Health Care, September 2, 2005

⁷See full criteria here: “A payment methodology based on the 50th percentile or higher of a statistically credible aggregated billed charge database, updated (at least) annually, for the relevant geographic area; and A payment methodology based on an amount at least 10%-20% above the payor’s average contracts rates for similar services; and A payment methodology based on an amount above the current Medicare fee schedule for similar services (unless the payer demonstrated that the payer’s average contract rates for similar services is 10%-20% less than the current Medicare fee schedule); and Adequate procedures to timely and fully consider the remaining “*Gould*” criteria upon the provider’s submission of relevant supporting documentation as part of either the original claim submission or the payer’s appeal process/dispute resolution mechanism.”

services rendered. A few states have applied this mechanism to all services rendered by OON facility-based providers, including non-emergent cases.

- Colorado (§10-16-704(3), C.R.S.) – A 2006 law that was recommended for reoption requires insurance companies to hold consumers harmless from balance billing practices for all care delivered by an out-of-network provider in an in-network facility. The success of the law is detailed in a 2010 report by the Colorado Commissioner of Insurance.

“Over the last three years, some carriers have found ways to negotiate with out-of-network providers and keep out-of-network billed charges for in-network services at reasonable rates, without balance billing consumers. Other carriers continue to feel that §10-16-704(3), C.R.S., puts carriers at the mercy of providers...”⁸

- Illinois (*Public Act 096-1523*) – Recent legislation was signed in Illinois to ensure that consumers utilizing OON care in an in-network facility are not liable for out-of-pocket costs greater than the in-network requirement.

“When a beneficiary, insured, or enrollee utilizes a participating network hospital or a participating network ambulatory surgery center and, due to any reason, in network services for radiology, anesthesiology, pathology, emergency physician, or neonatology are unavailable and are provided by a nonparticipating facility-based physician or provider, the insurer or health plan shall ensure that the beneficiary, insured, or enrollee shall incur no greater out-of-pocket costs than the beneficiary, insured, or enrollee would have incurred with a participating physician or provider for covered services.”

Alternative Dispute Resolution (Arbitration / Mediation)

Some states have enacted laws to require binding arbitration or mediation in to encourage facility-based providers and payers to agree to a contract. Some states, such as Illinois, require the provider and payer to enter into binding arbitration if an agreement on payment is not made within 30 days. Other states, such as Texas, permit a consumer to initiate mediation if that person is the result of balance billing by a non-participating provider in a hospital.

- Illinois (*Public Act 096-1523*) - “If attempts to negotiate reimbursement for services provided by a nonparticipating facility-based provider do not result in a resolution of the payment dispute within 30 days after receipt of written explanation of benefits by the insurer or health plan, then an insurer or health plan or nonparticipating facility-based physician or provider may initiate binding arbitration to determine payment for services provided on a per bill basis. The party requesting arbitration shall notify the other party arbitration has been initiated and state its final offer before arbitration. In response to this

⁸ <http://www.dora.state.co.us/Insurance/legi/2010/consParNonPar01212010.pdf>

notice, the nonrequesting party shall inform the requesting party of its final offer before the arbitration occurs. Arbitration shall be initiated by filing a request with the Department of Insurance.”

- Texas (*House Bill 2256*) – A 2009 law gives patients the opportunity to enter into mediation when they are balanced billed for an OON claim if two criteria exist:
 - ✓ The patient is responsible for a payment greater than \$1,000 to a facility-based physician after paying all deductibles, co-payment and coinsurance;
 - ✓ The facility-based physician provided the services in a participating hospital.

Independent Databases / Consumer Disclosure

Some states either through litigation (New York) or legislation (Texas) have established an independent claims database to collect aggregated billed charges from providers to use as markers for reimbursement levels. New Jersey currently has two pieces of legislation, A-2096 (Conaway) / S-1539 (Vitale) which would establish a claims database in New Jersey to be operated by a college or university (not Rutgers).

- New York – In 2009, Attorney General Andrew Cuomo sued UnitedHealth Group for the operation of its subsidiary Ingenix, which was used to determine rates to OON providers. As a result, a new independent database called FAIR Health, Inc. was launched earlier this year.⁹ This new database is based on the best available data, analyzed and organized by experts in the field. A simplified version of information from FAIR database is posted online so doctors and patients can see the so-called usual, customary and reasonable rates.
- Texas (*SB 1731*) - A section of SB1731, as enacted, requires the collection and publication of data on reimbursement rates of health plans paid to healthcare providers, aggregated by geographical region. This publication is not permitted to identify any healthcare provider or health plan by name. The statute specifies that the Texas Department of Health may publish this on its web site, but does not mandate any particular form of publication. As currently provided for in the informal draft, information will be aggregated using Public Health Service Regions of the state (there are eight such regions in Texas). As permitted by the statute, the Texas Department of Insurance (TDI) plans to publish the data it collects on the department’s web site. Consumers will be able to use their zip code to find geographically relevant data on the TDI web site. Most of the provisions of SB1731 are meant to ensure transparency in billing.

In the same law, Texas also requires network and payment disclosures to consumers. New York is considering something similar.

- Texas (*SB 1731*) - Healthcare facilities and private physicians are required to develop, implement and enforce written policies for billing and to conspicuously post a notice of the availability of these policies in waiting areas. Patients must be informed of any

⁹ <http://www.fairhealthus.org/>

possible discounts, if late payments will incur interest, and how to file complaints about services. Patients may request from a physician an estimate of the cost of proposed services including out-of-pocket cost, due within 10 days of the request. A similar request by a patient choosing elective inpatient services or nonemergency surgery must be honored by a hospital within 10 days, as must a request of a patient's health plan regarding what the plan will cover. The statute requires health plans to clearly identify in their physician directory or web site the hospital-based physicians who are covered and not covered by the plan. When a patient enters a hospital that is part of their plan's network, the patient must be notified of the possibility that some physicians at that facility are not covered by the plan, and that these physicians may bill the patient directly for services. Health plans also must include in a patient's explanation of benefits when the plan has paid an out-of-network physician.

- New York (S5068¹⁰) – This bill as proposed would “require a health insurance company to disclose to its subscribers and enrollees a description of its methodology for reimbursing healthcare treatment by physicians not participating in the plan's network...” as well as “disclose anticipated out of pocket costs for specific healthcare services received on an out-of-network basis.” In addition to this piece of legislation, New York also is considering proposing regulations in 2012 to promote consumer disclose and limit balance billing.

Conclusion

As the debate continues to grow over controlling rising out-of-network costs within our healthcare system it is apparent that reform is needed. New Jersey must consider innovative ways to reduce the rising costs and provide relief to patients.

¹⁰ Pending in Health committee